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MARK TWAIN
HEALTH CARE DISTRICT

P. O. Box 95
San Andreas, CA 95249
(209) 754-4468 Phone
(209) 754-2537 Fax

Meeting of the Board of Directors
Wednesday March 27, 2019
7:30 am
Mark Twain Medical Center Classroom 2
768 Mountain Ranch Rd,
San Andreas, CA

Agenda

Mark Twain Health Care District Mission Statement

"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. **Call to order:**
2. **Roll Call:**
3. **Approval of Agenda:** Action
4. **Public Comment on matters not listed on the Agenda:**

   The purpose of this section of the agenda is to allow comments and input from the public on matters within the jurisdiction of the Mark Twain Health Care District not listed on the Agenda. (The public may also comment on any item listed on the Agenda prior to Board action on such item.) **Limit of 3 minutes per speaker**. The Board appreciates your comments however it will not discuss and cannot act on items not on the agenda.

5. **Consent Agenda:** Action

   All Consent items are considered routine and may be approved by the District Board without any discussion by a single roll-call vote. Any Board Member or member of the public may remove any item from the Consent list. If an item is removed, it will be discussed separately following approval of the remainder of the Consent items.

   A. Un-Approved Minutes:

   - The Finance Committee Was Unable to Meet in February:
   - Un-Approved Special Board Meeting Minutes for February 6, 2019:
   - Un-Approved Board Meeting Minutes for February 27, 2019:

6. **MTHCD Reports:**

A. President's Report:……Ms. Reed

- **Association of California Health Care Districts (ACHD):**
- **Board Self-Assessment:**

B. Chief Executive Officer's Report: ……..……..……..……..Dr. Smart

- **VS H&W Center - Draft Policies:** Action

1. DRAFT Universal Precautions
2. DRAFT STERILE SUPPLIES AND INSTRUMENTS
3. DRAFT Sterile Shelf Life
4. DRAFT STERILE FIELD
5. DRAFT Infection Control – Overview
6. DRAFT INFECTION CONTROL
7. DRAFT HAZARDOUS WASTE
8. DRAFT Handwashing 112018
9. DRAFT Fit Testing 112018
10. DRAFT Exposure Control Plan
11. DRAFT Exam Table and Exam Room Cleaning and Disinfecting 112018
12. DRAFT Contagious Patient 112018
13. DRAFT CLEANING DUTIES
14. DRAFT Blood Borne Pathogen Exposure 112018
15. DRAFT Biohazard Material Management 112018
16. DRAFT Aseptic Procedures 112018
17. DRAFT Medical Assistant Scope of Practice 111918
18. DRAFT Information Technology Rules of Use 111918
19. DRAFT ePHI Policy 111918
20. DRAFT Demonstrated Competency 111918
21. DRAFT Marketing Policy 111218
22. DRAFT Compliance Policy 111218
23. DRAFT Volunteer Deployment 111918
24. DRAFT Unscheduled Downtime of Electronic Medical Record 111918
25. DRAFT Transfer Of Patient To A Hospital 111918
26. DRAFT Threatening or Hostile Patient 111918

- **Strategic Plan Matrix (Last Updated 3-19-2019):**
- **MTMC Amended Parcel Map:**

C. Corp. Board Report:……Ms. Reed / Ms. Atkinson

D. Stay Vertical Calaveras:……..Steve Shetzline

E. Ad Hoc Real Estate: ……..……..……..……..……..Ms. Reed / Ms. Al-Rafiq

- **Update on the Valley Springs Health & Wellness Center**:……..……Dr. Smart
  - Construction:……..……Dr. Smart
    - Project Manager:……..……..Pat Van Lieshout
  - Operations and Development:……..……Dr. Smart
    - VS H&W Center Manager:
    - Employee Benefit and Wages:
- **Update on Valley Springs Property - Phase II**:……Ms. Reed / Ms. Al-Rafiq

7. Committee Reports:

A. Finance Committee:……..……..……..……..……..Ms. Atkinson / Ms. Radford

- Financial Update:……..……..……..……..……..……. Mr. Wood
- Financial Statements (Feb. 2019) Recommendation-Approval: Action……...Ms. Atkinson
- Investment Activities:……..Mr. Wood
- Community Member: Action:……..……..……..……...Ms. Atkinson

B. Ad Hoc Lease Review Committee:……..……..……..……...Ms. Reed / Ms Atkinson

- Bylaws – Oversite Committee: Action……Dr. Smart

C. Ad Hoc Policy Committee:……..……..……..…Ms. Atkinson / Ms Al-Rafiq

D. Ad Hoc Community Grant:……..……Ms. Radford / Ms. Sellick

- Recommendation for Awarding Grants:

8. Board Comment and Request for Future Agenda Items:

A. Announcements of Interest to the Board or the Public:

9. Next Meeting:

A. Wed. April 24, 2019

10. Reconvene to Open Session:

A. Report of Action taken (if any) in Closed Session:

11. Adjournment: Action:

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MARK TWAIN
HEALTH CARE DISTRICT

P. O. Box 95
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Special Meeting of the Board of Directors
Wednesday February 6, 2019
3:00 pm
Mark Twain Medical Center - Classroom 5
768 Mountain Ranch Rd
San Andreas, CA

Un- Approved Minutes

Mark Twain Health Care District Mission Statement
"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. Call to order:

The meeting was called to order by Talibah Al-Rafiq at 3pm**.**

2. Roll Call:

Present for roll call was Ann Radford, FNP: Debbie Sellick, CMP and Talibah Al-Rafiq. Absent were Lin Reed, MBA OTR/L; Susan Atkinson, MSW.

3. Approval of Agenda: Action

Ms. Radford moved to approve the agenda. Ms. Sellick provided her second and the motion passed 3-0.

4. Public Comment on matters not listed on the Agenda:

Hearing none.

5. Cejka Search - Physician Recruiting Contract: Action

Dr. Smart by phone: Thanked the Board members for making this meeting a priority at such short notice. He described the Cejka Search (Physician Recruiter) contract (in the Board pkt) to the Board as; having met Tom Hoecker, VP of the organization; the organization is well known in the rural areas of CA; the contract before the Board is a second version and he intends to negotiate additional items per Board approval; he also explained the need for three but prefers to open the VS H&W Center with five physicians; given an average of a 154 day search he feels the need to begin the search immediately; this expenditure was an unknown during the budget process however it will not put the

District in jeopardy; he answered questions and explained the difference in a Cejka search vs the District finding a suitable fit.

Ms. Radford moved to approve the contract as presented and to give authorization for Dr. Smart, CEO to negotiate additional items as necessary before executing the final agreement. Ms. Sellick provided her second and the motion passed 3-0.

6. Board Comment and Request for Future Agenda Items:

A. Announcements of Interest to the Board or the Public:

Herring none.

7. Next Meeting:

A. Wednesday. February 27, 2019

8. Adjournment: Action:

Ms. Sellick moved to adjourn the meeting at 3:14pm. Ms. Radford provided her second and the motion passed 3-0 to adjourn.

MARK TWAIN
HEALTH CARE DISTRICT

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Meeting of the Board of Directors
Wednesday February 27, 2019
7:30 am
Mark Twain Medical Center Classroom 2
768 Mountain Ranch Rd,
San Andreas, CA

Un- Approved Minutes

Mark Twain Health Care District Mission Statement

"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. Call to order:

The meeting was called to order by President, Lin Reed at 7: 32am.

2. Roll Call:

Present for roll call was Lin Reed, MBA OTR/L; Susan Atkinson, MSW; Debbie Sellick CMP and Talibah Al-Rafiq. Ann Radford, FNP was absent.

3. Approval of Agenda: Action

Ms. Al-Rafiq moved to approve the agenda. Ms. Atkinson provided her second and the motion passed 4-0.

4. Public Comment on matters not listed on the Agenda:

Hearing none.

5. Consent Agenda: Action

A. Correspondence:

- Stay Vertical Calaveras Thank You - Tina Karratti (Feb. 12, 2019)
- Stay Vertical Calaveras Thank You - Patty Pierce (Feb. 13, 2019)

B. State Controller Financial Transaction Report 1-30-2019

C. Un-Approved Minutes:

- Un-Approved Special Finance Committee Meeting Minutes for January 16, 2019
- Un-Approved Special Board Meeting Minutes for January 30, 2019

Ms. Atkinson moved to approve the Consent Agenda. Ms. Sellick provided her second and the motion passed 4-0.

6. <u>MTHCD Reports:</u>

A. Presidents Report:

- **Association of California Health Care Districts (ACHD):**

Ms. Reed: Mentioned the ACHD materials in the Board pkt. and suggested the Board consider future webinars. She will be attending a Board Leadership Retreat.

Ms. Reed: Announced the Executive Director position has been upgraded to CEO (effective 1-30-2019)

B. Executive Director Report: ……..……..……..……..……..Dr. Smart

- **VS H&W Center - Draft Policies:** Action

1. **DRAFT Standardized Procedure for Visual Acuity Testing 111118**

Amend (pkt. pg. 35 last paragraph, first sentence) Change the word "of" to read "for". Staff to consider combining with (pkt. pg. 51) DRAFT Visual Acuity.

2. **DRAFT Standardized Procedure for Urinalysis 111118**

Amend (pkt. pg. 36, Procedure: third paragraph) to read the "website link"…..

3. DRAFT Standardized Procedure for Strep A 111118
4. DRAFT Standardized Procedure for Pulse Oximeter 111118
5. DRAFT Standardized Procedure for Pregnancy Testing of Patients on Contraception 111118
6. DRAFT Standardized Procedure for Physical Examinations 111118
7. DRAFT Standardized Procedure for Hemoglobin Assessment 111118
8. DRAFT Standardized Procedure for Glucose Testing of Diabetic Patients 111118
9. DRAFT Standardized Procedure for Childhood Health Screenings 111118
10. DRAFT Standardized Procedure for Administration of Flu Shots 111118

11. **DRAFT Withdrawal of Care 111218**

Amend (pkt. pg. 50, item 11. first paragraph, last line) to read "after utilizing this policy".

12. DRAFT Visual Acuity 111218

Staff to consider combining with (pkt. pg. 35) DRAFT Standardized Procedure for Visual Acuity Testing.

13. DRAFT Venipuncture 111218

14. DRAFT Vaccine Administration 111218
Amend (pkt. pg. 58, item h.) the word "temperature" is duplicated.

15. DRAFT Urine Collection Clean Catch Male 111218
16. DRAFT Urine Collection Clean Catch Female 111218

17. DRAFT Urinary Catherization 111218
Item pulled to add confirmed consent. Amend (pkt. pg. 63) remove 4. "i" (there's no content).

18. DRAFT Telephone Request for Medical Advice 111218
Item pulled - add nurses can get medical advice.

19. DRAFT Splints Ace Wraps 111218
Amend (pkt. pg. 66 Item 4. a. first line) remove "a" to read "Place cotton or gauze"….

20. DRAFT Sensitive Services 111218

21. DRAFT Shelter in Place for Patients and Staff 111918
Amend (pkt. pg. 69 Item 2.e. i.) Change room numbers to "X".

22. DRAFT Patient with Urgent Complaint or Distress 111918
23. DRAFT Operation During Internal Disaster 111918

24. DRAFT Medication Management Response to Power Failure 111918
Clarify (pkt. pg. 75 item 7.) Is contact information correct or should it read "X" for now?

25. DRAFT Mass Casualty Response 111918
Amend (pkt. pg. 77 Item 6.) the word "building" is duplicated. (Item 8.) City of Soledad is incorrect. Adjust spacing within paragraph.

26. DRAFT Initial Patient Contact and Medical Emergencies 111918
27. DRAFT Fire Safety 111918
28. DRAFT Extreme Temperatures 111918

29. DRAFT External Hazmat Incident 111918
Amend (pkt. pg. 87 Item 7.) Word "take" should read "tape". Verify info is current and add mask information.

30. DRAFT Emergency Situation Unresponsive Patient 111918
Amend (pkt. pg. 90 Item f.) Should read "Clinical" Director.

31. DRAFT Earthquake or Weather Emergency 111918
Amend (pkt. pg. 91 Item 1. A. iii. Strike "(north west parking lot as designated)".

32. DRAFT Natural Gas & Disruption of Electrical Service 111918
Amend (pkt. pg. 92 Items vi., viii., ix.) Replace Administrator with "Clinic Director". (pkt. pg. 93 pulled to access generator language.

33. DRAFT Disaster Plan 111918

34. **DRAFT Disaster - Water Contamination 111918**

Amend (pkt. pg. 96 Item 3. b.) Change to read "Mar-Val" instead of "Albertson" Grocery Store.

35. DRAFT Cardiopulmonary Resuscitation-Code Blue 111918

36. **DRAFT Bomb Scare 111918 (pkt. pg. 78 is a duplicate of pg. 99)**

Amend (pkt. pg. 99 Item 4.) Change to read …."serious injury "of" many innocent people". Staff to review "code" language.

37. DRAFT Bioterrorism Threat 111918

38. **DRAFT Alternate Communication in an Emergency Situation 111918**

Amend (pkt. pg. 101 Item 6.) Change to read "Radios, batteries and chargers will be stored in the clinic in accessible locations.

39. **DRAFT Active Shooter 111918**

Amend (pkt. pg. 103 Item 3) Remove duplicate number "3". Staff will verify if information is current and add a meeting place.

40. DRAFT Standardized Procedure Urinalysis for Pregnant Patients 111118

Ms. Sellick moved to approve the policies as amended. Ms. Atkinson provided her second and the motion passed 4-0.

- **Strategic Plan Matrix (Last Updated 12-1-2018):**

Dr. Smart: Gave the following updates to the Matrix (pkt. pg. 105) Item 6. as been completed. Item 41. Ms. Radford volunteered to attend the Opioid Coalition meetings and report back to the Board.

- **ACHD Board Self-Assessment:**

Dr. Smart: Most Board's do a self-assessment and the last one completed for this Board was 2014. ACHD offers it members a third-party platform to complete the assessment taking (approx..) 30 minutes. The District's recertification with ACHD is due in April so would like to see the Board set a time to proceed to. It is a good tool to gather honest feedback on how to improve.

Ms. Al-Rafiq: Sees the process being beneficial to learn of things the District isn't doing or things the District can do better.

Ms. Reed: Suggests the Board should do a self-assessment annually as part of their transparency. Most Districts run a hospital so feel free to reply with "not applicable" (NA) on the questions that do not apply to this District. She would like to see the Board accomplished the assessment during the March 1-15 window.

- **New Email Address:**

Dr. Smart: An Outlet Tek technician is on sight today to assist Board members with their devices and to move their old email addresses to the new email server. Staff will contact the firm to assure the old email addresses roll over to the new address.

- **Personnel Manual - Change:** Action

Dr. Smart: With the opening of the VS H&W Center it will be necessary to hire staff, so the 2000 Hiring Process of the Personnel Manual needs to be reviewed and changed as needed.

The Board directed staff to make some changes in the policy and bring it back to the April meeting.

- **Finance Committee Meeting Member:**

Dr. Smart: Was contacted by an Arnold applicant with an MBA that is interested in being the volunteer on the Finance Committee. Staff will set a meeting for the Treasurer and himself to meet with the applicant.

Ms. Atkinson: Is pleased the District has two applicants to consider.

C. Corp. Board Report:

Mr. Philipp: New Pres. & CEO, Doug Archer, will be joining the team on March 18. He has been working in the Sutter System in Los Banos and wants to relocate to the foothills; Mr. Archer has deemed the clinics his first priority; He will stay for a time to help Mr. Archer in his transition; Mr. Archer took part in the CFO interviews; Surgeries and census have been on the increase so finances have been much better; the Earnings Before Interest, Tax, Depreciation and Amortization (EBITDA) has been positive thru Jan.

Ms. Reed: The HCAHPS scores have been rising again. Mr. Archer has CEO experience and a marketing background.

Ms. Atkinson: Liked Mr. Archer having a community minded approach.

Ms. Al-Rafiq: Recalls Mr. Archer being very involved in Amador County.

Mr. Philipp: Update on the Angels Camp Clinic – the slab was poured, and they are framing; they have had 30 rain-day delays so looking at an August completion date.

D. Stay Vertical Calaveras:

Mr. Shetzline: Had the pleasure of speaking at the MTMC Plan 4 Me program about the Stay Vertical Calaveras program which has exploded in the community providing a needed physical and social event for 352 residents; suggested everyone refer to the correspondence section of their Board pkt to read testimonies; there is a class designed for Parkinson residents; all the training has been completed and a new class schedule will be coming; once posted the details will be on the District's website. www.mthcd.org.

Dr. Smart: The SVC program is a District sponsored “pilot” program aimed at fall-prevention. Later in the year the Board will review the data to determine the need for the program and if it will be continued.

E. Ad Hoc Real Estate:

- **Update on the Valley Springs Health & Wellness Center**:
  - **Construction:**
    - **Project Manager:**

Mr. Van Lieshout: There have been no rain-days at the VS H&W Center project because the contractors weatherized the site some time back; the internal metal framing is in progress, then the electric goes on the roof then the roof will follow; the team works Saturday’s to keep up the pace; the site work will be started when the weather improves; his construction office trailer fell on its side in the last wind storm; he will see to the repairs before it is returned.
Dr. Smart: Has received the 7th application for payment and the contractor has been getting paid within 5 days or less.

  - **Operations and Development:**
    - **VS H&W Center Manager**:
    - **Physician Recruiting:**

Dr. Smart: Circulated the promotional folder he will be using to recruit staff for the clinic; he has a check list of items to be done when a prospective provider visits the clinic; on the check list is a meet and greet dinner that he would like two Board members to attend; cejka is currently searching for a family provider, an internist and a pediatrician; other staffing can be done locally; he has been included in Athena Electronic Medical Records (EMR) training.

    - **Employee Benefit and Wages:**

Dr. Smart: Has been working on employee benefits which is part of the recruiting package he has been preparing. He will be calling on the Ad Hoc Personnel Committee to assist as he needs a fair market value to attract the staff the clinic needs.

- **Update on Valley Springs Property - Phase II**:

Ms. Al-Rafiq: Will be meeting with Matt Peterson; PACE (Elderly Care Program) will be having an open house (Stockton); she and Dr. Smart had a conference call with USDA regarding a 30-75% grant; there has also been discussion on the District having a mobile unit.
Ms. Reed: Encouraged discussion with the new MTMC CEO to foster a partnership as it could be a real service to the area/County.

7. Committee Reports:

A. Finance Committee:

Due to severe weather the Finance Committee was unable to meet in February therefore, financial statements were presented at this meeting for the first time without Finance Committee review.

- **Financial Update:**

Dr. Smart: Reminder to the Board that the budget season is approaching, and they should send their input to staff or Mr. Wood.

- **Financial Statements (Jan 2019) Recommendation-Approval:** Action

Mr. Wood: Seven months into the year the District is on track with the budget except for the items relating to the new lease; the VS H&W Center will have a separate report then added to the total; the minority interest figures will be added to the Profit & Loss report; some of the items on the journal entry report will go away at the signing of the lease; staff will be assigning new names to categories.

Ms. Reed: Likes the new easy-to-understand financial schedules.

Dr. Smart: There are two options for payroll i.e. paychecks and payroll people; the consultant is comparing the two options which offer HR components as well as payroll functions.

Ms. Al-Rafiq moved to approve the January Financials. Ms. Sellick provided her second and the motion passed 4-0.

- **Investment Activities:**

Mr. Wood: With the new finance process the District has $700k more than a year ago; funds have been moved from Umpqua Bank to Five-Star Bank for a better yield (2.4%); as funds mature at Umpqua they will be moved to a Five-Star account then to Cal Trust for investing; FDIC is insurance for private funds; public funds are collateralized at 110% so fully insured with no limit.

- **Draft Reserve Policy No. 30**: Action:

Dr. Smart: Some time back the Little Hoover Commission started looking at funds held by a District(s). CSDA developed a guide on how best to manage reserve funds; one consideration for this District is a five-year utility payment due to the MTMC upon the signing of the new lease.

Ms. Reed: For the betterment of the District suggested the District plan for “future life changes” that take place after this Board is gone i.e. lease dissolution.

Ms. Atkinson: Suggested having a fund and contributing to it each month/year to support the District’s goal because it speaks to the intent as the Board changes/leaves.

Dr. Smart: Suggested $3million be added to 1. c. for the utility obligation and to add to 2. d. (last line) to read …..outside lighting improvements, “hospital lease termination”, etc.).

Ms. Atkinson: Suggested not creating another policy (30) but to use this language to amend Policy 25 which is already in place.

Ms. Al-Rafiq moved to approve Policy 25 as amended and staff to add language (above). Ms. Sellick provided her second and the motion passed 4-0.

- **March meeting dates**:

Dr. Smart: March 13th doesn't work for the Finance Committee meeting so staff will need to reschedule.

A. Ad Hoc Lease Review Committee:

Ms. Reed: She and Dr. Smart met with the Dignity team and are moving forward with the next step which will be a mid-March meeting in LA.

Dr. Smart: The lease was to close tomorrow but now will be after the mid-March meeting and likely at the end of April.

B. Ad Hoc Policy Committee:

Ms. Atkinson: The Committee will be setting a time for the next meeting.

C. Ad Hoc Community Grant:

Ms. Sellick: Is reviewing the CHS Scholarships and expects to receive the BH Scholarships any time; the (Golden Health Community) Grant applications are still coming in for a March 1st deadline; currently 12 applications has been received for consideration.

8. Board Comment and Request for Future Agenda Items:

A. Announcements of Interest to the Board or the Public:

Hearing none.

9. Next Meeting:

A. Wed. March 27, 2019

10. Closed Session:

Board members moved into closed session at 9:49am

A. Public Employee Performance Evaluation (Govt. C. sec. 54957). Title: Executive Assistant.

11. Reconvene to Open Session:

A. Report of Action taken (if any) in Closed Session:

Reportable action taken: Executive Assistant was evaluated and will receive a bonus. Future evaluations will be conducted by the CEO.

12. <u>Adjournment</u>: Action:

Ms. Sellick moved to adjourn the meeting at 10:34am. Ms. Atkinson provided her second and the motion passed 4-0.

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

March 2019

ACHD Advocate

In This Edition

From the Desk of Ken Cohen, Chief Executive Officer

We've just wrapped a two-day Board of Directors retreat and I'm encouraged by the wealth of ideas and astute direction to come from our time together. As our Board fine tunes our strategies for 2019-20, you'll hear more from us on how our planning will benefit the communities that Healthcare Districts serve and also how we can build a stronger Association to support all our members.

I hope to see you all during our ACHD 2019 Legislative Day - Advocacy in Action - April 8 and 9. As you saw earlier this week, we are honored to have Assemblymember Aguiar-Curry as our Legislative Speaker on April 9. She will share her perspective on local government issues and how Healthcare Districts can prepare for the year ahead. Early bird registration rate ends in just 10 days on March 18 so make sure to take advantage of this pricing.

Member education and support remains a top priority here at ACHD, and with that we are pleased to see Petaluma Health Care District become the latest District to complete their Re-Certification through our Certified Healthcare District portal. Congratulations to the Petaluma team! Be sure to learn more about the Certified Healthcare District Program and the value it can add for your District in ensuring you maintain the highest levels of transparency and accountability.

Legislative Update

February 22 marked the final day for the Legislature to introduce bills, and the ACHD Advocacy Team is hard at work reviewing all of them. There is a notable focus in the Legislature to look at health care and health care delivery, along with education, and emergency response and preparedness. These themes are also heavily addressed in Governor Newsom's proposed 2019-20 budget.

The ACHD Advocacy Team has been watching informational hearings and attending briefings in preparation for the policy discussions before the Legislature this year. Among these was a conversation hosted by the Public Policy Institute of California with Ann O'Leary, the Governor's Chief of Staff, where she discussed the Governor's first 100 days in office, his proposed 2019-20 budget, and his long-term goals. Notably, Ms. O'Leary highlighted the many cost crises in California, and the need to address affordability in many forms including health care, housing, and education. In her interview she went on to address health care, re-iterating the robust health care package laid out in the Governor's budget and explaining that the goal is to move the needle toward coverage for all Californians. View the full interview here.

During a panel briefing attended by ACHD staff, The California Future Health Workforce Commission presented their top 10 recommendations for addressing the looming workforce crisis in the health care industry. The Commissioners presented a high-level explanation of the comprehensive action plan for building the health workforce needed in California by 2030. This plan includes an emphasis on rural health care pipeline programs, physician recruitment and retention, and telehealth. The panel emphasized the importance of granting expanded scope for nurse practitioners in underserved areas, which is a legislative effort championed by Assemblymember Jim Wood in his newly introduced AB 890. Panelists also stressed the need for collaboration and community engagement, expressing that tools like telehealth and paramedicine act as a complement but not a solution to the workforce shortage. Read the full report and recommendations here.

The ACHD Advocacy Team is analyzing legislation that impacts Healthcare Districts and will continue to participate and report on the larger health care policy discussion. We look forward to seeing you at our 2019 Legislative Day in Sacramento, where the ACHD Advocacy Team will be presenting on these policy topics and more.

Upcoming Events

Webinar
An Overview of the Blue Zones Project
March 28, 2019 at 10:00AM

Learn about the Blue Zones Project and how the Beach Cities Health District has used it to advance well-being in their community, and how the same model can be applied in other communities. Ben Liddle of the Blue Zones Project and Tom Bakaly, CEO of Beach Cities Health District will present this webinar.

Register here.

To access webinars on demand, click here.

Register today!

About ACHD

The Association of California Healthcare Districts (ACHD) represents Healthcare Districts throughout the state. The Association serves the diverse needs of California's Healthcare Districts by enhancing public awareness, training and educating its members and advocating for legislation and regulatory policies that allow Healthcare Districts to deliver the best possible health services to Californians. Learn more at achd.org.

SUMMARY RESULTS

Mark Twain Health Care District
2019 Governance Self-Assessment

Provided as a Member Service By

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Self-Assessment Overview

In March 2019 the Mark Twain Health Care District Board of Directors assessed the board's overall leadership performance. The board also identified issues and priorities for the future.

Board members assessed the board's overall performance in eight leadership areas, including:

- Mission, values and vision;
- Strategic direction;
- Leadership structure and processes;
- Community relationships;
- Relationship with the CEO;
- Financial leadership;
- Community health; and
- Organizational ethics.

Board members rated 132 total criteria in these eight areas.

How the Self-Assessment Was Conducted

The governance self-assessment was conducted using an online survey. All five Mark Twain Health Care District board members completed the self-assessment.

Respondents rated a variety of statements in the eight areas above, using a scale ranging from "Level 5 (Strongly Agree)" to "Level 1 (Completely Disagree)." "Not Sure" and "Not Applicable" choices were also available for each statement.

Mean scores for each statement were calculated using a five point scale (Level 5 - Level 1). No points were assigned to "Not Sure" and "Not Applicable" ratings.

Finally, board members provided insights about their priorities for the board in the next year; defined the board's strengths and weaknesses; identified key issues that should occupy the board's time and attention in the next year; provided insights about the most significant trends the board must be able to understand and deal with in the next year; and identified critical factors that must be addressed for the organization to successfully achieve its goals.

Rating Methodology

The following rating scale was used to evaluate overall board performance:

- Level 5: I *strongly agree* with this statement. We always practice this as a part of our governance. Our performance in this area is *outstanding*.
- Level 4: I *generally agree* with this statement. We usually practice this as a part of our governance, but not always. We perform *well* in this area.
- Level 3: I *somewhat agree* with this statement. We often practice this in our governance, but we are not consistent. We perform *fairly well* in this area.
- Level 2: I *somewhat disagree* with this statement. We inconsistently practice this as a part of our governance. We *do not perform well* in this area.
- Level 1: I *disagree* with this statement. We never practice this as a part of our governance. We perform *very poorly* in this area.
- N/S: Not sure. I do not have enough information to make a determination about our performance in this area.
- N/A: Not applicable.

Reviewing This Report

Board member ratings of board self-assessment criteria are depicted throughout this report in graphs.

The criteria in each graph are displayed in order from highest to lowest mean score. The mean score for each individual rating criterion appears to the right of the graph.

To facilitate the identification of areas that may require governance and/or management attention, each graph includes the number of Level 5 - Level 1 responses to each statement in the color-coded bars. Responses are grouped and color coded, with "Level 5" appearing in dark green, "Level 4" in light green, "Level 3" in yellow, "Level 2" in orange, and "Level 1" in red. "Not Sure" responses appear in gray, and "Not Applicable" responses appear in white.

Longer lists of criteria have been separated into higher and lower rated sections for ease of display and analysis.

Board member responses to all open-ended questions appear throughout the report, where applicable, and on pages 21-22.

Mission, Values and Vision

Mission, Values and Vision
(sorted by highest to lowest mean score)

Suggestions for Governance Improvement

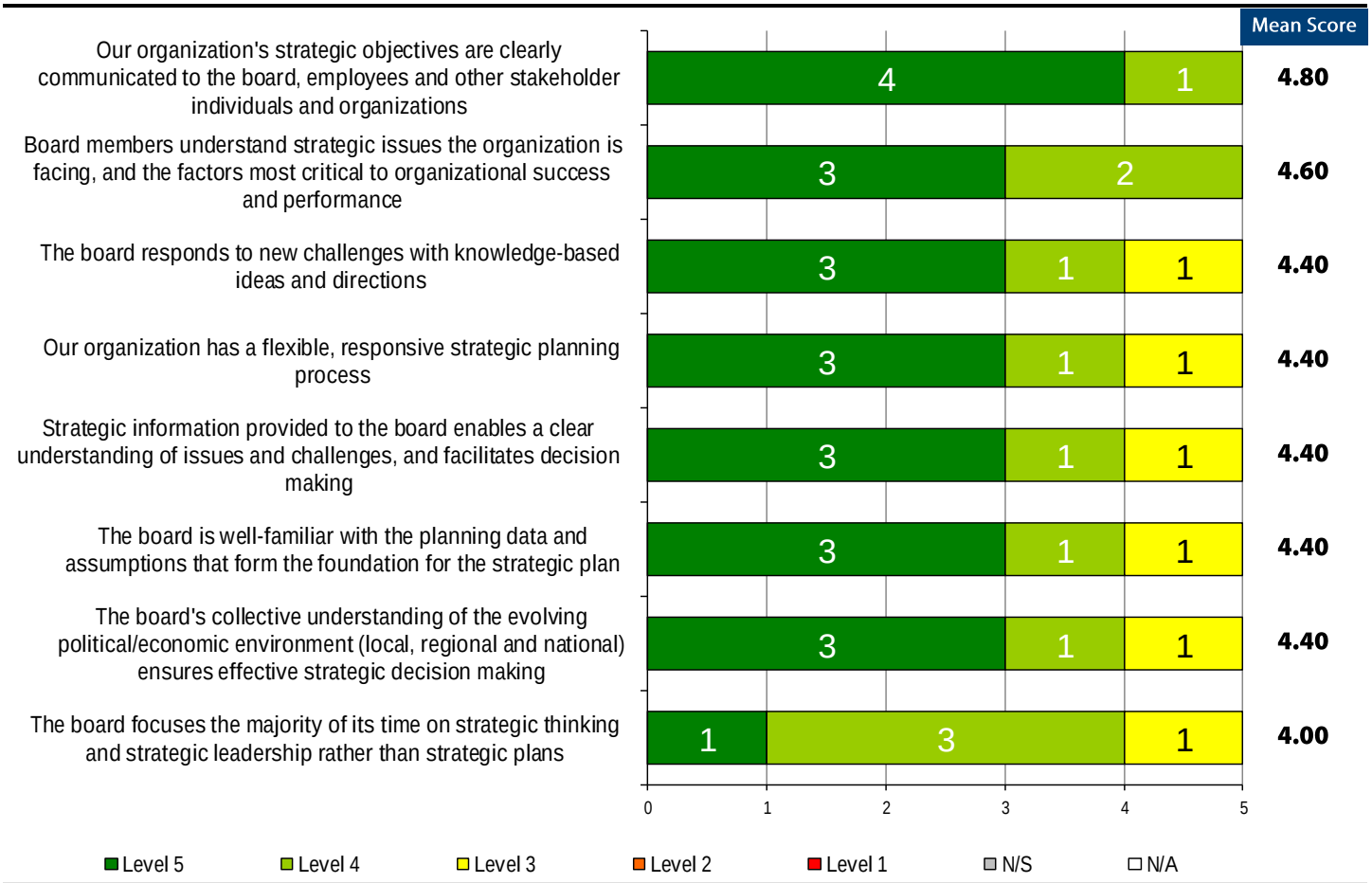
Board members provided the following suggestions for governance improvement in this section:

- I am so very grateful and blessed to have such a great board to work with. We all listen to each other to make sure our vision and mission for our community is the best it can be!
- We have goals not values. May be helpful to the public and our board if we had both (we used to have stated values, I think).
- We could do better by visiting our mission and vision with possible updates, especially during a period of huge growth.

Strategic Direction

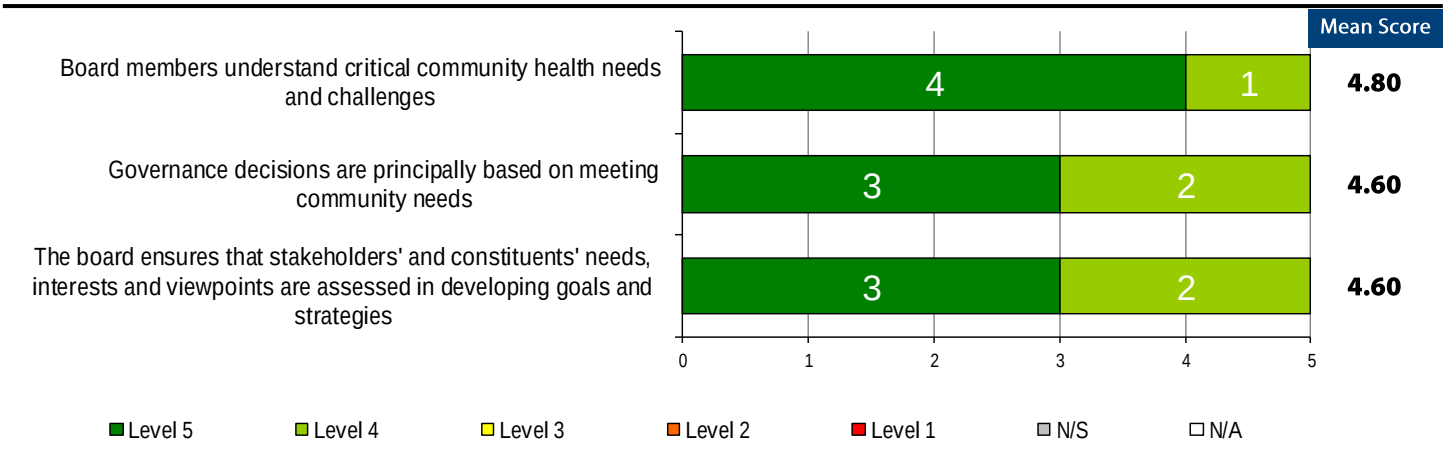
The Strategic Planning Process

(sorted by highest to lowest mean score)



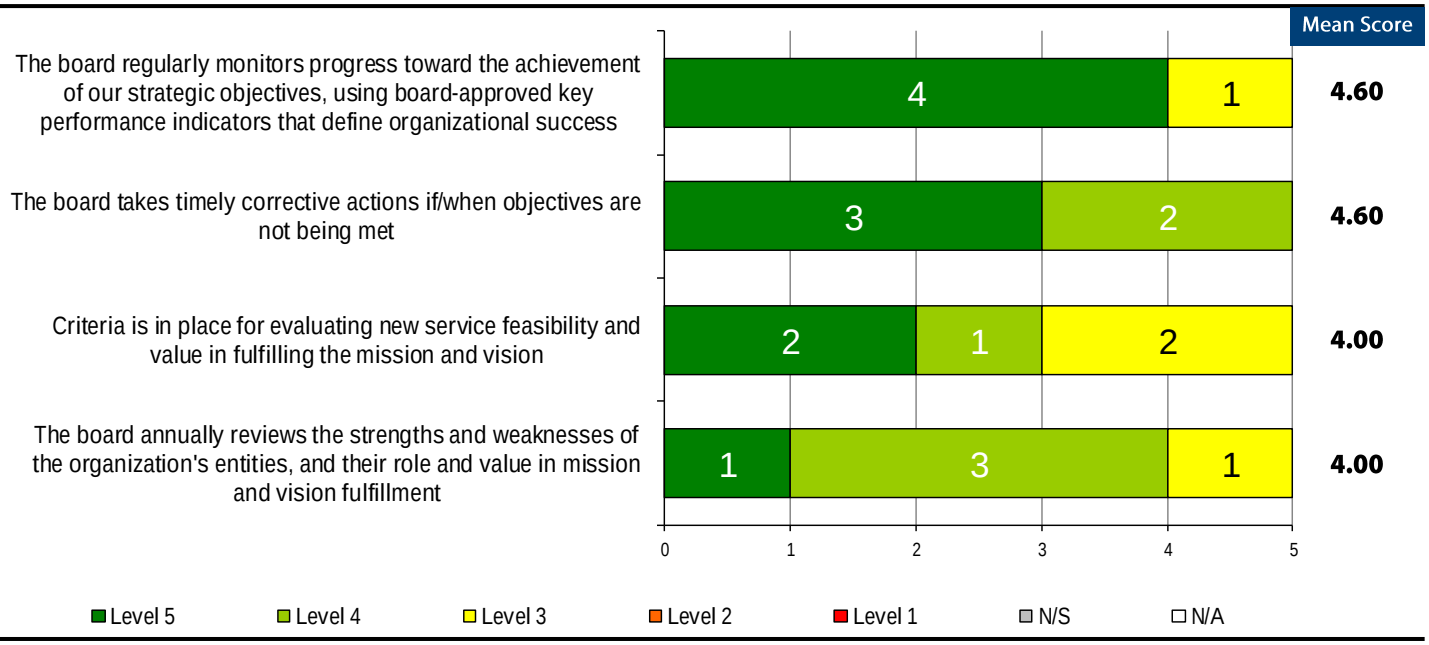
Community and Stakeholder Perspectives

(sorted by highest to lowest mean score)



Monitoring Progress

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

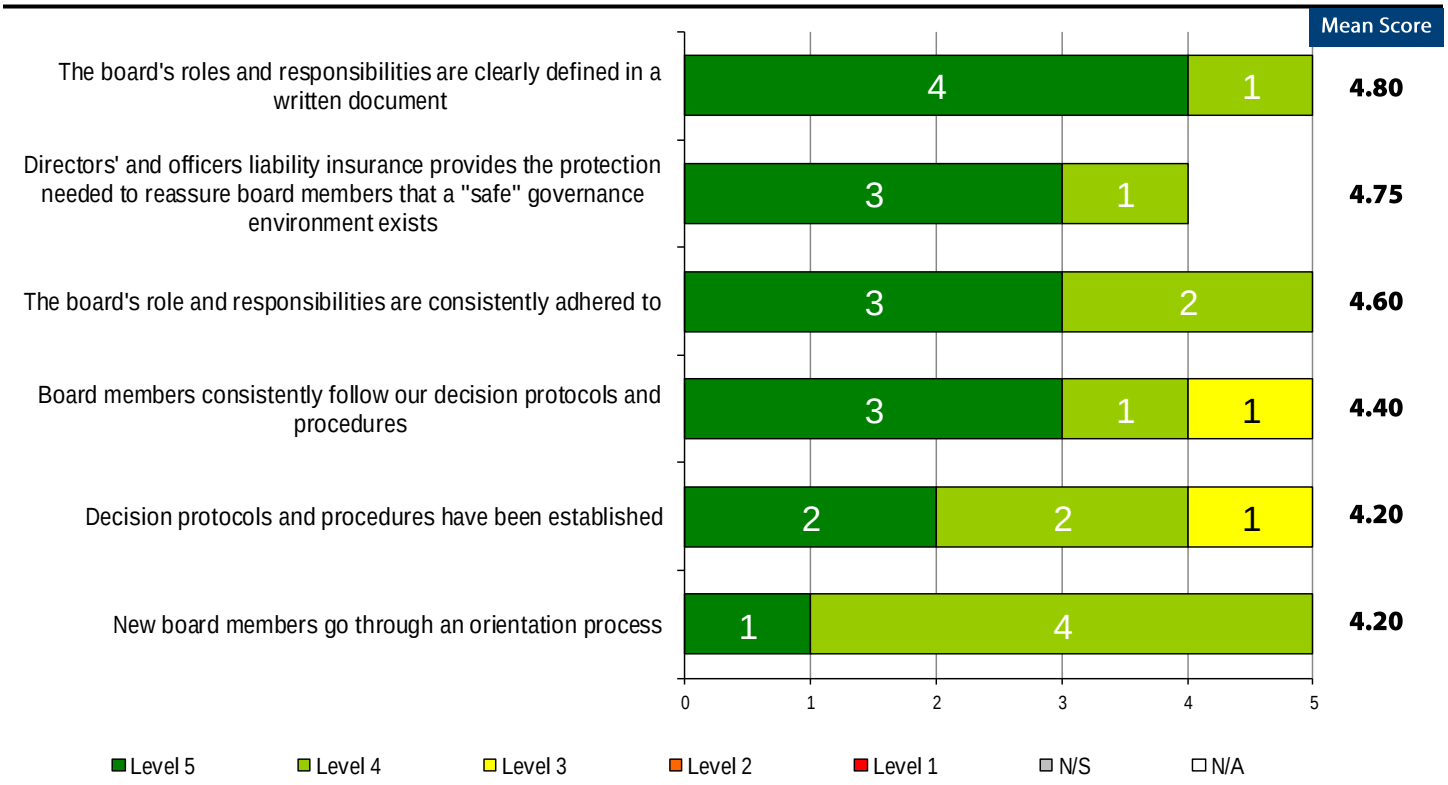
Board members provided the following suggestions for governance improvement in this section:

- We have not been doing self-assessments annually - we should be. We have become much more inclusive of stakeholders' involvement with townhall meetings and targeted community meetings, as well as updating our website to be more user friendly; and reaching out to various community groups to join in their meetings and initiatives and vice versa. Though this is an ongoing need that must continue. Our strategic planning meeting last year - all day x 2 - should be an annual activity as well. We are reviewing this monthly now. We do recognize when we are not on target for something and why, then collectively rethink it and revise the plan/due date. Our administrative staff are excellent at keeping us informed of progress and asking for our governance input as needed and when appropriate.
- We are building a new clinic. We recently changed the title of our Executive Director to CEO of clinic and District. Do we need a new vision/mission for the clinic?
- We all already work good for great leadership.

Leadership Structure and Processes

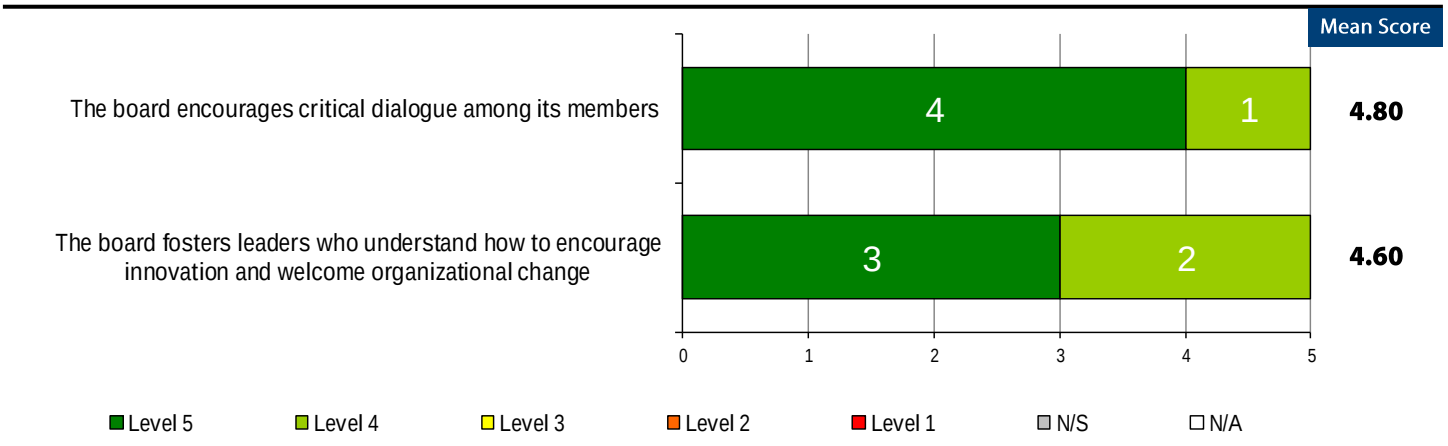
Board Roles and Responsibilities

(sorted by highest to lowest mean score)



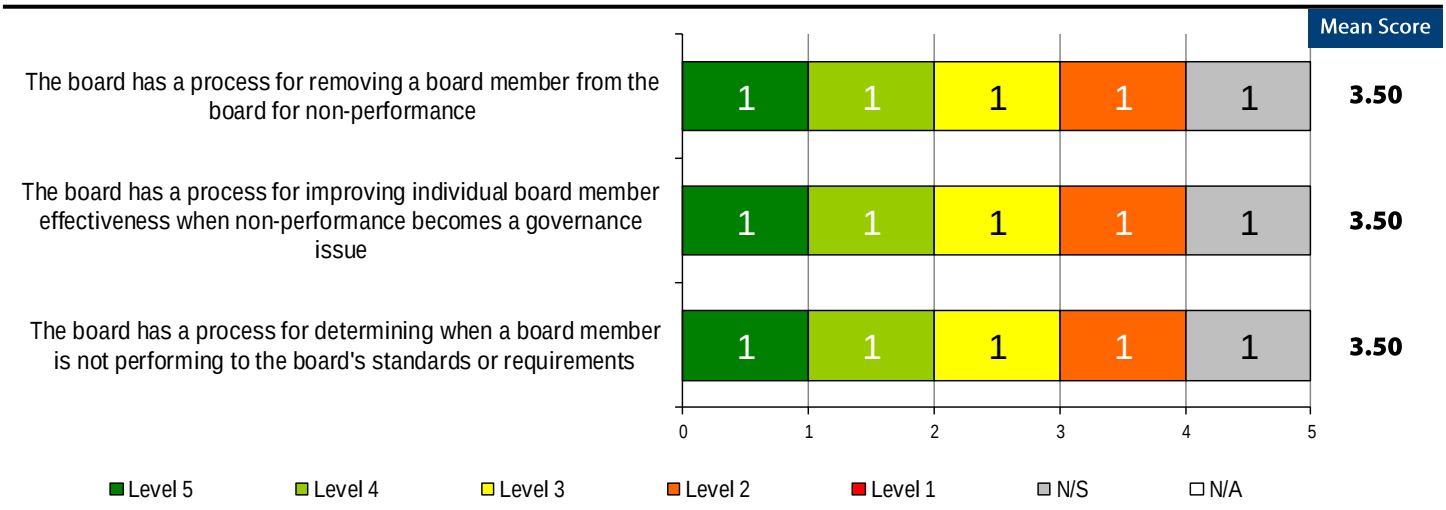
Board Structure and Composition

(sorted by highest to lowest mean score)



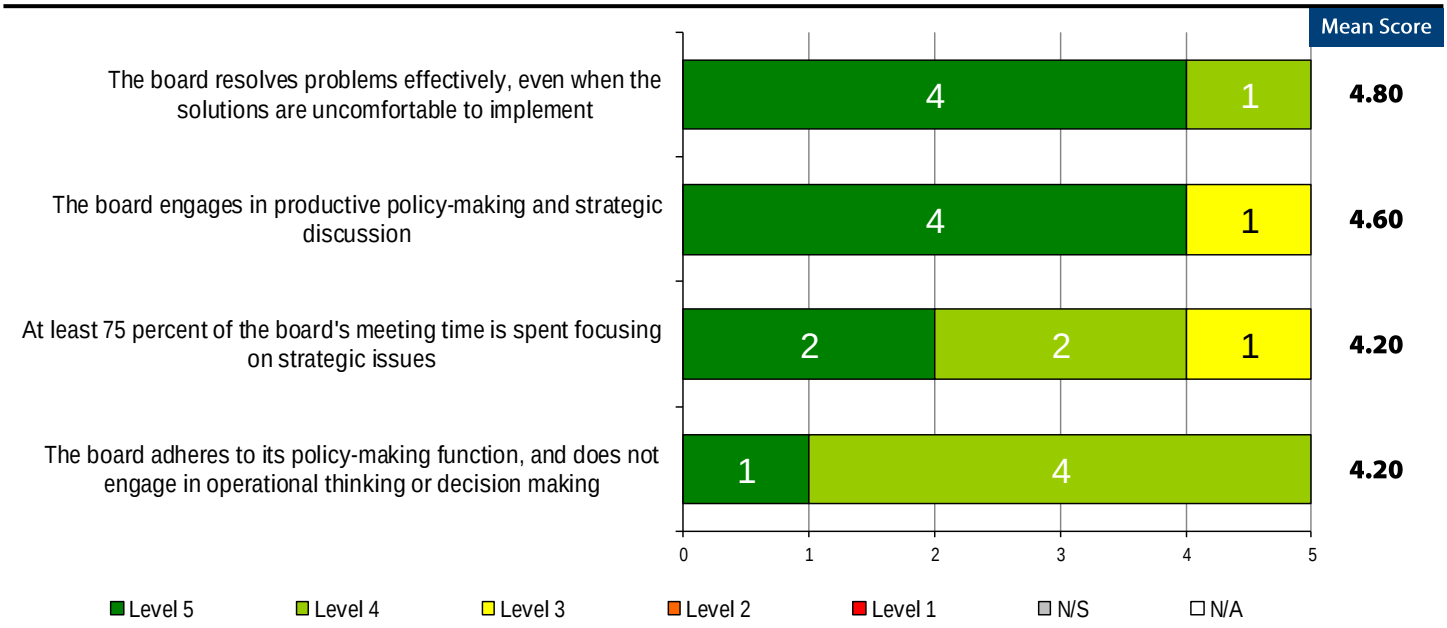
Board Member Performance

(sorted by highest to lowest mean score)



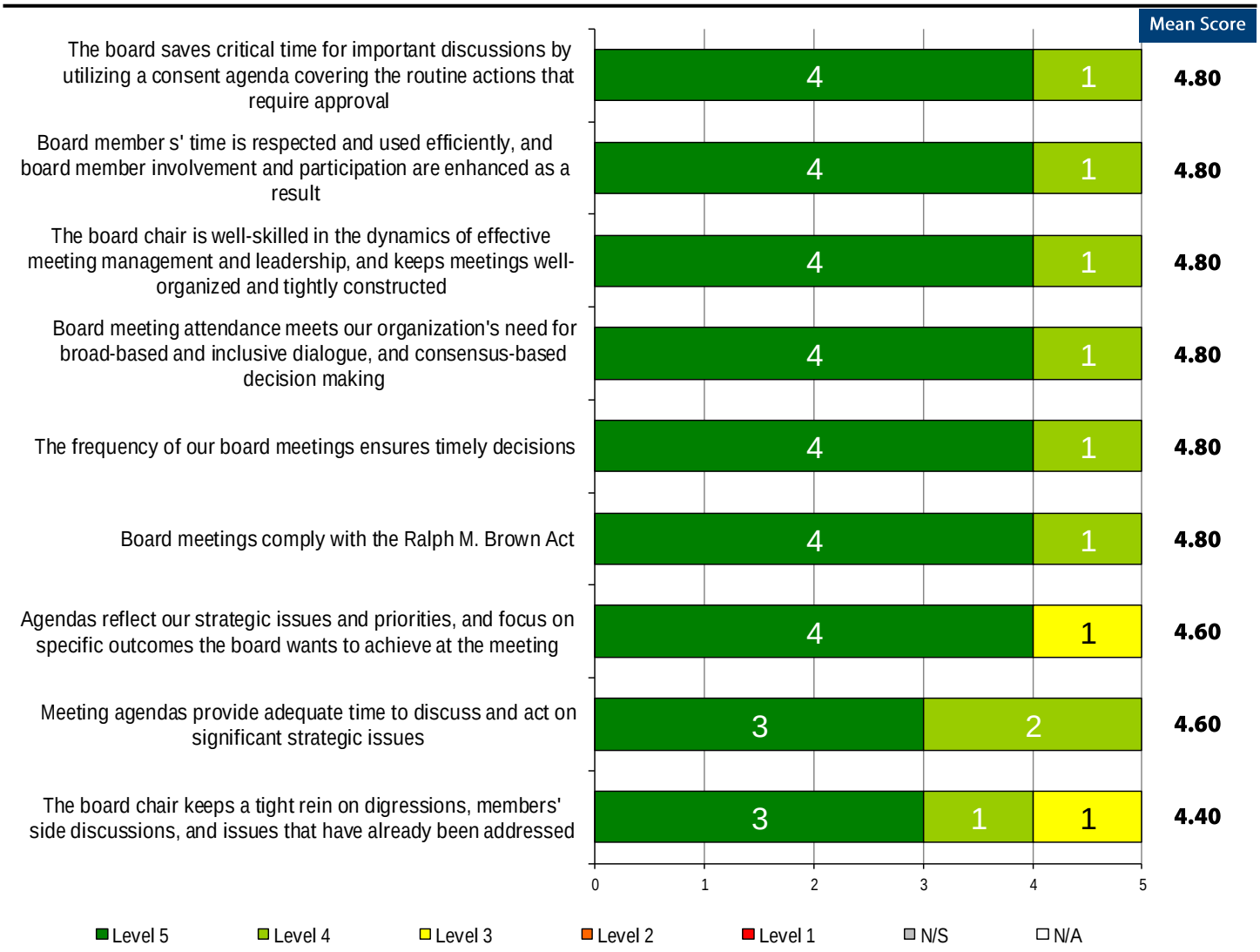
Strategic Focus

(sorted by highest to lowest mean score)



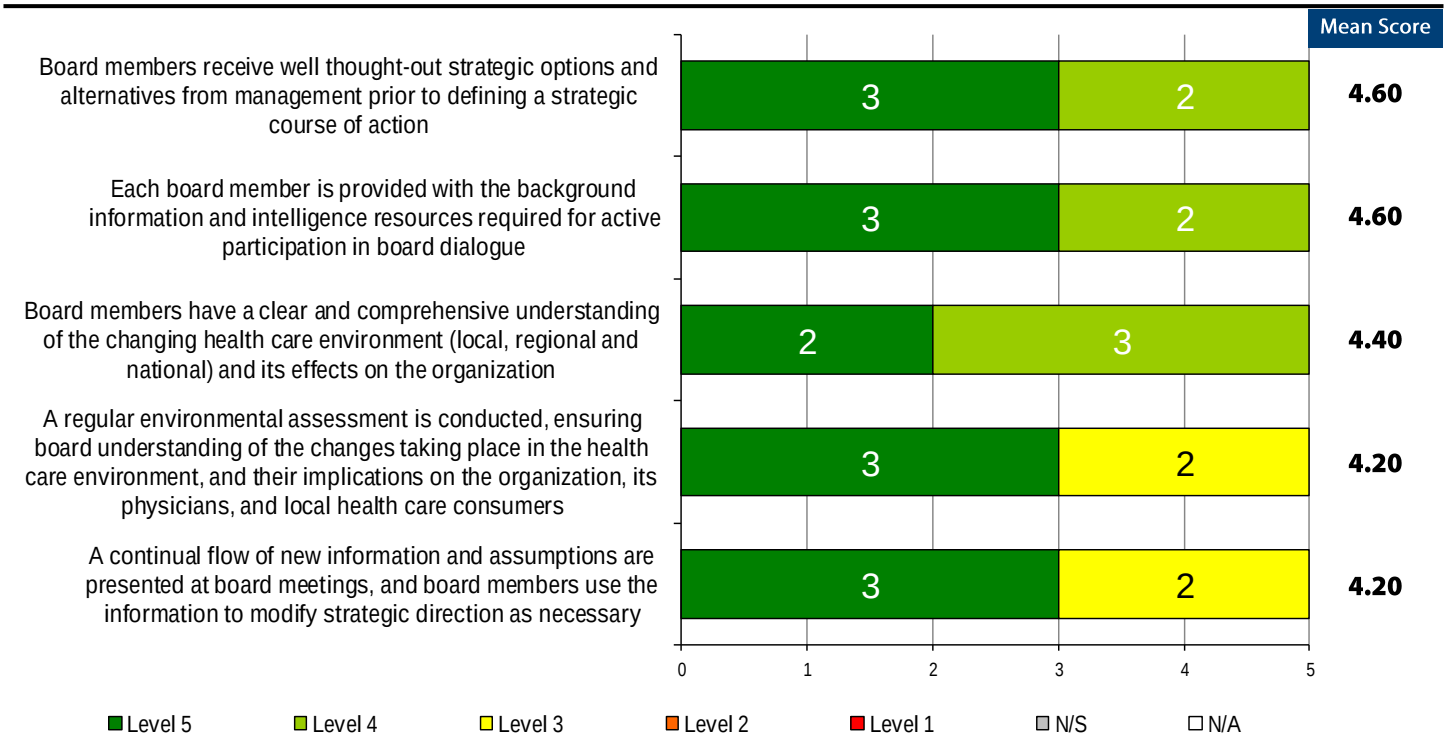
Board Meetings

(sorted by highest to lowest mean score)



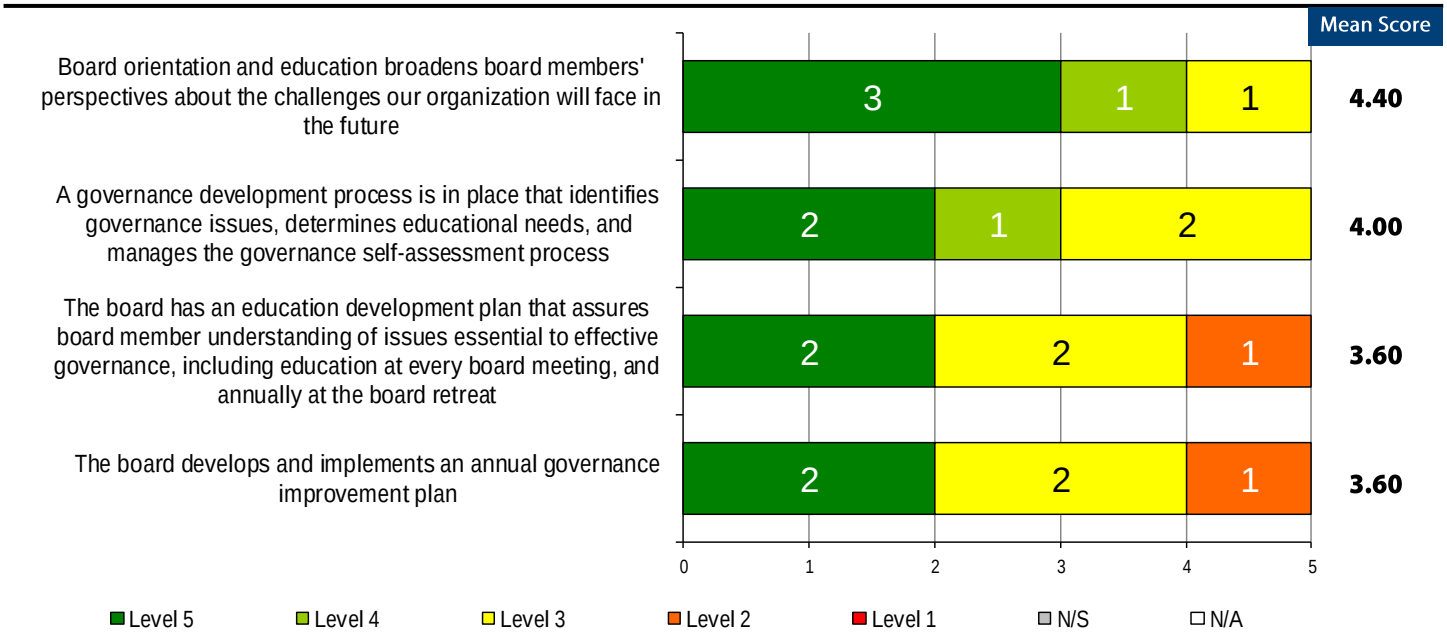
Board Member Knowledge

(sorted by highest to lowest mean score)



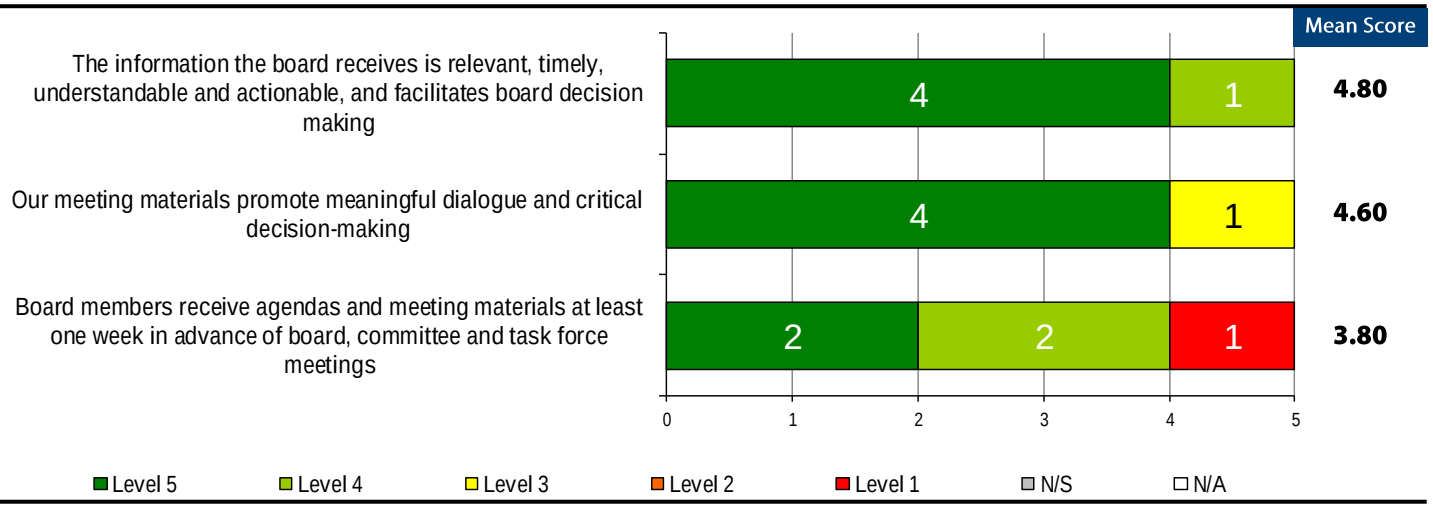
Governance Development

(sorted by highest to lowest mean score)



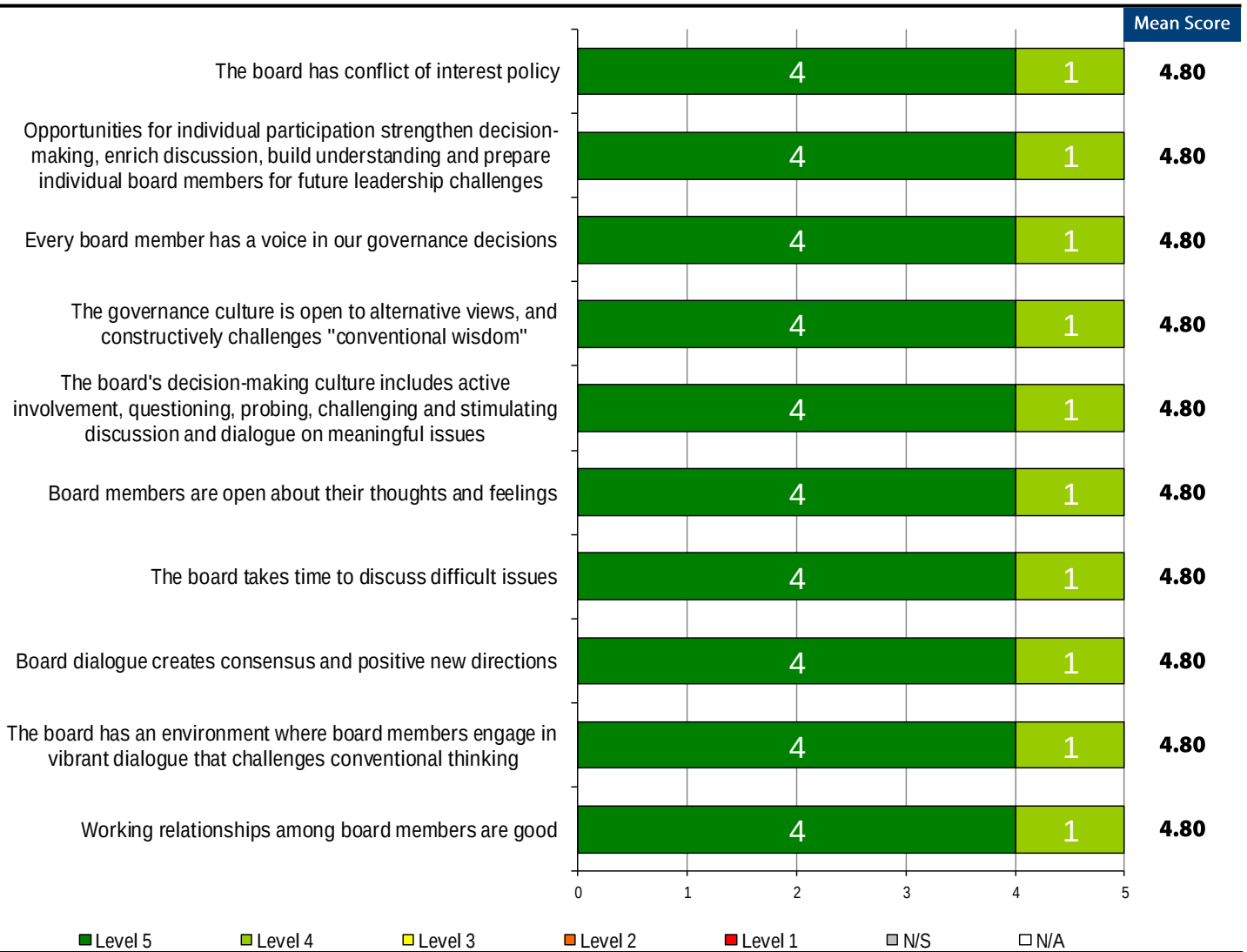
Meeting Materials

(sorted by highest to lowest mean score)



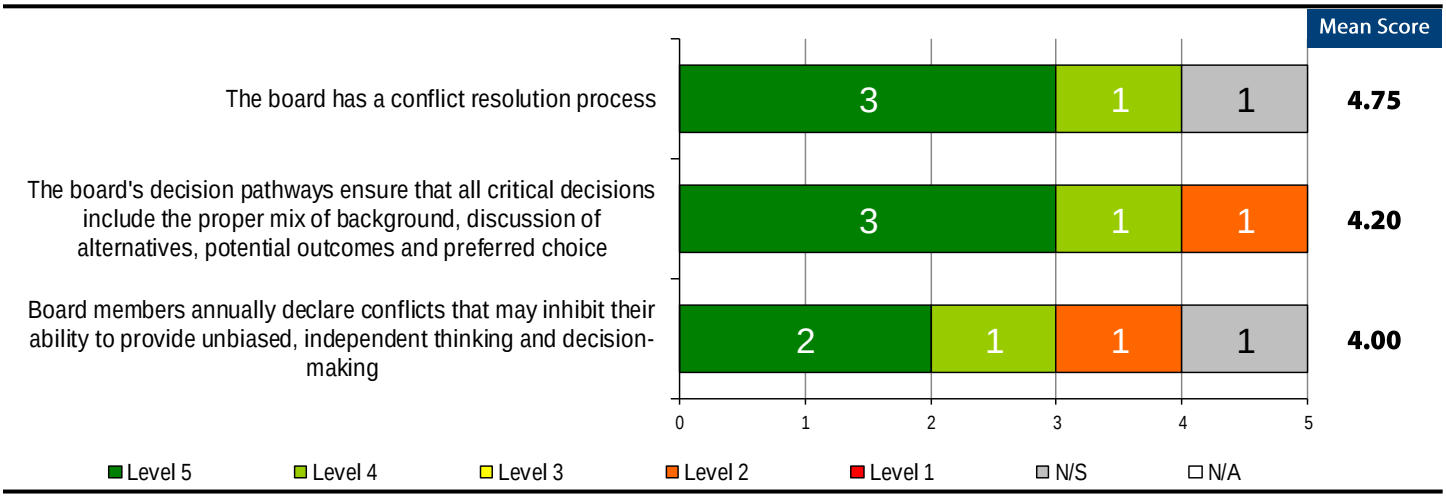
Board Relationships and Communication: Higher-Rated

(sorted by highest to lowest mean score)



Board Relationships and Communication: Lower Rated

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

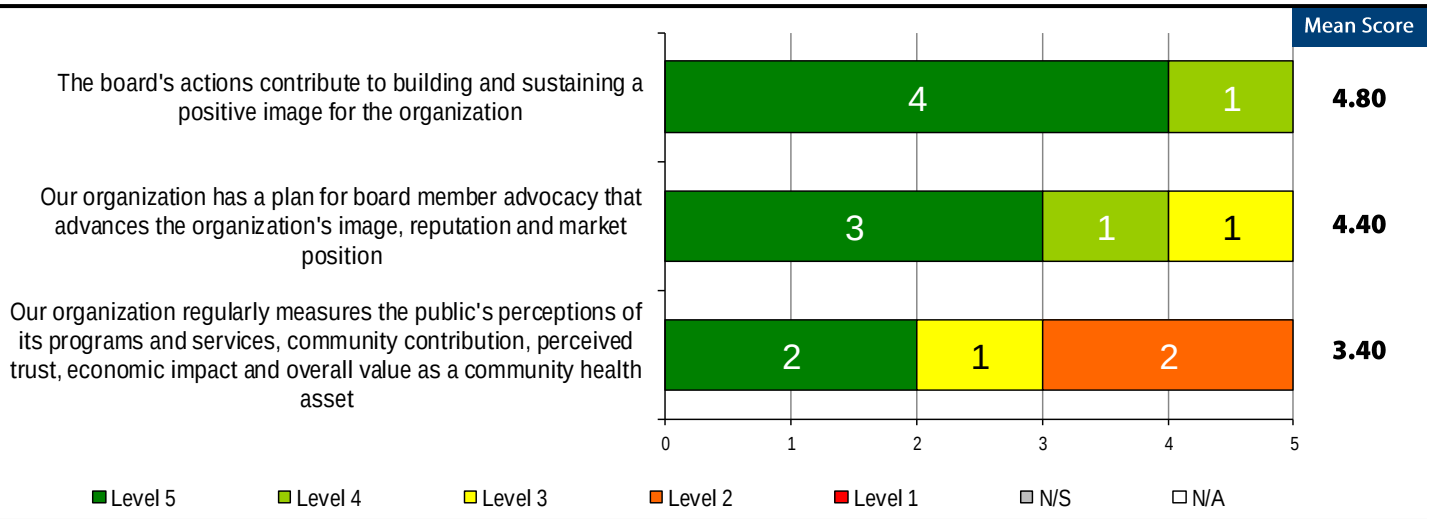
Board members provided the following suggestions for governance improvement in this section:

- Work more on community knowledge of the District.
- It would be a good idea to have a governance assessment tool with annual education planning around that. We have improved with our Board attending annual ACHD meetings which includes trainings, but it is not specific to that individual Board member's learning curve/gaps etc. Also, we could do more with providing an environmental landscape of health care, and its impact to our District on a quarterly or twice a year basis.

Community Relationships

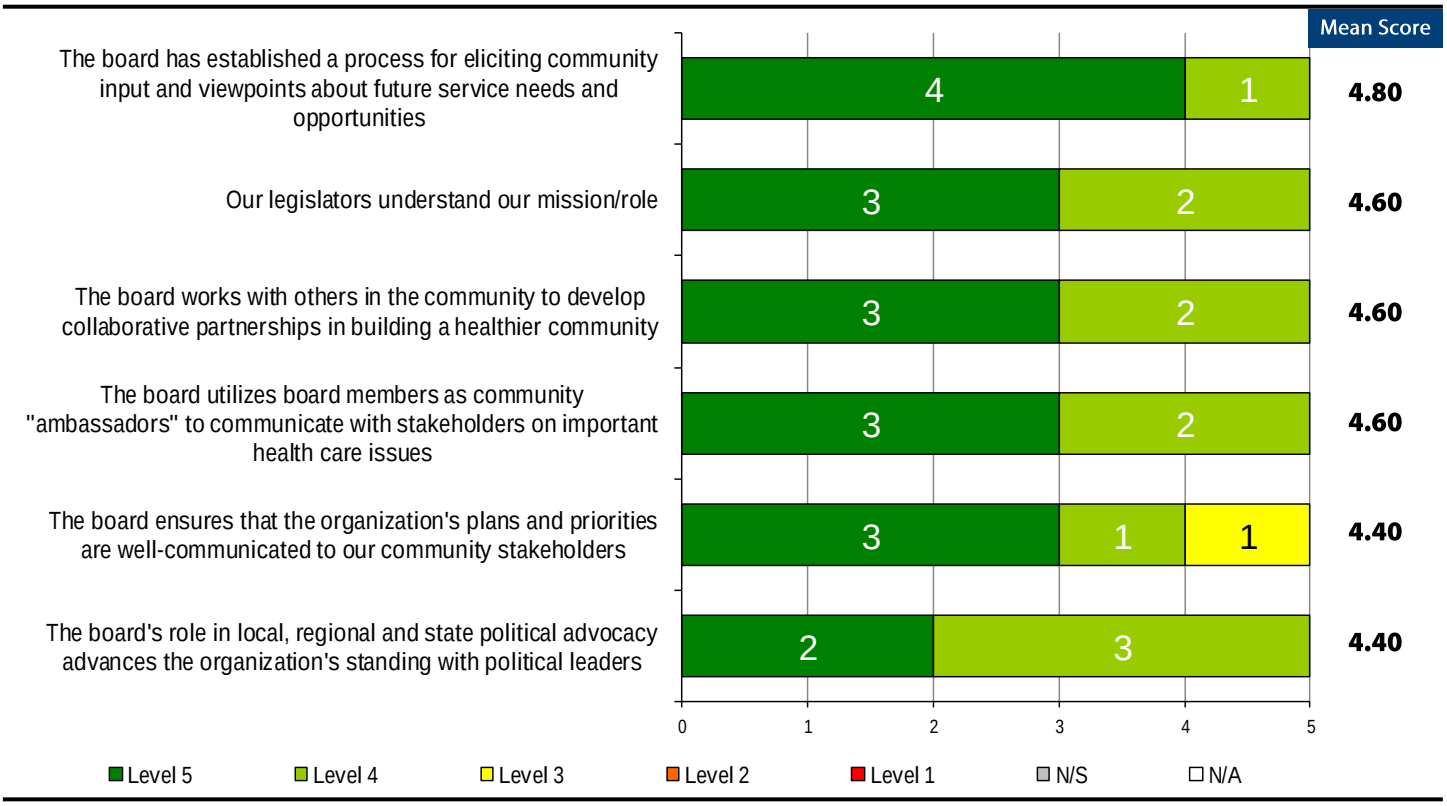
Ensuring Public Trust and Confidence

(sorted by highest to lowest mean score)



Ensuring Community Communication and Feedback

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

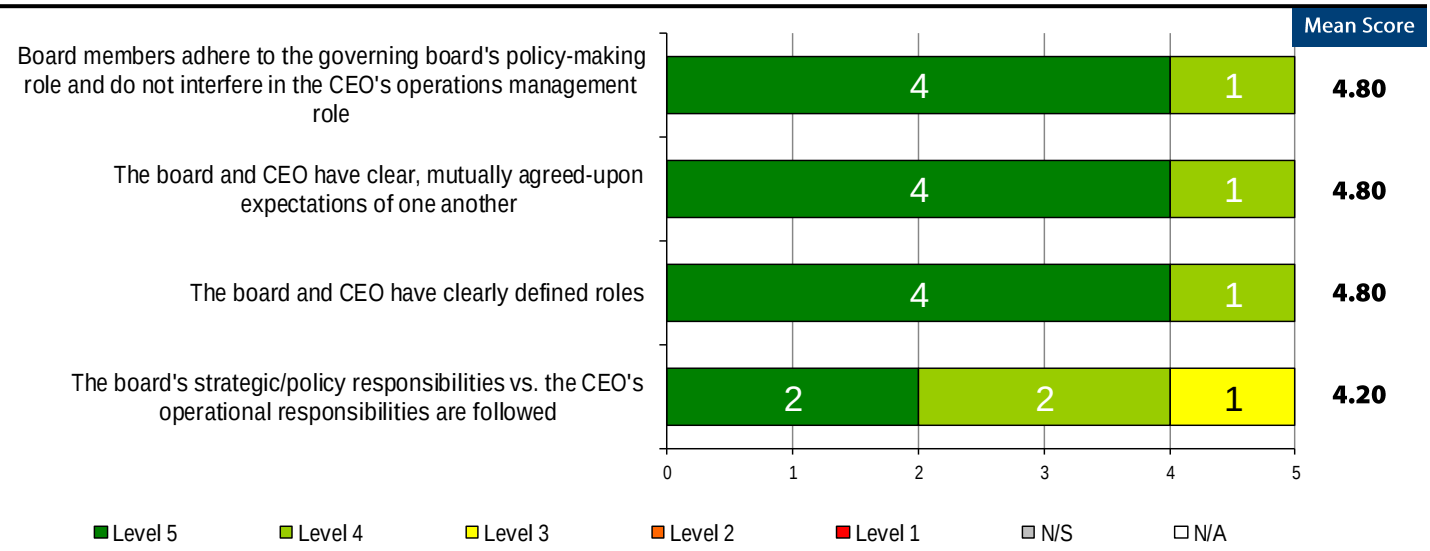
Board members provided the following suggestions for governance improvement in this section:

- Get more legislators' involvement.
- Need to do a regular survey so we keep our name out there. Continually educate the community and hear their issues/ concerns routinely in a format different than in-person meetings. Our board could be more engaged with other local/ regional/state groups. We could self-assign ourselves as ambassadors to local groups.

Relationship with the CEO

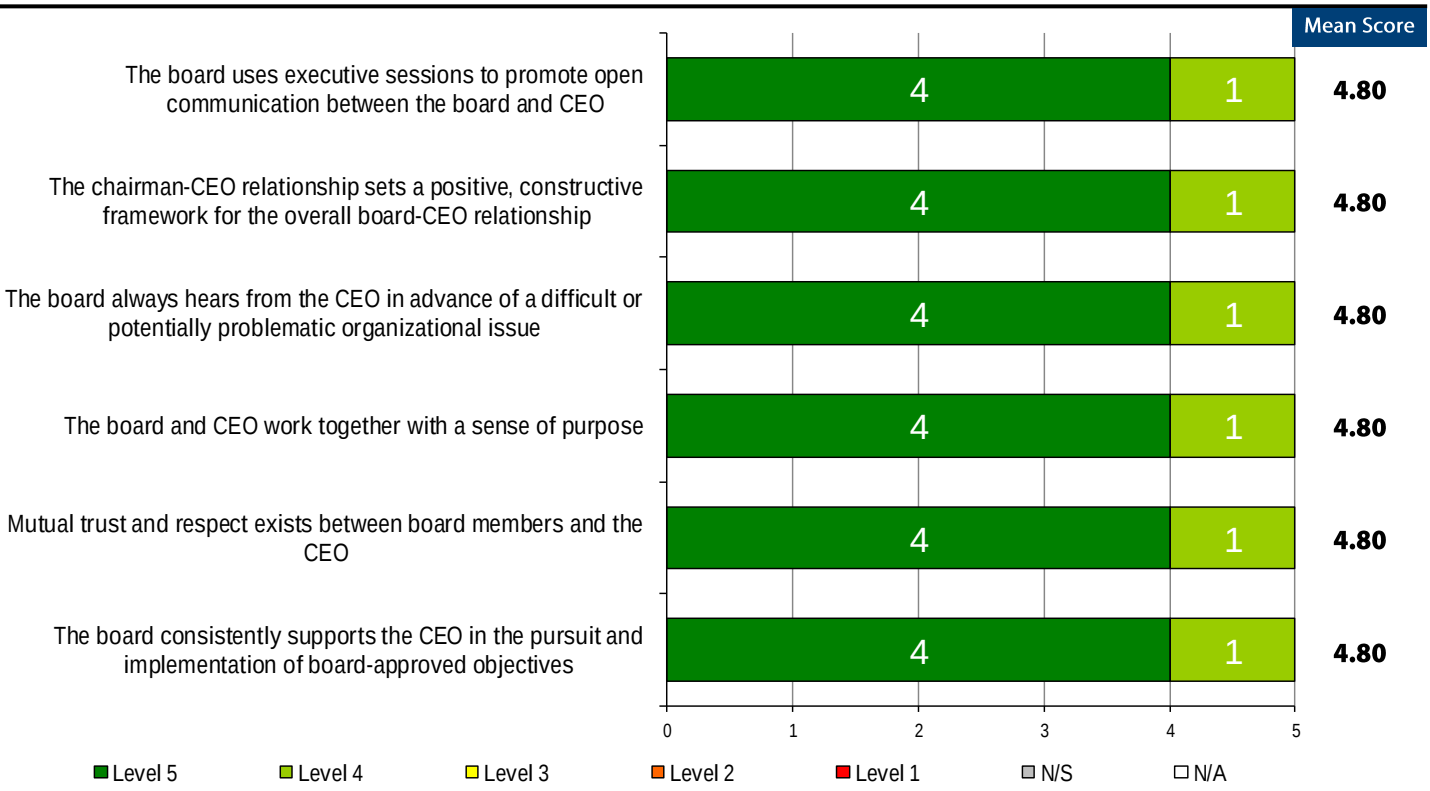
Board and CEO Roles

(sorted by highest to lowest mean score)



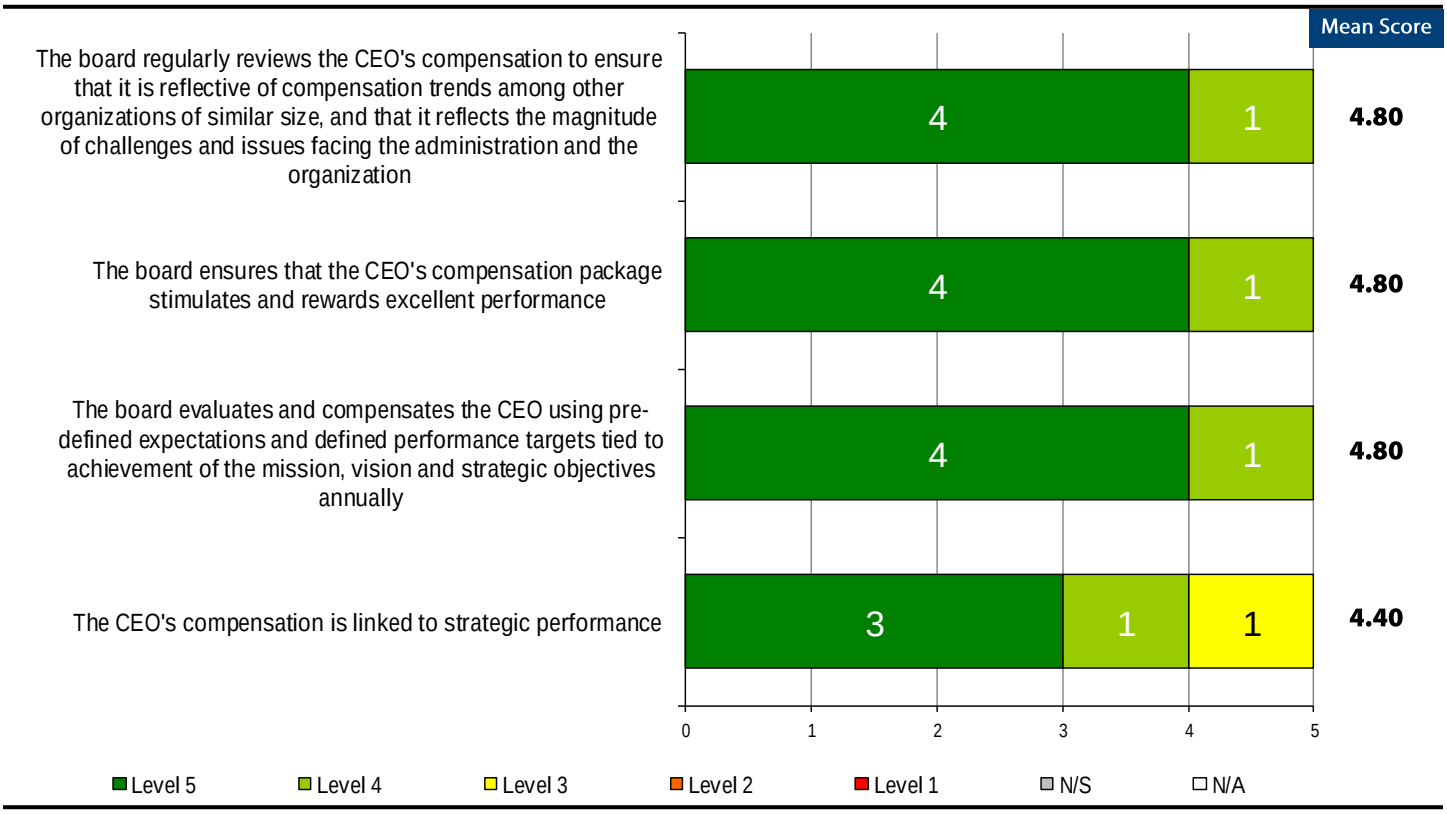
Communication, Support and Shared Goals

(sorted by highest to lowest mean score)



CEO Evaluation

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

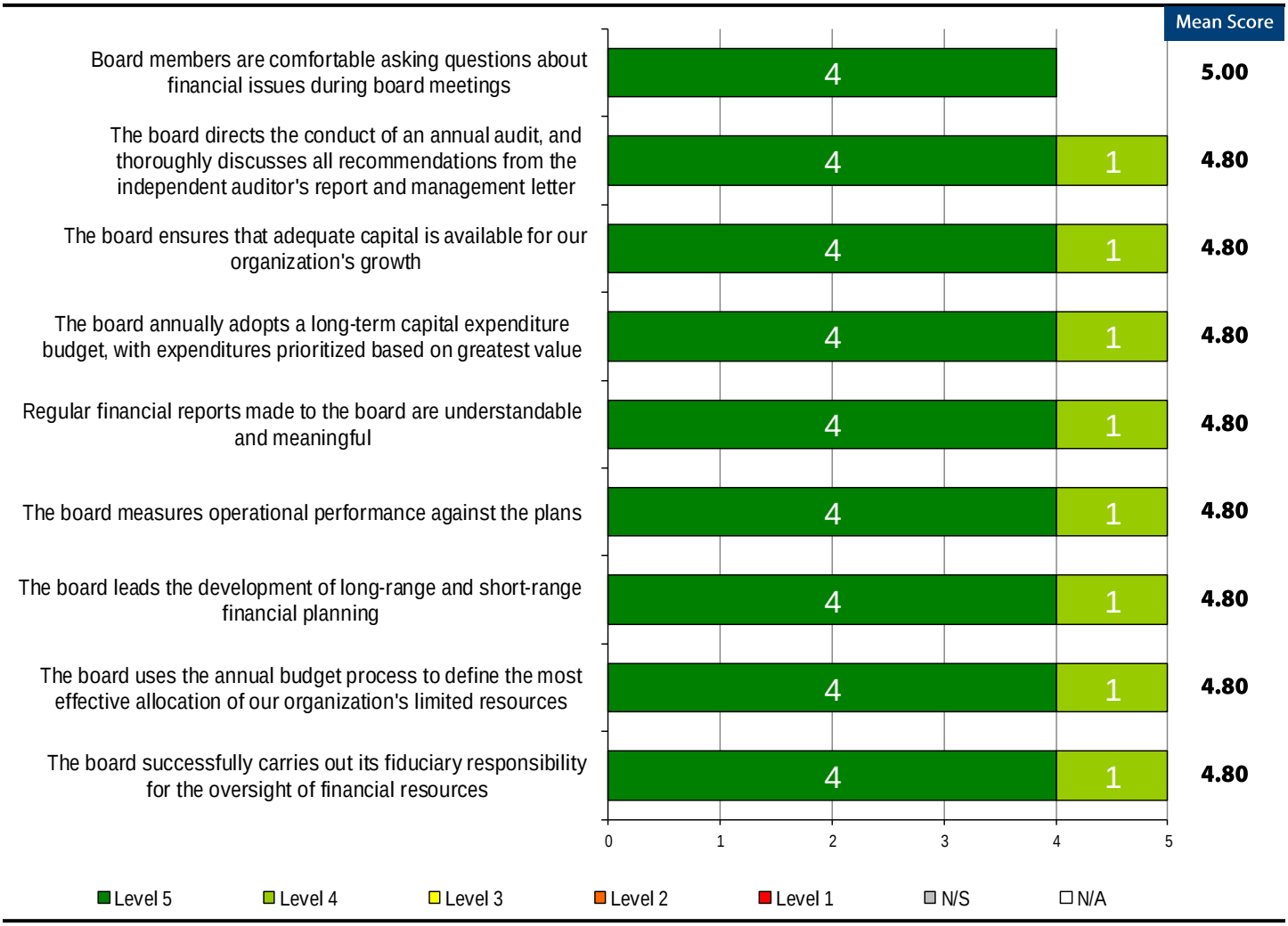
Board members provided the following suggestions for governance improvement in this section:

- All work well together.

Financial Leadership

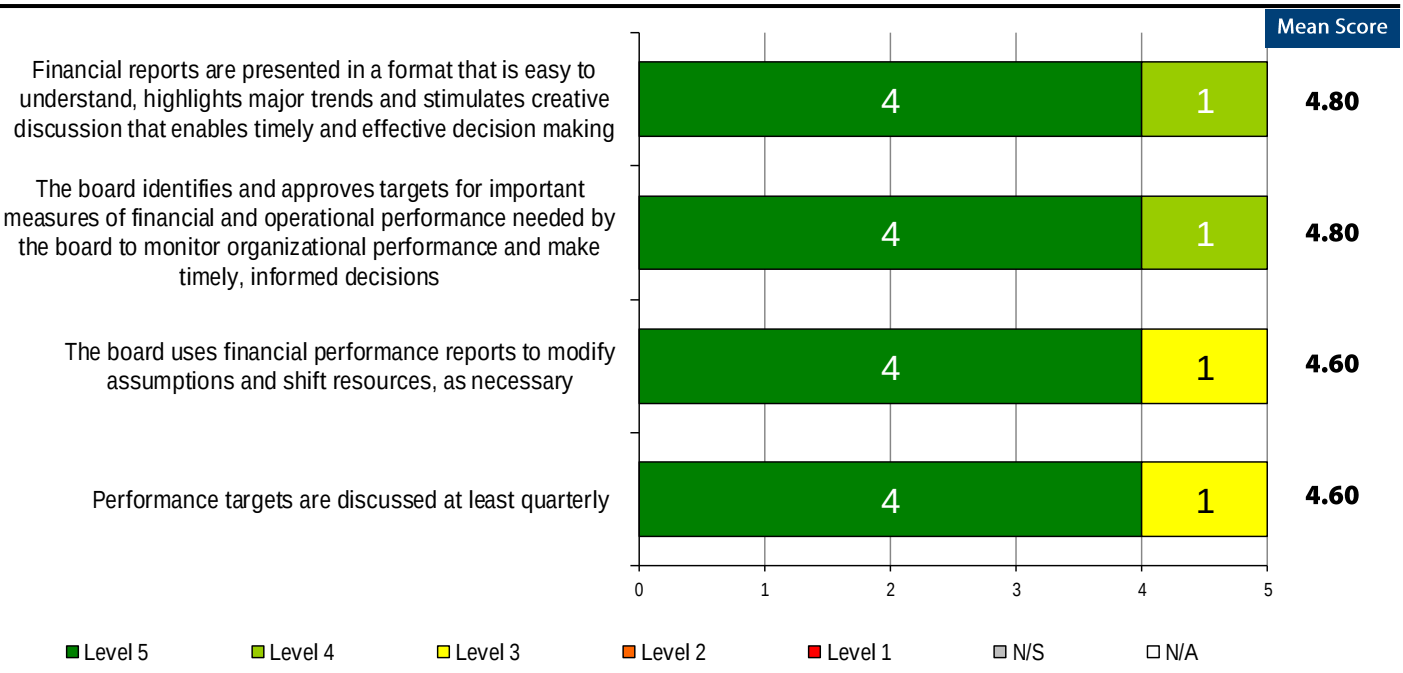
The Fiduciary Responsibility

(sorted by highest to lowest mean score)



Monitoring Progress

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

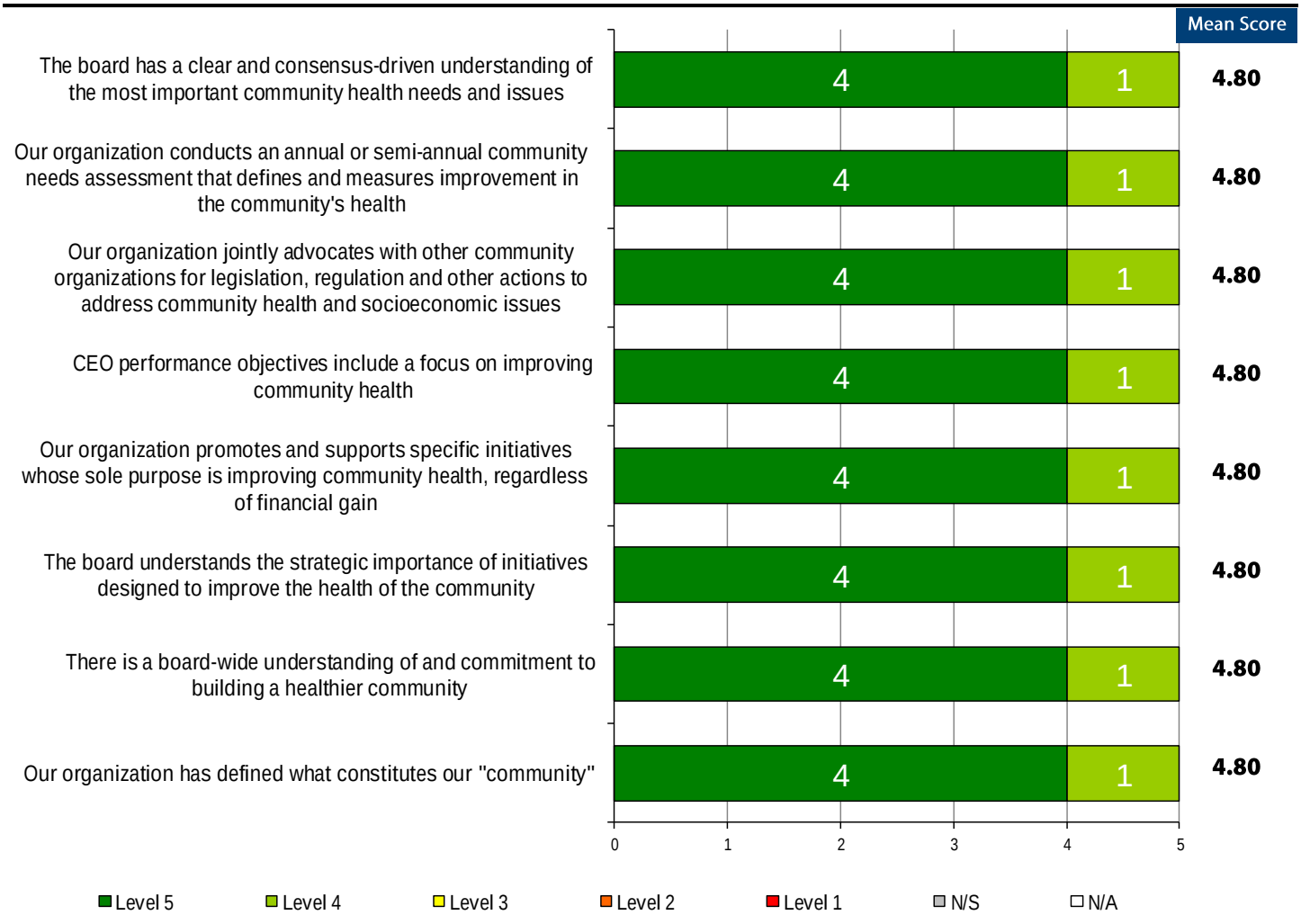
Board members provided the following suggestions for governance improvement in this section:

- Our staff and Board do an excellent job of review (finance, board meetings) and matching with strategic direction, etc.
- We have a great financial team.

Community Health

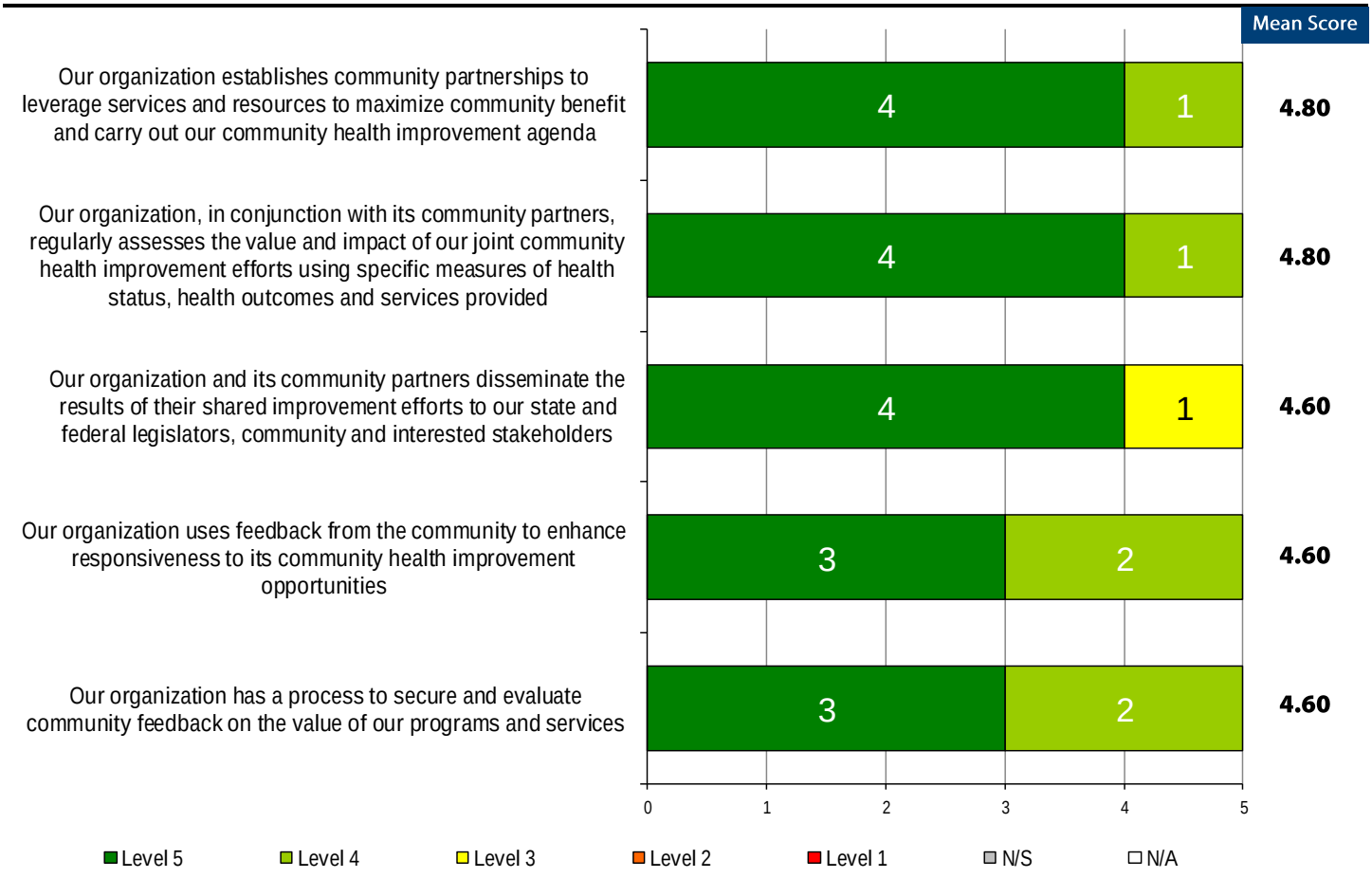
Development and Support of Community Health Initiatives

(sorted by highest to lowest mean score)



Community Involvement and Communication

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

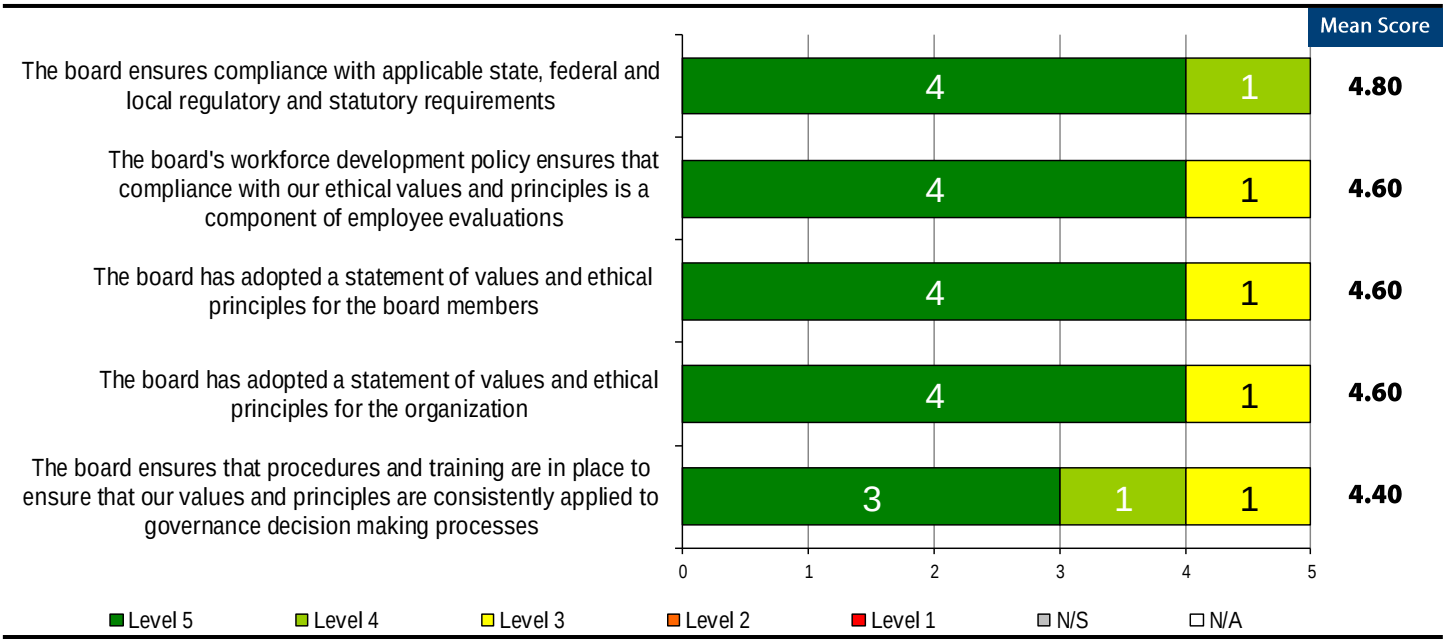
Board members provided the following suggestions for governance improvement in this section:

- Our own survey and community assessment are leading the county-wide initiative. In the future, may be indicated once we are a direct service provider in the clinic.

Organizational Ethics

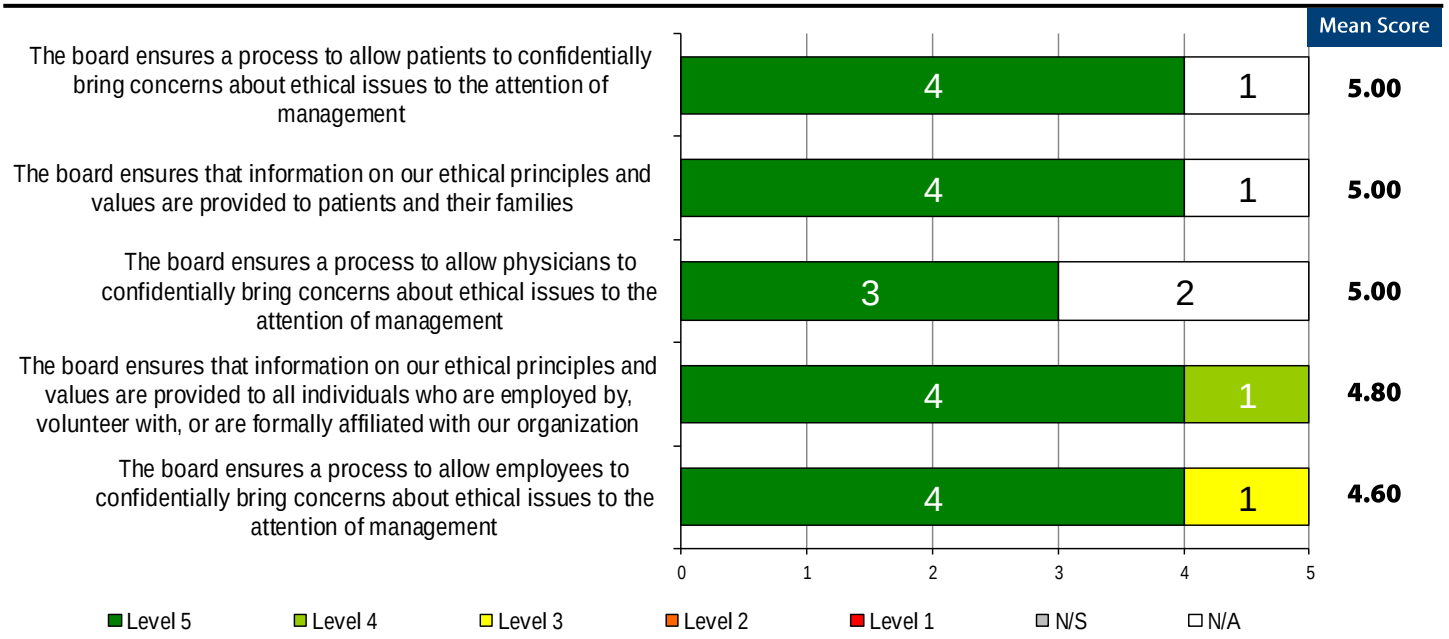
Ensuring Development and Implementation of Organizational Ethics

(sorted by highest to lowest mean score)



Awareness of Ethical Issues

(sorted by highest to lowest mean score)



Suggestions for Governance Improvement

No comments or suggestions for governance improvement were provided in this section.

Issues and Priorities

Highest Priority for the Board in the Next Year

Question: What is your single highest priority for the board in the next year?

- Successful opening of the new clinic.
- Open the Valley Springs Health & Wellness Center.
- Finish and open new clinic.
- For each Board member to be fully engaged - promote the HCD, and participate as/when needed in activities related to the opening/roll out of the VS clinic.
- Getting more information about our District out to our community.

Most Significant Strengths

Question: What are the board's most significant strengths?

- Goal-driven awareness of community needs.
- Ability to work well together for the common good of the community.
- Advocacy for access to health care in our County/HCD.
- We work as a team and express ourselves respectfully of each other. Meetings are structured and work gets completed.
- Communication working as a team.

Most Significant Weaknesses

Question: What are the board's most significant weaknesses?

- Not enough resources to accomplish the work needed to be done.
- Too few staff to do too much work.
- So busy - need more time with lots going on.
- At times its difficult for committees to have a meeting as we are all very busy.

Key Issues for Board Focus in the Next Year

Question: What key issues should occupy the board's time and attention in the next year?

- Getting our new clinic finished, staff hired and opened for the community.
- Providing health care and excellent patient service in the new clinic.
- VS clinic.

- Delving in to running a clinic.
- Rapid growth of staff and impact in the VS community due to the VS clinic (being able to be nimble as unforeseen issues arise-governance wise).
- Transition to new 30 year lease with DH/MTMC.
- Transitioning into a new management lease.
- To get more community involved with awareness of our district.

Significant Trends the Board Must Understand and Deal with in the Next Year

Question: What do you see as the most significant trends that the board must be able to understand and deal with in the next year?

- Changes in health care payment and its impact to the hospital and our new clinic, and possible impact on service delivery in our new clinic. Possible need to re-align the district if challenged politically and legally.
- Lots of financial obligations, primarily with respect to running a new clinic.
- Protecting our future investments, provide health care for the community, continue funding special grants, listening to community input, and being ready for disasters in county.
- Grant program guidelines that conforms to AB2019.
- The community needs.

Critical Factors to Address to Successfully Achieve Goals

Question: What factors are most critical to be addressed if the hospital is to successfully achieve its goals?

- Listen to the community, evaluate issues and be flexible to change.
- To be aware of the needs in our community.
- Needs of the community are met.
- Ensuring we, the board, "stay in our lane" of governance as the organization grows significantly the next 2-3 years, yet knowing when/if we need to dig in more with possible future risk areas (financial, compliance, regulatory) and ensuring we support the CEO to remain/continue his successful path and allocate the resources necessary to do so, when needed.
- Strong board.
- Good relationship with Mark Twain Medical Center.
- Financial future.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Universal Precautions	REVIEWED: 11/20/18
SECTION: Infection Control	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Universal Precautions

Objective: To prevent the transmission of blood borne pathogens by following universal precautions as recommended by the Centers of Disease Control, the California Department of Public Health and other pertinent regulatory agencies.

Response Rating: Mandatory

Required Equipment:

Procedure:

General Guidelines:

1. Blood and body fluid precautions will consistently be practices for all patients since medical history and examination cannot reliably identify all patients infected with HIV or other blood borne pathogens.

2. Wash hands between all patient contacts and immediately if soiled with blood or body fluids.

3. Skin or other mucous membranes should be washed with soap and water, or flushed with water, as appropriate, as soon as feasible following contamination with blood or other body fluids.

4. Gloves will be worn in the following situations:

    a. Touching blood and body fluids
    b. Touching mucous membranes (e.g. inside mouth, rectum, vagina)
    c. Touching non-intact skin of all patients or when health care worker's skin is not intact
    d. Handling items or surfaces soiled by blood or other body fluids
    e. Performing venipuncture
    f. Processing blood or any other fluid specimen

5. Gloves should be changed after contact with each patient and hands should be thoroughly washed with soap and water.

6. Surgical masks and protective eyewear (e.g. goggles) should be worn during procedures that are likely to generate droplets, splattering or aerosolization of blood or body fluids, to prevent exposure to

mucous membranes of the mouth, nose, and eyes.

7. N95 masks will be utilized when the patient presents with symptoms of infectious diseases that require airborne precautions (i.e.: H1N1, flu, tuberculosis).

8. Impermeable gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other bodily fluids.

9. Disposable personal protective equipment shall be removed and placed in refuse containers in the immediately area after single patient use.

10. All procedures involving blood or other potentially infectious material shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of the substances.

11. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials are present.

Use and disposal of needles and "sharps":

1. Precautions should be taken to prevent accidental injuries with needles, scalpels, or other sharp devices used during procedures, when cleaning reusable instruments, during disposal of needles, or when handling sharp instruments during or after procedures.

2. Contaminated needles and other contaminated "sharps" shall not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulate by hand.

3. If the procedure would require that the contaminated needle be recapped or removed and no alternative is feasible and the action is required by the medical procedure, the recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique.

4. After use, needles and syringes, scalpel blades, and other sharp disposable items should be placed in a puncture resistant container for disposal. Reusable "sharps" containers should be sealable, puncture resistant, labeled with a biohazard label and leak proof.

5. All collection containers when filled shall be sealed and put in the appropriate place for disposal. Containers shall be disposed of when ¾ full or every 90 days.

6. Although saliva has not been implicated in the transmission of HIV< to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices will be available for use in areas where the need for resuscitation might arise.

7. Personnel with exudative skin lesions or weeping dermatitis should refrain from direct patient contact or handling patient care equipment, until the skin condition resolves. If this is not possible, gloves must be worn during patient examination procedures.

Sterilization and Disinfection:

1. All non-disposable instruments, items, and devices that come in contact with blood, other body fluids, or mucous membranes, shall be sterilized prior to re-use.

2. Medical devices that require sterilization shall be thoroughly cleansed prior to sterilization with the germicidal soap.

3. When a brush is used to wash instruments prior to sterilization, workers shall be careful to avoid splashing to the eyes and face (eye goggles or a face shield are recommended).

4. Surfaces contaminated with blood and body fluids shall be decontaminated with an appropriate chemical germicide. Gloves shall be worn during this procedure.

Specimens:

1. Body fluids, tissues, and other potentially infectious materials shall be placed in a container that prevents leakage during the collection, handling, processing, storage, and transport of the specimen.

2. Any specimens that could puncture a primary container shall be placed within a secondary container that is puncture resistant.

3. If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container that prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

Management of Exposures:

1. An incident must be documented on a Personal Accident/Incident and OSHA 300, 300A, and 301 report forms (see Personal Accident/Incident Policy Exposure Control Policy) in the event there is a:

    a. Parenteral (e.g. needle stick or cut) or mucous membrane (e.g. splash of the eye or mouth) exposure of blood or other body fluids;

    b. Cutaneous (e.g. skin) exposure involving large amounts of blood.

2. If the source of exposure is known and available, testing for Hepatitis B and C and HIV should be carried out with informed consent and counseling. See HIV Testing policy.

3. If the source refused testing, follow the procedure for an unknown source.

4. If the source is unknown, the employee should be advised to have blood drawn as soon as possible following the incidents and this blood should be tested for HIV, Hepatitis B and C.

5. If on the basis of clinical history or laboratory information it is suspected that the patient from whom the blood came from might be infected with HIV, following the current Human Resources Policy requirements.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: STERILE SUPPLIES AND INSTRUMENTS	REVIEWED: 11/20/18
SECTION: CLINICAL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Sterile supplies and implements

Objective: To maintain sterility of sterile supplies and instruments in an effort to prevent infection.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Sterile supplies and instruments will be checked monthly and before each use to insure the package integrity and expiration date.

2. Supplies that are in the manufacturer's packaging will be considered sterile in accordance with the packaged expiration date and/or printed information if package integrity has been maintained.

3. Supplies or equipment whose package integrity has been breached will be replaced, re-sterilized, or disposed of in accordance with manufacturer's recommendation and OSHA regulations.

4. Staff will perform sterilization of re-usable implements on site, using the autoclave.

5. Sterile instruments and supplies autoclaved on site will observe the following expiration guidelines:

    a. Paper wrap – 3 months
    b. Cloth wrap – 3 months
    c. Cellophane pouches which are tape-sealed – 90 days

6. Any damage or break in packaging is cause for re-sterlization of the item.

7. Packages will be labeled prior to sterilization with the label including:

    a. Description of package contents
    b. Date of sterilization
    c. Month, day, and year of expiration (i.e.: exp 7/11/18)
    d. Initials of staff member performing sterilization

8. Every use of the autoclave will be logged on the autoclave log and will include:

   a. Date and time of sterilization
   b. What was sterilized
   c. Cycle used
   d. Name of staff member performing sterlization

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: **Sterile Shelf Life**	REVIEWED: 11/20/18
SECTION: **Clinical**	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Sterile Shelf Life

Objective: To ensure delivery of sterile, quality product for patient care, with sterility being determined by proper sterilization technique and uncompromised package integrity rather than by date on the package. As maintenance of sterility is event related, not time related, all items sterilized are to be labeled "sterile unless package is damaged or opened". The user will have the ultimate responsibility to examine packaging prior to use to determine the integrity of the packaging.

Response Rating: Mandatory

Required Equipment:

Procedure

1. Each sterilized package is to have the name of the contents, the date of sterilization and the sterilizer load number. It will also have the initials of the person who prepared and processed the package. No expiration date will be present.

2. All items processed for sterilization are to be properly wrapped and processed in such a manner as to provide an effective barrier to microorganisms. Infrequently used items will be packaged in peel pouches. Items that are properly packaged and sterilized will remain sterile indefinitely unless opened or the integrity of the package is compromised.

3. Packages that contain medications are to have an expiration date that reflects the expiration date of the medication. Materials that deteriorate with the passage of time will have an expiration date.

4. Stock is to be rotated so that it is current and paper wrappers do not age to the point of brittleness. Supplies are to be pulled from the right, front or top of the shelf, depending on how the shelf is arranged and newly processed supplies will be added to the shelf from the left, back or bottom.

5. All packages are to be inspected before use. If the package is torn, wet, has a broken seal or has been damaged in any way, it is to be considered contaminated and reprocessed.

6. Sterile supplies are to be stored in a clean, dust free environment and in a manner that does not aid in the compromise of the packaging of the product.

7. Sterile items that remain unused on the shelf for longer than two (2) years are to be evaluated for continued need for sterile storage. These items will either be removed from sterile storage or reprocessed.

8. Commercially processed supplies are to have a shelf life label indicating the date beyond which the items should not be used. This will generally apply when something in the package may deteriorate with time rather than loss of sterility unless labeled otherwise, or if the package is damaged.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: STERILE FIELD	REVIEWED: 11/20/18
SECTION: CLINICAL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Sterile Field

Objective: To provide sterile procedure field in the effort to prevent infection.

Response Rating:

Required Equipment:

Procedure:

1. A sterile drape is to be placed over a Mayo stand.
2. Do not place non-sterile items on the sterile drape sheet.
3. The Nurse or Medical Assistant will consult with the practitioner as to which items are needed.
4. Requested items will be placed in their non-sterile package wrapping on the counter.
5. The practitioner will set up their own sterile field after donning sterile gloves.
6. Staff may be asked to assist with the opening of packages and other ancillary tasks in support of the practitioner.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: **Infection Control - Overview**	REVIEWED: 11/20/18
SECTION: **Infection Control**	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Infection Control

Objective: Staff will follow infection control policies in order to protect themselves and others from contaminated materials.

Response Rating: Severe

Required Equipment:

Procedure

1. Hands
    a. Each examination room will have soap and/or alcohol-based gel hand sanitizer which will to be used before and after the care of each patient.
2. Instruments
    a. Instruments are to be sent to the lab area for sterilization.
    b. Single use implements are to be properly disposed of after single use. Single use implements will never be sterilized and re-used.
3. Thermometers
    a. The oral digital thermometer will be marked ORAL and used with disposable plastic covers, orally, only.
    b. The rectal digital thermometer will be marked RECTAL and used with disposable plastic covers, rectally, only
    c. The temporal scan thermometer will be sanitized between uses, per manufacturer's recommendation.
4. Room cleaning
    a. Routine cleaning is the responsibility of the Housekeeping Service.

b. The Clinic staff is responsible for the cleaning of examination tables and door handles with a germicidal solution after each patient visit and after any spills or contamination.

5. Contaminated Materials and Garbage Collection

a. Contaminated materials shall be bagged and transported to the infectious material pick-up area.

b. Non-contaminated materials are to be placed in plastic bags to be picked up by Housekeeping Service each day.

6. Biologicals

a. Biologicals will be stored in the refrigerator located in the medication room or laboratory.

b. Dated materials are to be checked once a month and discarded according to the Sterile Shelf Life policy.

7. Syringes and Needles

a. Syringes and needles shall be of disposable material and discarded in appropriate sharps containers located in each examination room and lab area.

8. Contaminated Wounds

a. All cases are to be treated as having been possibly contaminated.

b. Disposable materials will be wrapped and placed in an infectious waste bag.

c. The infectious waste bag shall be disposed of according to the procedure for Contaminated Materials.

9. Airborne Pathogens

a. Patients who are coughing and/or sneezing will be offered a disposable mask and asked to wear same, in order to reduce exposure of other patients, guests and staff members.

b. After patient care has been completed and the patient has vacated the examination room, assigned staff will don gloves and clean the room surfaces (door knobs, examination table, guest chairs, counter top).

c. N95 masks will be utilized when the patient presents with symptoms of infectious diseases that require airborne precautions (i.e.: H1N1, flu, tuberculosis).

d. Staff will utilize the cleaning products approved by the Infection Control Committee and issued by the Housekeeping Service. After cleaning is completed, the room will be taken out of service (for a minimum of 15 minutes, maximum of 60 minutes), allowing the damp surfaces to air dry.

e. Where possible, examination room windows will be opened to allow the circulation of fresh air.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: INFECTION CONTROL	REVIEWED: 11/2/18
SECTION: INFECTION CONTROL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Infection Control

Objective: To establish guidelines that will assist staff to prevent the spread of infection, ensure the use of aseptic technique and report communicable diseases.

Response Rating: Mandatory

Required Equipment: Soap, water, sterile gloves, and approved disinfectant.

Implementation:

1. Wash hands with soap and water:

a. Before coming on duty
b. Before and after direct and indirect patient contact.
c. Before and after performing any body functions, such as blowing your nose or using the toilet
d. After direct or indirect contact with **any** body fluid (urine, blood. sputum)
e. Before and after catheter insertions, blood draws, dressing changes and other sterile procedures
f. Before and after caring for a patient with known or suspected infection
g. After completing your shift

2. Other guidelines:

a. Clean under your fingernails with brush before and after working in a high-risk situation
b. Avoid hand creams while working as it may interfere with antiseptic solutions
c. Always wash hands before and after wearing sterile gloves
d. Between patients, it is acceptable use alcohol based hand sanitizers if your hands are not visibly dirty

3. Disinfectant Guidelines:

a. Make fresh disinfectant solution as needed according to manufacturer directions
b. Mark disinfectant solution with name and date prepared, your initials and expiration date
c. Never add fresh disinfectant solution to an already prepared solution

4. Guidelines for medical equipment coming in contact with body fluid

   a. Clean article according to manufacture guidelines.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: HAZARDOUS WASTE	REVIEWED: 11/20/18
SECTION: INFECTION CONTROL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Purpose: Hazardous Waste

Objective: The Environmental Protection Agency has grouped certain chemicals and chemical groups into categories which have been classified as toxic. This means that in concentrated form or by accumulating and combining with other chemicals (even the air) these chemicals can be hazardous to human health if exposure occurs.

Policy: The Clinic insists that employees not create hazardous wastes that will contaminate the environment. Whenever possible, employees should choose non-hazardous materials. If an employee uses hazardous materials, he must properly dispose of them. No employee shall knowingly dump any hazardous wastes into the environment at any time. Violation of this policy will result in disciplinary action, including termination of employment.

If any employee suspects that the wastes he may encounter as an employee are hazardous (whether or not they are being created by the Clinic), should inform the supervisor immediately. If any employee does not know how to control or dispose of hazardous wastes and what to do if he is exposed to hazardous wastes, the employee should consult with the provider on duty and refer to the Safety Data Sheets reference book located in the lab.

- Focus on patient and staff safety.
- Be alert to hazardous wastes.
- Wear appropriate personal protective equipment.
- Know how to properly dispose of hazardous wastes.
- Direct any questions to your supervisor.
- Report all exposures immediately.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Handwashing	REVIEWED: 11/20/18
SECTION: Infection Control	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Handwashing

Objective: To support Universal Precautions and staff and patient safety, all employees, volunteers, contractors, and medical staff shall wash their hands frequently with soap, friction, and running water to minimize the likelihood of hands serving as vectors for nosocomial infections.

Response Rating:

Required Equipment: Soap and water

Handwashing Indications (soap and water):

- Upon arriving at work
- Before and after performing invasive procedures
- Before and after touching wounds
- After situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood, body fluids, secretions, or excretions, other potentially infectious materials
- After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms
- Between contacts with different patients
- After the removal of gloves or any other personal protective equipment (PPE)
- Before eating or drinking, applying cosmetics or lip balm
- After using the restroom
- After blowing one's nose
- After the work shift
- After handling patient equipment

- When hands are visibly soiled or contaminated with proteinaceous material

Procedure:

Handwashing with soap and water

1. Stand near the sink, avoiding direct contact.
2. Turn on the water to a comfortable temperature. Water that is too hot will cause chapped skin.
3. Wet hands/wrists with running water.
4. Obtain handwashing agent (usually 3-5 ml or per manufacturer's recommendations) from the dispenser and apply to hands. Thoroughly distribute over hands.
5. Vigorously rub hands together for 10-15 seconds, generating friction on all surfaces of the hands and fingers. Pay particular attention to fingernails and nailbed areas.
6. Rinse hands thoroughly with running water to remove residual soap. Water flow should be from fingertips to wrist.
7. Obtain paper towel and dry hands thoroughly.
8. Discard paper towel.
9. Obtain second paper towel to turn off the faucet.
10. Discard second paper towel.

Handwashing indications (alternative to soap and water with an alcohol-based waterless hand rub)

1. If hands are not visibly soiled, use an alcohol-based waterless antiseptic agent for routinely decontaminating hands in all other clinical situations.
2. Decontaminate hands after contact with a patient's intact skin (as in taking a pulse or blood pressure).
3. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, as long as hands are not visibly soiled.
4. Decontaminate hands if moving from a contaminated body site to a clean body site during patient care.
5. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
6. Decontaminate hands before inserting indwelling urinary catheters or other invasive devices that do not require a surgical procedure.
7. Decontaminate hands after removing gloves.

Handwashing (hand hygiene) with water less antiseptic agent such as an alcohol-based handrub

1. Apply product to palm of one hand. (Follow the manufacturer's recommendations on the volume of the product to use.)

2. Rub hands together, covering all surfaces of hands and fingers, until hands are dry. (If an adequate volume of an alcohol-based handrub is used, it should take 14-25 seconds for hands to dry.)

Reference:

- "Guideline for Hand Hygiene in Health-Care Settings", retrieved on 1/12/16 from cdc.gov.gov/mmwr/PDF/rr/rr5116.pdf.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: **Fit Testing**	REVIEWED: 11/20/18
SECTION: **Clinical**	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Fit Testing

Objective: Clinic personnel will comply with the N95 mask fit testing program, consistent with California Aerosolized Pathogen Guidelines.

Response Rating: Severe

Required Equipment: N95 mask

Procedure

1. All Clinic personnel will be fit tested for N95 masks within the first 90 days of their employment.
2. Personnel will not be allowed to use a N95 mask prior to completing their initial fit test.
3. All Clinic personnel will be re-tested annually.
4. N95 masks will be utilized when the patient presents with symptoms of infectious diseases that require airborne precautions (i.e.: H1N1, flu, tuberculosis).

Reference: https://www.dir.ca.gov/title8/5199a.html January 2018

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Exposure Control Plan	REVIEWED: 11/20/18
SECTION: Infection Control	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Exposure control plan

Objective: To ensure compliance with OSHA and FOSHA blood borne pathogen and universal precaution standards.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Exposure determination

   a. OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. The job classifications in this category are nurse practitioners, physician assistants, registered nurses, licensed vocational nurses, medical assistants, radiology technicians.

2. Tasks and procedures that may expose employees to blood borne pathogens

   a. The scope of occupational tasks and procedures that may expose Clinic employees to blood borne pathogens is rapidly changing. This is intended to be a general guideline against which all tasks can be measured.

   b. Any tasks and procedures that could be reasonably anticipated to provide contact with the employee's skin, eye, mucous membrane, or blood with potential infectious materials are included. Potentially infectious material means:

      The following human body fluids: blood, semen, vaginal secretions, cerebrospinal fluid, synovial (joint) fluid, pleural (chest cavity) fluid, peritoneal (abdominal cavity) fluids, amniotic fluid,

saliva in dental procedures, any body fluid that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

- Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
- HIV-containing cell or tissue cultures, organ cultures, and HIV-or HBV or HCV-containing culture medium.

3. Compliance methods

a. Universal precautions

i. Universal precautions shall be observed in order to prevent contact with blood or other potentially infectious materials. See universal precautions policy.

ii. All blood or other potentially infectious materials shall be considered infectious regardless of the perceived status of the source individual.

b. Engineering and work practice controls

i. Engineering and work practice controls shall be utilized to eliminate or minimize exposure to employees.

ii. Where occupational exposure remains after institution of these controls, personal protective equipment shall be utilized.

iii. The following engineering controls shall be utilized:

- Disposable sharps waste containers

iv. The above controls shall be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows:

- Sharps containers shall be checked with each use and changed when three-quarters (3/4) full or every 90 days, whichever comes first.

c. Hand washing facilities

i. See hand washing and glove use policies.

ii. Hand washing facilities or hand sanitizers are available to the employees who incur exposure to blood or other potentially infectious materials. These facilities shall be readily accessible after incurring exposure and are located in each patient care area.

d. Eyewash station

i. The eyewash station will be easily accessible and unobstructed for ease of use to employees who are performing those tasks that may result in splashes of hazardous chemicals to the eye.

ii. The employee will be able to access the eyewash station within 10 seconds of exposure. The eyewash station will operate with a one-hand movement to initiate water flow. Hot water will not be available to the station. Once water flow has been initiated, the station will operate hands free with water flowing from both sides to the face and with sufficient force for the water to meet in the middle.

iii. The employee will flush eyes for 15 minutes holding both eyelids open.

iv. The eyewash station will be inspected weekly for ease of access, one hand movement water flow initiation, and hands free operation. The inspection will last no less than 3 minutes.

e. Needles

i. Contaminated needles and other contaminated sharps shall not be bent, recapped, removed, sheared, or purposely broken. They shall be immediately discarded into a labeled sharps container easily accessible to personnel and close to the area of their use. The containers shall comply with OSHA regulations.

ii. OSHA allows an exception if the procedure would require that the contaminated needle be recapped or removed and no alternative is feasible and the action is required by the medical procedure. If such action is required, then recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique.

f. Containers for reusable sharps

i. Contaminated sharps that are reusable are to be placed immediately, or as soon as possible, after use into appropriate, hard-sided containers for the purpose of moving the item(s) from the patient care area to the designated sterilization area.

ii. Those containers should be sealable, puncture resistant, labeled with a biohazard label, and leak proof. The containers shall comply with OSHA regulations.

g. Work area restrictions

i. In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke, handle contact lenses. Food and beverages are not to be kept in

refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials are present.

ii. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

iii. All procedures shall be conducted in a manner that minimizes splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials.

h. Specimens

i. Specimens of blood or other potentially infectious materials shall be placed in a container that prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

ii. The container used for this purpose shall be labeled or color-coded in accordance with the requirements of the OSHA universal precautions.

iii. Primary containers that contain specimens which could puncture the container or are contaminated shall be placed within a secondary container which is puncture resistant and prevents leakage during the handling, processing, storage, transport, or shipping.

iv. Refrigerators or other storage areas where specimens are kept shall not contain food or drink. They shall be labeled in compliance with the OSHA universal precautions.

i. Contaminated equipment

i. Equipment that has been contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping.

ii. Decontamination shall be performed as necessary unless the decontamination of the equipment is not feasible.

j. Personal protective equipment

i. All personal protective equipment used at this facility shall be provided without cost to employees.

ii. Personal protective equipment shall be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment shall be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions and for the duration of time, which the protective equipment shall be used.

iii. Protective clothing shall be provided to employees and within the work area where exposure is reasonably expected to potentially infectious materials.

iv. All personal protective equipment shall be cleaned, laundered, and disposed by of by the employer at no cost to employees. The employer at no cost to employees shall make all repairs and replacements.

v. All garments, which are penetrated by blood, shall be removed immediately or as soon as feasible. All personal protective equipment shall be removed prior to leaving the work area.

vi. Gloves shall be worn where it is reasonably anticipated that employees shall have contact with blood, other potentially infectious materials, non-intact skin, and mucous membranes. Gloves shall be available in every patient care area. Specialized gloves, powderless or hypoallergenic gloves shall be made available to any employee requesting them. They shall be kept in an area central to the employee's workspace.

vii. Disposable gloves are not to be washed or decontaminated for reuse and are to be replaced as soon as practical when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised. Utility gloves may be decontaminated for re-use provided that the integrity of the glove is not compromised. Utility gloves shall be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

viii. Masks in combination with eye protection devices, such as goggles or glasses with solid side shield, or chin length face shields, are required to be worn whenever splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and eye/nose, or mouth contamination can reasonably be anticipated. This shall include work procedures that require pouring of potentially infectious liquids.

ix. Appropriate protective clothing, such as gowns, aprons, or similar outer garments that are impervious to liquids are to be worn whenever splashes, spray, splatter or droplets of blood or other potentially infectious materials may be generated and skin or clothing contamination can be reasonably anticipated.

k. Contaminated work surfaces, containers, and glass

i. All contaminated work surfaces shall be decontaminated after completion of procedures and immediately, or as soon as feasible, after any spill of blood or other potentially infectious materials, as well as at the end of the day if the surface may have become contaminated since the last cleaning.

ii. All bins, pails, can, and similar receptacles shall be inspected and decontaminated monthly and as needed when there is evidence of leakage of waste onto the surface of the container. The Clinic staff shall assume responsibility and documentation of this shall be maintained.

iii. Any broken glassware, which may be contaminated, shall not be picked up directly with then hands. Broken glass clean up shall be accomplished using a broom and dustpan.

l. Regulated waste disposal

i. All contaminated sharps shall be discarded as soon as feasible in a sharps container. Sharps containers are located in each area in which sharps are used with potentially infectious materials.

m. Waste handling

i. Waste that contains blood or other potentially infectious materials shall be placed in bags that confirm to the OSHA universal precautions in construction and color coding or labeling. They shall not be compressed and shall be collected and disposed in a manner consistent with the hazardous waste regulations of the state and federal government.

n. Hepatitis B vaccine

i. All employees who have been identified as having exposure to blood or other potentially infectious materials shall be offered the Hepatitis B vaccine, at no cost to the employee.

ii. The vaccine shall be offered within 10 working days of their initial assignment to work involving the potential for occupational exposure to blood or other potentially infectious materials unless the employee has previously had the vaccine or wishes to submit to antibody testing which shows the employee to have sufficient immunity.

o. Employee tuberculosis protocol

i. Employee training

a. Upon employment all employees will be trained about TB transmission, symptoms, medical surveillance, and therapy.

ii. Employee surveillance

a. Upon employment, the Clinic offers the Mantoux skin test at no charge to employees

- The Mantoux test is also immediately offered to any employee who is exposed to known or suspected TB patients.
- The Mantoux test is administered to any employee that presents with TB symptoms.
- Mantoux tests are administered once as an initial baseline screen, annually for all employees, every six months for workers with known exposure.

- The physician/nurse practitioner for local health department will promptly evaluate any employee who has a positive PPD test.
- Any employee that has active TB will be placed under the care of a physician, local health department or physician of employee's choice (as circumstances dictate). The medical director will remain informed of the employee's TB status through frequent updates provided by the selected healthcare provider.
- Document exposures on the OSHA form 300, 300A, and 301.

b. Unless under the care of a providing physician, all TB test results should be CONFIDENTIALLY returned to the Human Resources Director.

4. Post-exposure evaluation and follow-up

A. Post-exposure evaluation

1. When the employee incurs an exposure incident, it shall be reported to the physician who shall ensure that a personal accident/incident form and OSHA forms 300, 301A, and 301 are completed and that the physician or nurse practitioner sees the employee immediately. The following information must be included on the OSHA forms:

   - Name and SSN of employee
   - Date and description of incident
   - Type of PPE worn (or not worn)

2. All employees who incur an exposure incident shall be offered post-exposure evaluation and follow-up in accordance with the OSHA standards.

3. Testing should occur as soon as possible. The employee will be tested for HBV, HCV, HIV/AIDS. If the employee declines to be tested they must sign a statement indicating their refusal to be tested and their serum should be saved for 90 days.

B. Interaction with health care professionals

1. The physician shall provide a written opinion for the following post-exposure instances:

   - When the employee is sent to obtain the Hepatitis B vaccine.
   - Whenever the employee is sent to a health care professional following an exposure incident.

2. The written opinion shall be limited to:

   a. Documentation of the incident;

   b. Identification and documentation of the source, unless prohibited by law;

   c. Determination of need for the employee to receive the Hepatitis B vaccine and if the employee has received the vaccine;

d. That the employee has been informed of the results of the evaluation; and

e. Instruction that should be given to the employee regarding any medical conditions that could result from exposure to blood and/or other potentially infectious materials.

3. The employee shall be provided a copy of this written opinion within 15 days of the completion of the evaluation.

C. Training

1. Training for all employee shall be conducted prior to initial assignment to tasks where occupational exposure may occur and annually thereafter.

2. Training shall include the following explanation of:

- The OSHA universal precautions for blood borne pathogens
- Epidemiology and symptomology of blood borne diseases
- Modes of transmission of blood borne pathogens
- This exposure control plan
- Procedures that might cause exposure to blood or other potentially infectious materials at the Clinic
- Personal protective equipment available at the Clinic
- Who should be contacted, and follow-up procedures concerning an exposure incident; post-exposure evaluation
- Signs and labels used at the facility
- Hepatitis B vaccine program at the Clinic

3. The training shall provide an opportunity for interactive questions and answers by a person knowledgeable in the subject matter.

D. Record keeping

1. Medical records

a. Shall contain requirements for documentation of incidents.
b. Records cannot be disclosed without consent.
c. Records must be maintained throughout employment plus thirty (30) years.

2. Training

a. Dates, attendance, and SSN of attendees shall be documented.

b. Records shall be maintained for a minimum of three (3) years.

5. Needlestick safety and prevention act

A. Annually, the Clinic will review the Exposure Control Plan to ensure that it reflects changes in technology that will help eliminate or reduce exposure to blood borne pathogens.

B. The Clinic will involve non-managerial workers in evaluating and selecting safety engineered devices.

1. Sharps evaluation procedure

a. The Medical Director will:

i. Determine which products are to be evaluated and provide at least four or more test samples for each individual evaluating the product. (Each evaluator should have enough samples to disassemble and examine the design thoroughly.) Employees chosen for the sharps evaluation procedure should currently use a similar category of product in the Clinic.

ii. Provide visual instructions and demonstrate the proper use of each device. Be sure testers can evaluate products in a simulated patient environment.

iii. Review the instructions and rating system with each evaluator.

iv. Require each evaluator to complete an evaluation form.

v. Review responses on evaluation forms; make conclusions, and recommendations.

b. The evaluators will:

i. Re-enact all steps of intended or possible procedures performed with the device.

ii. Attempt to misuse the device and circumvent or disable the safety feature.

iii. Answer each question on the evaluation form including any short answer sections at the end. If you do not understand a question, the evaluator will write their comments directly on the sheets.

C. The Clinic will maintain a sharps injury log that ensures employee privacy and contain, at a minimum, the type and brand of device involved in the incident, if known; the location of the incident; and a description of the incident.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURE

POLICY: EXAM TABLE AND EXAM ROOM CLEANING AND DISINFECTION	REVIEWED: 11/20/18
SECTION: INFECTION CONTROL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Exam Table and Exam Room Cleaning and Disinfection

Objective: To reduce nosocomial infections to patients and staff, ALL non-autoclavable materials and surfaces will be sanitized and cleansed with approved agents which are used according to manufacturers' instructions.

Acuity Rating: Mandatory

Procedure:

1. Exam tables, chairs, gurneys, and wheelchairs shall be cleaned between patients.
2. All table paper and pillow covers will be changed between patients.

3 All exam tables will be wiped with approved sanitizing wipes between patients and allowed to air dry..

4 Surfaces coming into direct contact with a patient or used during a treatment or procedure, will be wiped with sanitizing wipes and allowed to air dry.

5 Blood and body fluids must be thoroughly cleaned from all surfaces prior to disinfecting.

6 For large amounts of blood and/or body fluids, an approved spill kit will be used.

7 Allow moisture left on surface from cleaning products to air dry. DO NOT WIPE SURFACES TO DRY.

8. Wipes can be used once gross contamination is removed.

9. Disposable gloves and personal protective equipment (PPE) are to be used while cleaning and to prevent direct contact with blood, body fluids and any surface that may be contaminated by an infectious source.

10. When cleanup is finished, remove gloves and PPE and wash hands.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: **CONTAGIOUS PATIENT**	REVIEWED: 11/20/18
SECTION: INFECTION CONTROL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Contagious Patient

Objective: To contain and limit the spread of contagious illnesses and/or conditions to patients in the waiting room, x-ray areas and to clinic personnel.

Response Rating: Mandatory

Required Equipment: None

Procedure:

1. Signage will be posted on all entry doors advising patients who are presenting with a rash to not enter the waiting room. Patients are to send in friends/family members to advise staff of a potential infectious condition before entering or may call the Clinic from their vehicle parked on the premises.

2. Patients who are coughing and sneezing will be asked to use a disposable mask to contain their airborne germs with patients and staff.

3. The receptionist, nurse, or medical assistant will not make a definitive diagnosis but should depend on visible signs of contagious disease.

4. Patients who are potentially contagious will be instructed to enter through the back door.

5. Room XXX will be used for potentially contagious patients.

6. All registration, discharge, and any billing functions will be performed in the patient room.

7. Personnel assisting the potentially contagious patients will wear personal protective equipment (PPE) as designated by the practitioner

    a. Contact precautions (measles-like rash, poison oak/ivy): gloves, gown, mask
    b. Airborne precautions (suspected tuberculosis, H1N1): gloves, gown, N95 mask

8. If the patient is confirmed contagious, they will be discharged through the back exit.

9. The practitioner will advise staff or any preventive measures or treatments required after a potential

exposure from a contagious patient.

10. Exposure that may cause any illness, injury or side effects to staff, or other patients will be reported on an incident report and sent to the Clinic Manager immediately. The Clinic Manager will meet with the Medical Director and/or Human Resources to take appropriate steps to protect the staff and patients and provide treatment and/or access for any required preventative or required post exposure treatment.

11. Diagnosis of any communicable disease monitored by the County Health Department will be reported following the protocol and guidelines for Communicable Disease Reporting. Appropriate report forms will be completed.

12. Exam room will be cleaned with an approved disinfectant cleaner. All counter, exam tables, pillows and equipment in the room will be wiped with cleaner. Floors will be damp mopped. Where possible, windows will be opened to allow for the exchange of fresh air.

13. Room will be taken out of service for a minimum of 30 minutes.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: CLEANING DUTIES	REVIEWED: 11/20/18
SECTION: INFECTION CONTROL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: **Cleaning Duties**

Objectives: To limit the spread of nosocomial infections by maintaining a hygienic, sanitized environment.

Acuity Rating: Mandatory

Required Equipment: Germicidal solutions, general cleaning supplies, gloves.

Applies to: All Personnel

Procedure

1. All surfaces will be cleaned with an approved germicidal solution on a daily basis.
2. Exam tables will be covered with disposable paper covers and cleaned between patients with an approved germicidal solution.
3. All exam tables will be wiped with approved sanitizing wipe or spray at the end of the shift. This includes the underside of the table.
4. Blood or body fluids spilled will be cleaned up immediately by staff using an approved spill kit.
5. Sinks and door knobs will be cleaned in each examination room, between each patient encounter.
6. Thorough cleaning by a janitorial service will be performed 6 days per week after business hours.

Daily Cleaning

a. Exam tables, chairs, wheelchairs, and gurneys will be wiped by staff with an approved germicidal wipe after each use.
b. Clinic supplied toys for patients and guests will be stored in the receptionist work area, offered to patients, then wiped with an approved germicidal wipe after each use and returned to the designated storage area.
c. Spot cleaning of floors and walls is done as needed, using approved products only
d. Front counters and patient chairs and tables will be wiped as needed using sanitizing wipes and/or sprays. (Frequently during infectious disease outbreaks ie: flu/viral infections.)
e. Equipment contaminated with body fluids will be cleaned immediately.
f. Waiting room, and restrooms will be monitored throughout the shift and shall be kept free of debris and remain in clean status.

Unscheduled non-hazardous spills, non-biohazardous spills, and/or visibly soiled floors

a. The spill area may be visibly cleaned with a dry or wet mop utilizing an approved product.
b. In no circumstance is the dry or wet mop to replace the current approved disinfectant product for hazardous or biohazard waste.

Weekly Cleaning

a. IV stands, vital monitors, cardiac monitors, laboratory equipment, and all medical equipment will be cleaned per manufactures' instructions using approved germicidal and sanitizing products.
b. Laboratory, exam room, triage, front office, and nursing station counters will be cleaned and free of supplies, papers, notes and etc. and will be dusted behind and around computer equipment.
c. Medication dispensing machine will be wiped down.
d. Door handles will be wiped.
e. Trashcan surfaces will be wiped down.

Monthly Duties

a. All walls, ceilings, lights, vents, windows and doors will be cleaned. Monthly cleaning will be performed by the janitorial service.

Communication with Janitorial Service

A communication log for the janitorial service will be kept at the front desk. Any concerns or non-urgent task that needs to be addressed will be written in the Housekeeping Communication Log. Any issues with the janitorial service will be addressed with the clinical administrator.

Hazardous Conditions/ Broken Equipment/Building Damage

a. Conditions that have a potential to cause harm/injury to patients and/or staff are to be reported to the Clinical Director or District Executive Director immediately. A maintenance form will be completed and faxed following telephonic notification of the hazard.
b. Areas affected by hazardous conditions will be taken out of service and marked as restricted from use.
c. Equipment which is broken or functioning outside of approved parameters will be removed from service and marked DO NOT USE, SERVICE/REPLACEMENT PENDING.
d. Where hazardous conditions, broken equipment, and/or building damage put patients and/or personnel at risk, the Clinical Director, District Executive Director and/or the District Board of Trustees may make the decision to close the clinic to use until the hazardous conditions, damage, etc. are resolved.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Blood-borne Pathogen Exposure	REVIEWED: 11/20/18
SECTION: Infection Control	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Blood-borne pathogen exposure policy

Objective: To present an overview of the Exposure Control Plan for Blood Borne Pathogens or Other Potential Infectious Materials (OPIM); to protect the health and safety of the persons directly exposed to biohazard/infectious materials by ensuring the safe handling, storage, use, processing, and disposal of biohazardous/infectious medical waste; to train workers to minimize exposure by using the appropriate engineering controls, protective personnel equipment, and work practices.

Response Rating: Mandatory

Required Equipment:

Definitions:

Health Care Worker (HCW): persons who are in contact with patients, blood, or other physiological fluids.

Employee Health Service (EHS): the Infection Control physician, nurse, and appropriate members of the Infection Control Committee.

Personal Protective Equipment (PPE): use of the appropriate equipment (gowns, gloves, goggles, masks, etc) to minimize/prevent exposure to blood and other physiological fluids.

Hepatitis B Virus (HBV): the blood borne virus that causes Hepatitis B.

Hepatitis C Virus (HCV): the blood borne virus that causes Hepatitis C.

Human Immunodeficiency Virus (HIV): the blood borne virus that causes HIV infection and has been linked to Acquired Immune Deficiency Syndrome (AIDS).

Biological Hazard: refers to any viable infectious agent (etiologic agent) or injurious agent that presents a risk, or a potential risk, to the well-being of any human. Blood, semen, vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids, and any other bodily fluid with visible blood are considered to be biological hazardous materials. Not included under universal precautions are feces, urine, nasal secretions, sputum, tears, vomitus, and sweat.

Medical Waste/Injfectious Waste: all waste emanating from human or animal tissues, blood or blood products, or fluids, all cultures of tissues, cells of human origin, or cultures of etiologic agents; specimens of human or animal parts or tissues removed by surgery, autopsy, or necropsy.

Universal Precautions: refers to a system of infectious disease control that assumes that every direct contact with body fluids is infectious and requires that every employee exposed be protected as though such body fluids were infected with blood borne pathogens. All infectious/medical material must be handled according to Universal Precautions (OSHA Instruction CPL 2.2.44A).

Engineering Controls: the tools/equipment used to minimize exposure risks (i.e. sharps containers, biohazard bags, etc.).

Work practices: habits/procedures used by employees to minimize exposure risk.

Introduction: By law, an infection control plan must be prepared for every person that handles, stores, uses, processes, or disposes of infectious medical wastes. This infection control plan complies with the OSHA requirement 29 CFR 1910.1030, Blood Borne Pathogens. This plan includes requirements for personal protective equipment, housekeeping, training, and a procedure for reporting exposures.

Exposure Categories

Category I

- The normal work routine involves exposure to blood, body fluids, and/or tissues. Any procedure or job-related task that has the potential for spills or splashes of the same.
- Employees are required to use personal protective equipment and procedures.

Category II

- The normal work routine involves no exposure to blood body fluids, or tissue, but the employee might be required to perform an unplanned Category I type task (i.e. clean up spills, etc.)

Category III

- The normal work routine involves no exposure to blood, body fluids, or tissues. Category I tasks are not a part of this job. Persons who perform these duties are not called upon as a part of their work to be potentially exposed in some other way. Category III tasks involve handling implements or utensils; using public or shared bathrooms or telephones; and personal contact **such as hand shaking.**

Exposure Determination

- The normal work in the laboratory involves exposure Category I and II.

Methods of Compliance

- All employees will receive Infection Control and Universal Precaution educations and training when hired, and annually thereafter.
- Universal Precautions shall be observed to prevent contact with blood or Other Potential Infectious Material (OPIM). All physiological material will be considered infectious.

- Failure to use universal precautions is subject to disciplinary action, up to and including termination.

Engineering Controls

- Needles/sharps will not be recapped, bent or clipped. Any attempts to recap or remove needles must be done with a mechanical device or by using a one-handed technique.
- Needle/sharps disposal containers are located throughout the laboratory. Dispose of all needles/sharps in these containers only.
- Biohazard disposal containers are puncture resistant, lined with a red plastic bag labeled with a biohazard insignia, and leak-proof on the sides and bottom.
- All biohazard disposal containers will be double-bagged and closed with a container lid when not in use.
- Biological Safety Cabinets will be certified to meet manufacturer's specifications.

Infection Control Strategies

Work Practice

General

- Practice proper segregation of infectious/non-infectious waste.
- Laboratory director will ensure that the staff is trained in proper work practices, the concept of universal precautions, personal protective equipment, and in proper clean-p and disposal techniques.
- All personnel will be advised of the potential biohazard before being allowed to enter the work area.
- A universal biohazard symbol will be posted on all access doors at all times.
- Refrigerator/cabinets storing blood or other biohazardous materials must be labeled with a biohazard label indicating the presence of these materials.
- Eating, drinking, smoking, applying cosmetics or lip balms, or handling contact lenses where there is a potential exposure to blood or other potentially infectious materials is not allowed. The above actions may only be performed in designated areas.
- Food or drinks shall not be stored in refrigerators, freezers, cabinets, or shelves where there is a potential exposure to blood or other potentially infectious materials is not allowed. The above actions may only be performed in designated areas.
- Food or drinks shall not be stored in refrigerators, freezers, cabinets, or shelves where blood or other potentially infectious materials are stored.
- No employee shall pipette or suction blood or other potentially infectious materials by mouth.
- Good hygiene practices will be expected. Employees will practice washing of hands before entering administrative areas.

Waste

- Infectious waste shall never to mixed with non-infectious waste.
- All infectious waste will be placed into designated infectious waste containers.
- Infectious waste containers must be labeled with biohazard labels; red biohazard bags must be used as liners; container lids must be fit tightly and properly, and must remain closed when not in use; foot operated mechanisms are required.
- All biohazardous waste is deposited into red waterproof bags.
- Infections/biohazardous wastes must be picked up and disposed of by a contracted, licensed vendor.
- Biohazard disposal containers will be double bagged and ¾ filled before starting new waste bag.

Environment

- The Clinic environment is to remain clean and sanitary at all times. PPE will be used to clean contaminated areas and/or equipment.
- Each department must clean and decontaminate all equipment and working surfaces before and after each working shift with 1:10 bleach solutions or other EPA approved cleaning agent after contact with blood or other potentially infectious materials.
- All reusable equipment or apparatus that is contaminated or has a reasonable likelihood for becoming contaminated must be disinfected in an autoclave or soaked in a disinfecting agent prior to being reused.
- Contaminated broken glassware shall be picked up by a mechanical means, not be hand.
- Liquid germicidal soap dispensers must be available in work areas. Cleaning equipment used for biohazardous materials should not be used for non-biohazardous materials.
- Stock solutions of suitable disinfectants must be maintained in the Clinic.

Spill Clean Up

- Employees will wear appropriate Personal Protective Equipment when cleaning up spills or biohazardous wastes.
- All spills will be cleaned with suitable, non-reusable materials.
- Spills areas will be disinfected with a 1:10 bleach solution or other EPA approved cleaning agent.
- Body areas contaminated with a spill will be flushed with generous amounts of running water, followed by an anti-germicidal soap.

Personal Protective Equipment

- The Clinic will provide suitable equipment to protect employees from hazards in the workplace. The Clinic Director or Safety Coordinator can advise the employee on what protective equipment is required for the task.
- The Clinic Director must obtain the PPE and ensure that it is used regularly and properly.

- Protective clothing is not a substitute for adequate caution and common sense in the dealing with infectious and hazardous waste or other potentially injurious situations. Protective clothing however, shall be worn and effectively maintained as a condition of continued employment and part of the mutual obligation to comply with the Occupational Safety and Health Act.
- Personal protective equipment (i.e. gloves, gowns, masks, and goggles in various sizes) are provided, maintained, repaired and/or replaced at no cost to the employee.
- All employees will wear the appropriate protective clothing (i.e. gowns, aprons, lab coats, or other similar garments) whenever there is a potential for exposure. The type of garment will depend on the task or degree of exposure anticipated.
- All employees will wear masks, eye protections, and face shields whenever there is a risk of splashes, sprayed atomized particles, splatter or droplets of blood or other potentially infectious material and in stances where eye, nose, or mouth contamination can be reasonably anticipated.
- Preventive measures will be taken to minimize splashing, spraying, spattering, and generating droplets when working with blood or other potentially infectious material (i.e., before removing a rubber stopper from a specimen tube, it will be covered with gauze to reduce splatter).
- Cover gowns and gloves shall be worn when working with biological waste and infectious materials.
- Specified footwear must be worn.
- Respirator masks must be worn when there is a potential for inhalation of toxic fumes.
- Back supports must be worn when lifting heavy equipment and supplies.
- No jewelry shall be worn during invasive procedures.
- Seat belts shall be worn when driving vehicles during the performance of business.
- Employees must wear gloves when it can be reasonably anticipated that the employee may have contact with blood or OPIM, (i.e., mucous membranes, and non-intact skin) when performing vascular access procedures, when touching contaminated items or surfaces, and when mixing chemotherapy agents.
- Disposable gloves are supplied in different sizes. Avoid petroleum-based lubricants since they may eat through latex.
- Personnel who are sensitive to regular gloves must tell the Clinic Director so hypoallergic gloves can be ordered.
- Disposable gloves will:

  Be replaced as soon as possible if they are contaminated, torn, punctured, etc., and disposed of in the red biohazard waste bags.

  Not be washed, decontaminated or reused.

Skin Conditions

- Employees shall refrain from high-risk exposure tasks when a skin condition exists

Cuts, scratches, and abrasions must be suitably dressed and covered during exposure situations.

Rashes, skin disorders and diseases should have medical attention and clearance for work.

Hand washing

- Hands will be washed with a suitable germicidal agent under, but not limited to, the following situations:

  Upon arrival to and leaving the work area

  After the removal of protective barriers and gloves

  Immediately or as soon after possible contamination with blood or body fluids

- The proper hand washing technique will be to lather the hands with a suitable germicidal agent and warm water, followed by a vigorous rubbing of palms, the fingers, and in-between the fingers.

Hepatitis B Vaccination

- Hepatitis B Vaccination shall be made available to employees after they have received the required safety training and within 30 working days of initial assignment to all employees who have occupational exposure except under the following conditions:

  The employee has previously received the complete Hepatitis B vaccination series.

  Antibody testing reveals that the employee is immune.

  The vaccine is contraindicated for medical reasons.

- If the employee initially declines hepatitis B vaccination but at a later date, while still covered under the stand, decides to accept the vaccination, the employer shall make available the Hepatitis B vaccine at the time.
- The employer shall assure that employees who decline to accept Hepatitis B vaccination offered by the employer sign the Hepatitis B vaccination declination form. If the U.S. Public Health Service recommends a routine booster dose(s) of Hepatitis B vaccine at a future date, such booster dose(s) shall be made available.
- All medical evaluations and procedures, including the Hepatitis B vaccine and vaccination series, post-exposure evaluation and follow-up, including prophylaxis are available at no cost to the employee and provided according to recommendations of the U.S. Public Health Service.

Exposure

- All employees with accidental exposure to blood or OPIM must notify the Laboratory Director immediately so prompt and immediate attention can be initiated. The Clinic recommends compliance with the current CDC guidelines for exposure to HBV, HCV, and HIV.
- An occurrence report must be completed and the Laboratory Director must be notified of the incident as soon as feasible.
- Following a report of an exposure incident, the employee shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

  The route(s) of exposure, and the circumstances under which the exposure incident occurred;

  The identity of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law.

- The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV, HCV, and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When law does not require the source individual's consent, the source individual's blood, if available, shall be tested and the results documented.
- When the source individual is already known to be infected with HBV, HCV, or HIV, testing for the source individual's known HBV, HCV, or HIV status need not be repeated.
- Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations.
- The employer shall provide for collection and testing of the employee's blood for HBV, HCV, and HIV serological status:

  The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

  If an employee consents to baseline blood collection, but does not give consent at the time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing will be done as soon as feasible.

- The employer shall provide for post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service.
- The employer shall provide for counseling and evaluation of reported illnesses.
- Any employee may refuse to consent to post-exposure evaluation and follow-up from the Clinic. When consent is refused, we shall make immediately available to exposed employees a confidential medical evaluation and follow-up from an outside healthcare professional.

- Employee health files are confidential and will not be disclosed without the written consent of the employee.

Labels and Signs

Labels

- Warning labels shall be affixed to containers of regulated waste, refrigerators, and freezers containing blood or OPIM, and other containers used to store, transport, or ship blood or OPIM.
- Labels will use the OSHA standard legend for blood borne disease prevention, and shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in contrasting color.
- Labels shall either be an integral part of the container or shall be affixed as close as feasible to the container by string, wire, adhesive, or a method that prevents their loss or unintentional removal.
- Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements. Individual containers of blood or OPIM that are placed in a labeled container during storage, transport, shipment, or disposal are exempted from the labeling requirement.

Signs

- The Clinic shall post signs at the entrance to work areas showing the name of the infectious agent, special requirements for entering the area, and the name and telephone number of the Laboratory Director or other responsible person.
- These signs shall be fluorescent orange-red or predominantly so, with lettering and symbols in a contrasting color.

Employee Education and Training

- All employees will receive Infection Control and Universal Precautions education and training when hired, and annually thereafter. Training will be documented and kept with the employee record.
- Training shall be provided at the time of initial assignment to tasks where occupational exposure may take place and at least annually thereafter.

References

- Federal Register/Volume 56, No. 235
- 1001/Rules and Regulations, Department of Labor, Occupational Safety and Health Administration, Final Rule.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Biohazard Material Management	REVIEWED: 11/20/18
SECTION: Infection Control	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Biohazard Material Management

Objective: To instruct Clinic personnel on the proper way to handle and dispose of hazardous material.

Policy Notes:

- Biohazardous waste management is a program used for controlling the generation, collection, and storage of hazardous waste in the laboratory. The responsibility for storage and movement of these materials is that of the Clinic personnel.
- All hazardous materials will be contained in sealable waterproof covered containers with tight fitting lids.
- When collecting biohazardous waste, employees must wear personal protective equipment (PPE).
- Healthcare workers involved in handling regulated medical waste must receive safety training in accordance with the Department of Transportation's (DOT) guidelines.

Response Rating: Mandatory

Required Equipment: Personal protective equipment (PPE): gowns, disposable gloves, face shield; trash bin with lid (marked biohazardous waste); biohazard bags (red) and rubber bands; 10% bleach solution for spill cleanup.

Definitions:

Regulated Medical Waste – any reusable material that contains an infectious substance and is generated in the diagnosis, treatment, or immunization of people or animals. Materials generated in research or in the production and testing of biological products are also considered regulated medical waste. The DOT definition of regulated waste includes blood and blood products, sharps, pathological wastes, certain wastes from surgery, dialysis and the lab, as well as other infectious materials.

Universal Precautions – "health workers should follow universal precautions by using masks, eye protection and face shields whenever splashes spray atomized particles, splatter or droplets of blood or other potential infectious material may be generated and eye, nose, or mouth contamination can be reasonably anticipated."

Procedure:

Accidents and Spills

Immediate action

- Assess the type of spill and degree of hazard involved.
- Determine the most effective and least hazardous approach to clean up and decontaminate the spill. Refer to the SDS when necessary.

"Dry" spill with no significant aerosol formation

- Evacuation of the room is probably not indicated.
- Gloves, lab coat, and face shield must be worn for a clean up.
- Flood area with disinfectant solution.
- Soak up the disinfectant and contaminated materials with an absorbent material.
- All absorbent and contaminated material must be placed in a red biohazard bag.

Liquid spills on a bench or floor

- If significant aerosols are formed, the area should be evacuated and not reentered until the aerosols settle.
- Gloves, lab coat, and face shield must be worn during clean up.
- Cover the spill with an absorbent material.
- Dispose of the absorbent and contaminated material in red plastic biohazard bags.
- The spill area should be thoroughly washed with a disinfectant solution after clean up.

Centrifuge spills

- Shut off the instrument and evacuate the area at once.
- Do not re-enter the area until the aerosols have settled.
- The individual entering the area to clean up must wear protective clothing, gloves and a mask.
- If liquids are present, soak up in an absorbent material and handle as above. If not, clean the instrument and room thoroughly before allowing employees to return to work.

Spills in incubators, autoclaves or other closed areas

- Soak up liquids with an absorbent and dispose of as outlined above.
- The unit should be washed thoroughly after decontamination.

Reports

- Major accidents and spills must be documented and reported in detail to lab director
- Accident reports should include the cause of the accident, the type of contamination or hazard, the list of personnel possibly exposed, decontamination procedures used, and actions taken to prevent reoccurrences.

SHARPS containers

- The RED SHARPS containers are for disposing of hazardous wastes such as needles, scalpels, tips, glass, etc.
- Do not overfill SHARPS containers – between 2/3 and ¾ full is considered capacity.
- Make sure that the top is in locked position before using.
- Never reach into containers: drop sharps straight into the opening 3"-4" above the mount of the container.
- Never dispose of several sharps at once; take time to dispose of each sharp one at a time.
- Always virtually inspect the opening to ensure that there is room for the sharps – always look before putting sharps into a container. Never reach into the mouth of a sharps container.
- Never force anything into a sharps container that is larger than the opening. An alternative means of disposal must be found.
- Securely fasten the top by shaking down the sharps container.
- When a sharps container is 2/3 – ¾ of the way full secure the top and immediately replace the container with a new one.
- Full sharps containers are then transported to the hazardous waste storage area.

Handling and disposing of hazardous waste

- Never put a sharps container into a hazardous waste bag or box unless the container is damaged.
- Do not use a hazardous waste container that is damaged. If a container is damaged, but has already been used, place it inside another hazardous waste container and seal. Handle the damaged container with extreme caution.
- All hazardous waste containers (i.e. bags, cardboard, plastic, plastic containers, etc.) are to be treated as if they were hazardous to your health. All hazardous waste containers will be picked up and held:

  With gloved hands

  At arm's length away from the body

  Securely by the least amount of area held by the hands

  Wear a lab coat, gloves, and face shield. Additional shielding such as gowns, masks, face shields, etc. will be at the discretion of the health worker.

- Check the bottom of all bags for leaks, when bags become heavy with glass they tend to leak.
- In the event of a leak or spill, follow the procedure for biohazardous waste cleanup waste cleanup procedure.
- Wear a lab coat, gloves and face shield.
- Remove waste bags from bins, gently shake bag while holding the top of the bag to distribute waste evenly, twist top of bag to close (do not apply pressure to any part of the bag).
- Place double bags in all emptied bins. Look for leaks around or in the bin. If a leak has occurred, clean the area with a 10% bleach solution, following the biohazardous waste clean-up procedure.

- After transferring the double-bagged laboratory waste, remove your lab coat and gloves, wash hands.

Reducing the volume of hazardous waste

- Waste discarded into the biohazardous waste containers should be limited to those materials that come into contact with infectious materials (body fluids).

    Body fluid containers

    Stoppers, wipes, disposable shields, etc. which have come into contact with body fluids

    Used gloves and lab coats

    Slides, pipettes tips, etc (in sharps containers)

    Body fluids

    Used media

    Any physical item contaminated with body fluids or hazardous materials

    Paper goods contaminated with body fluids

    Waste not discarded in biohazardous containers (no contact with biohazardous materials)

        Paper items

        Cardboard boxes

        Exterior kit containers

        Office supplies

        All items not contaminated with body fluids

Safety reminders

- Place double bag in all empty bins.
- Only dispose of biohazardous waste in the biohazardous bins.
- Use common sense to determine if trash is 2/3 full

    Waste bags are considered full when a bin is half way full, when used for glass disposal, specimen tubes and microbiology plates

    Waste bin is considered full if it is 2/3 full. Periodically lift bag to determine if it is full.

- Always wash your hands after handling biohazardous material.

Safety precautions on medical waste handling

- The inner bags of regulated medical waste are closed securely, keeping them low to the ground and away from the body.
- The bags are handled only by the neck to avoid injury from stray or improperly contained sharp objects.
- General laboratory hygiene includes washing hands after every contact with medical waste containers, scrubbing thoroughly and vigorously.
- If an extensive exposure occurs, wash or flush the area with an approved hand washing agent or irrigating solution. If that exposure was to the eyes, ears or mouth, wash that area generously with water and report the incident immediately to see if any further precautions are needed.
- Exposure protection

  Gloves are the first line of defense and must be worn at all times.

  Gloves should be puncture resistant.

  Gown and face shield are required to be worn while handling waste materials

- Methods of avoiding accidents

  Avoid eating, drinking, gum chewing, smoking, applying makeup or handling contact lenses when working around medical waste.

Transportation of medical waste

- Transportation of medical waste is performed by XXXXXXX.
- XXXXXXX is responsible for the packaging, shipping, and transportation of all regulated medical waste.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: ASEPTIC PROCEDURE	REVIEWED: 11/29/18
SECTION: CLINICAL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Aseptic Procedures

Objective: To prevent surgical infections in patients undergoing procedures in the Clinic.

Acuity Rating: Mandatory

Required Equipment: Various re-useable instruments that require sterilization or sterile single use disposable instruments.

PURPOSE: Micro-organisms are naturally present in every patient environment. Some may be harmless to most people while others are harmful to many. An important part of providing care is to prevent the patient from acquiring infections by decreasing the spread of micro-organisms. Open wounds, either surgical or traumatic, are especially prone to infection.

Knowledge of sterile technique (surgical asepsis) is important in order to carry out certain procedures with minimal risk of infection. This is a basic skill for all medical assistants and providers.

The principles of surgical asepsis:

1. The sterile object or area becomes contaminated when touched by a non-sterile object.

2. For an infection to occur there must be:

   a. A sufficient number of organisms strong enough to produce infection.
   b. A susceptible host. Factors include age, nutrition, stress, exposure to heat or cold, allergies, chronic disease, and amount of rest.
   c. A means for organisms to reach the host, either directly (e.g. animal bite), indirectly (e.g. contaminated articles) or droplets (e.g. talking, sneezing, coughing).

Implementation:

1. Surgical Asepsis requires the use of sterile:

   a. Surgical gloves
   b. Instruments
   c. Medications (solutions, anesthetics, ointments)
   d. Suturing material and needles
   e. Dressing supplies (i.e. gauze, telfa, etc.)
   f. Containers to hold any of above supplies

g. Drapes (fenestrated or non-fenestrated)

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2. Surgical aseptic technique must be followed in certain procedures, including but not limited to those listed below and at any other time as determined by the Clinic medical staff.

   a. Suture removal
   b. Dressing change
   c. IV insertion
   d. Venipuncture
   e. Minor surgical procedures to include (but not limited to):
      1. Laceration repair
      2. Wart removal
      3. Removal of other skin growths/biopsies
      4. Excision of ingrown toenail
      5. I & D abscess/paronychia
      6. Release of subungual hematoma

Additional information:
See specific procedures for equipment and set-up for procedures such as laceration repair, burn treatment, wart removal, etc.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Medical Assistant Scope of Practice	REVIEWED: 11/19/18
SECTION: Clinical	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Medical Assistant Scope of Practice

Objective: To ensure Medical Assistants work within their legal scope of practice, Medical Assistants deployed in the Clinic will function within parameters defined by California Business and Professional Code.

Response Rating:

Required Equipment:

Procedure

1. A Medical Assistant may not perform the following functions:
    a. Diagnose or treat a condition or illness;
    b. Perform any invasive task (except injections and skin tests as noted above);
    c. Assess the patient's condition;
    d. Interpret results of skin tests (but may measure and describe the test reaction and make a record in the patient's chart);
    e. Place the needle for the starting of, or disconnect infusion tube of, an IV;
    f. Administer medications that are injected into an IV line;
    g. Administer medications that are injected into the vein;
    h. Chart pupillary responses;
    i. Insert urine catheter;

j. Independently perform telephone triage;

k. Inject collagen;

l. Use lasers to remove hair, wrinkles, scars, moles, or other blemishes;

m. Administer chemotherapy;

n. Administer numbing agents, alone or as a component of any medication administration.

o. Enter medication orders into the EMR.

p. Independently apply splints.

2. Technical support services may not be rendered by the Medical Assistant unless they have received a written order, signed and dated by the physician/nurse practitioner/physician assistant.

2. Under the Direction of a Physician (MD, DO), Nurse Practitioner, and/or Physician Assistant who are members of the Clinic Medical Center Medical Staff, Medical Assistants may perform technical support services, limited to:

a. Administration of medications by intradermal, subcutaneous, and/or intramuscular injection;

b. Performance of skin tests;

c. Application and removal of bandages;

d. Removal of sutures;

e. Performance of ear lavage;

f. Preparing patient for examination;

g. Shaving and disinfecting treatment sites;

h. Handing properly labeled, pre-packaged medications to the patient (except for controlled substances).

i.

3. In addition to approved technical support services, Medical Assistants may perform administrative and clerical functions as directed by Clinic Leadership.

4. The responsibility for the appropriate use of a Medical Assistant in the Clinic rests with the Physician.

5. If asked to perform tasks that exceed their legal scope of practice, Medical Assistants will respectfully decline and advise Clinic Leadership.

CROSS REFERENCE:

- California Business and Professions Code 2069-2071

- California Business and Professions Code 2544

POLICY AND PROCEDURES

POLICY: Information Technology Rules of Use	REVIEWED: 11/19/18
SECTION: Information Technology	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Electronic On-Line Services, Acceptable Use Policy, Employee/Contractor Obligations and Responsibilities

Objective: Define guidelines for the appropriate utilization of the internet, Clinic EMR, partner EMR interfaces/portals and related online resources

Response Rating: Mandatory

Required Equipment:

Definitions:

Electronic on-line services: internet access; District email, calendar, file storage, productivity applications; electronic medical record, patient eligibility applications; network printing, scanning and faxing, vendor or payor website access, government-run websites.

Procedure:

1. Employees and Contractors must sign a District Electronic On-Line Services User Agreement in order to use electronic on-line services. These services may not be used for any purpose that conflicts with the goals or the policies of the District or for illegal or unethical purposes.
2. Employees and Contractors are authorized to use the District's electronic on-line services in accordance with the user obligations and responsibilities specified below.
3. The user in whose name an on-line services account is issued is responsible for its proper use at all times. Users shall keep personal account numbers, home addresses and telephone numbers private. They shall use the system only under their own account number.
4. The system shall be used only for purposes related to business. Any use for political and/or personal use of the District's system is strictly prohibited. The District reserves the right to monitor any on-line communications for improper use.
5. Users shall not use the system to encourage the use of drugs, alcohol or tobacco, nor shall they promote unethical practices or any activity prohibited by law or District policy.
6. Users shall not transmit or receive material that is threatening, obscene, disruptive or sexually explicit, or that could be construed as harassment or disparagement of others based on their race, national origin, sex, sexual orientation, age, disability, religion or political beliefs.

7. Copyrighted material may not be placed on the system without the author's permission. Users may download copyrighted material for their own use only. Downloading of copyrighted music or video is prohibited by District policy.

8. Vandalism will result in the cancellation of user privileges. Vandalism includes uploading, downloading or creating computer viruses and/or any malicious attempt to harm or destroy the District's equipment or materials or the data of any other user.

9. Users shall not read other users' mail or files; they shall not attempt to interfere with the ability of other users to send or receive electronic mail, nor shall they attempt to forge mail of other users.

10. Users are expected to utilize professional email etiquette.

    a. Keep messages brief and use appropriate language.

    b. Be polite; never send or encourage others to send abusive, impolite messages

    c. Do not include personal information (personal phone number, personal email, home address) in business email messages

    d. Email sent and received on a District account is property of the District and, as such, is subject to review by the District and/or its representatives.

11. Electronic on-line services are offered by the District in support of District interests. Users of electronic on-line services shall have no expectation of privacy and understand that the District has the right to monitor and examine all system activities to ensure proper use of the system, equipment, and District resources.

12. Users may access patient information only as it relates specifically to the user's workplace roles and responsibilities.

    a. Users may not access personal information within the Clinic EMR or healthcare partner, vendor, and/or payor website

    b. Users may not access information regarding family members or friends within the Clinic EMR or healthcare partner, vendor, and/or payor website access

    c. Users seeking PHI regarding themselves will utilize the current medical records request form and follow Clinic policy regarding completion and submission of the request.

    d. Users seeking PHI regarding family members or friends will utilize the current medical record request form and follow Clinic policy regarding completion and submission of the request, assuming the user is legally allowed access to the requested information.

13. Users shall report any security problem or misuse of the network to the District Administrative office.

14. Users who fail to abide by these obligations and responsibilities shall be subject to disciplinary action up to and/or including termination.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Electronic Protected Health Information (ePHI)	REVIEWED: 11/19/18
SECTION: Administration	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Electronic Protected Health Information (ePHI)

Objective:

Response Rating: Mandatory

Required Equipment:

Definition: Electronic protected health information (**ePHI**) refers to any protected health information (PHI) that is covered under Health Insurance Portability and Accountability Act of 1996 (HIPAA) security regulations and is produced, saved, transferred or received in an electronic form. The following are examples of PHI: Names, Address, Social Security number, Family History, Telephone number, Fax number, Account numbers, Medical Record numbers, Dates (birthday, discharge, admission), Certificate/license numbers, Vehicle ID, Personal Assets, Device identifiers, Biometric (finger or voice print), Photographs, Any unique identifying number, code or characteristic.

Procedure:

1. Electronic Protected Health Information, (herein referred to as **ePHI**), must be protected at all times from deliberate, accidental or incidental disclosure to any unauthorized entity or person.

2. Access to **ePHI** will only be granted to those Clinic employees who have a specific "**need to know**" to fulfill their work responsibilities. Employees who are granted access to **ePHI** will have reviewed and acknowledged the necessary training in information security and policies and procedures pertaining to Protected Health Information.

3. Requests for access to **ePHI** by external Health Care entities will be submitted in writing and will be granted by the Executive Director ("Director") or his/her representative. If medical circumstances exist that make this impractical or detrimental to a patient, verbal confirmation by either the Director or his/her representative will suffice.

4. As a general rule of thumb, **ePHI** should ***not*** be transferred electronically but rather by registered mail, return receipt requested or transferred directly by the patient. If it must be transferred electronically, it must be transmitted utilizing a District approved encrypted email system with a return receipt requested. Additionally, all electronic transmissions will contain a District approved disclaimer which is intended to provide an additional level of awareness to the recipient that they may be in possession of a document containing **ePHI** and as such are responsible for safeguarding that information until it is destroyed.

5. The use of external storage devices by Clinic employees is totally discouraged and not permitted unless approved by the Director or his/her representative. All such devices pose a serious threat to **ePHI** and as such will be disposed of in a manner consistent to ensure that all data has been removed and that the device is rendered totally unreadable.

6. All **ePHI** data stored on the Clinic's server will be backed-up on a weekly basis using either magnetic tape or other approved means. Once the back-up is complete, it will be transferred to the District Office where it will be stored in a fire proof safe until such time that it is replaced by the most current version. After this occurs, the replaced back-up will be returned to the clinic where it will be stored in a secure area with the server until it is ready to be erased and reused.

7. All workstations will be configured so that user inactivity of 10 minutes or more will require that the user re-enter their password to log back into the workstation.

8. Employees who fail to comply with these obligations and responsibilities, shall be subject to disciplinary action up to and/or including termination.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Demonstrated Competency	REVIEWED: 11/19/18
SECTION: Human Resources	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Demonstrated Competency

Objective: To ensure personnel are capable of performing the tasks required by their position, competency will be demonstrated at the time of on-boarding and annually thereafter, in accordance with the Demonstrated Competency Checklist(s) in place at the time.

Response Rating: Mandatory

Required Equipment:

Definitions:

Demonstrated Competency: The ability to perform a work role or task to a demonstrated defined standard. To meet a competency standard, the activity is performed under specified conditions to the specified standard of performance.

Procedure:

1. Prior to assuming duties without direct supervision, all personnel will demonstrate competency according to the Demonstrated Competency Checklist currently approved for their job description.
2. Annually, all personnel will demonstrate competency according to the Demonstrated Competency Checklist currently approved for their job description.
3. Upon addition of new patient care equipment, patient care procedures, and/or waived testing kits in the Clinic, personnel will participate in orientation/education and then demonstrate their competency.
    a. Training will be documented with educational materials and documentation of personnel participation retained.
    b. After training is completed, competency will be demonstrated, documented and added to the current Demonstrated Competency Checklist as a “write-in”.
4. Annually, the Demonstrated Competency Checklist will be reviewed to ensure it accurately reflects the processes, equipment, techniques that are pertinent to the Clinic environment with new processes, equipment, and techniques added and unnecessary elements deleted.

5. The Medical Director will complete Demonstrated Competency evaluation and documentation for Nurse Practitioners and Physician Assistants.

6. A designated Nurse Practitioner will complete Demonstrated Competency evaluation and documentation for the Medical Assistants, Registered Nurses, and Licensed Vocational Nurses.

7. The Radiology Supervisor will complete Demonstrated Competency evaluation and documentation for the Radiology Technicians.

8. The administrative designee will complete Demonstrated Competency evaluation and documentation for Front Office personnel and any persons assigned responsibilities for billing and coding functions.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: MARKETING	REVIEWED: 1/12/18
SECTION: DISTRICT	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Marketing and Community Outreach

Objective: Develop and implement a successful marketing and community outreach plan consistent with the organization's mission. Plan will be developed by the Leadership Team and under the supervision of the XXX.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. The Clinic will maintain an active Marketing and Community Outreach Program that will include, but not be limited to:
    a. Signage (temporary and permanent), including billboards
    b. Website
    c. Direct mail pieces focused on clinic services and operations
    d. Social media, including Facebook, Twitter, Instagram
    e. Community outreach and service projects, such as:
        i. Health fairs
        ii. School and Recreation Department sports physicals
        iii. Employer-based flu shot clinics
        iv. Service group and church-based health-related functions
        v. District developed and managed wellness programs
    f. Bulletin boards and "of-the moment" postings at the Clinic
2. Marketing and Community Outreach plans will be developed by the Leadership Team with input and participation from Clinic personnel. The Plan(s) will be submitted to the Board of Directors for input and approval.

3. The website will be maintained by XXX under supervision of XXX.

4. The official Facebook page and other social media outlets will be maintained by District personnel under supervision of the District.

5. Clinic medical staff and personnel will be encouraged to submit content for the website and social media sites.

6. Advertising materials will focus on Clinic services, Clinic personnel, and health and wellness topics. Advertising materials will not compare Clinic services to other community service providers and will not disparage or demean other medical care providers.

7. Should advertising materials include photographs of patients or community members, photo releases will be obtained and kept on file to demonstrate that permission was obtained before the images were utilized.

8. Where appropriate, the Clinic will partner with the health department, service organizations, insurance plans and area physicians to develop additional outreach opportunities in an effort to improve the health and wellness of community members.

9. Where appropriate, budgets will be developed and program progress tracked/reported.

10. With the approval of the Executive Director and Medical Director, the Clinic may utilize posters, flyers, brochures and other third party developed materials to enhance existing Marketing efforts, including but not limited to, materials developed by nationally recognized organizations such as:

    a. American Cancer Society

    b. American Heart Association

    c. Arthritis National Research Foundation

    d. American Lung Foundation

    e. Susan G. Komen Foundation

    f. American Stroke Association

    g. National Institutes of Health

    h. Juvenile Diabetes Foundation

    i. American Diabetes Association

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: COMPLIANCE	REVIEWED: 11/12/18
SECTION: DISTRICT	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Compliance

Objective: In order to operate consistent with programmatic requirements, Mark Twain Health Care District Rural Health Clinics will implement and follow a comprehensive Compliance Plan.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Compliance review will focus on seven basic elements:
    a. Policy and procedure
    b. Standards of conduct
    c. The presence and activities of the Compliance Officer
    d. The implementation and monitoring of the Compliance Program
    e. Education of Board, leadership, providers, and staff
    f. Training of Board, leadership, providers, and staff
    g. Enforcement of standards and discipline
        i. Effective processes
        ii. Provides re-education
        iii. Provides remedial training
        iv. Consequences commensurate with the violation, up to and including termination

2. Benchmarking based upon auditing and monitoring

   a. Random medical records;

   b. Targeted medical records, based on specific issues or populations;

   c. Accounts receivable, with a focus on credit balance accounts that will be resolved in keeping with the policy for Billing Practices.

   c. Policy and procedure; and

   d. Program compliance checklists, including regular review of HEDIS scores.

3. Personnel

   A. Compliance Officer is the District Executive Director. Associate Compliance Officers are the Medical Director and Clinic Manager.

   B. Clinic personnel and medical staff will be trained annually

      1. Fraud, waste, and abuse
      2. Corporate compliance
      3. Standards of conduct – Employee Handbook (XX/XX) Section X page X
      4. Conflict of Interest/Ethics – Employee Handbook (XX/XX) Section X page X

   C. Communication

      1. Information will be disseminated to staff in writing and verbally

      2. Staff will have access to the Clinic Policy and Procedure Manual online and through a hard-copy document with guidance including but not limited to:

         a. Billing practices, including billing audits and chart review;

         b. Guidelines for marketing and community outreach;

         c. Disciplinary and corrective action

      3. Staff may report concerns to the Clinic Manager, Medical Director, District Human Resources and/or the District Administrator verbally and/or in writing.

         a. Where appropriate, written communication may utilize an Incident Report

4. Quality Assurance

   A. Clinic will develop and follow a Quality Assurance and Performance Improvement policy.

   B. QAPI meetings will be conducted monthly with reporting to staff personnel and the Board.

C. Required Clinic surveillance will be the foundation of the QAPI program with the addition of problem-resolution focused elements are required.

1. Spot audits of surveillance programs will be conducted and documented, in addition to month-end review of surveillance data.
2. Spot audits of non-surveillance programs will be conducted and documented.

D. Issue specific quality assurance/performance improvement projects will utilize the PDCA (Plan, Do, Check, Act) process

1. Thorough investigation of issue-specific topics will be completed and documented;

2. The problem will be identified and an initial plan developed and implemented to resolve the problem;

3. Data will be collected and reviewed to determine if the plan is resolving the identified problem;

4. Adjustments of the plan will be made as required until the desired results are achieved.

5. Risk Assessment

A. A Threat/Risk Assessment will be completed annually;

B. A Business Risk Assessment will be conducted at least annually in conjunction with the Board's Strategic Planning session(s);

C. An Annual Clinic Review will be conducted consistent with RHC program requirements.

5. Supervisors, managers, or employees are not permitted to engage in retaliation, retribution, or any form of harassment directed against any employee who, in good faith, reports a compliance concern.

Resources:

"OIG Guidance Physician Practice Compliance", downloaded June 10, 2016 from oig.hhs.gov/authorities/docs/physicians

"OIG Work Plan 2016 ", downloaded June 10, 2016 from oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016

"Practical Guidance for Boards", downloaded June 10, 2016 from oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Volunteer Deployment	REVIEWED: 11/19/18
SECTION: Safety	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR

Subject: Volunteer Deployment

Objective: To properly manage the use of volunteers in an emergency or other staffing strategies including the process and role for integration of State and Federally designated health care professional to address surge needs during an emergency.

Response Rating: Mandatory

Required Equipment:

Procedure

1. City, County, State, and/or Federal agencies may offer/direct volunteers to the Clinic in the case of an emergency/surge situation. All volunteers will be required to follow Clinic processes before being directed to the Incident Commander for deployment.

2. Volunteer provider and provider support staff will be accepted to serve at the Clinic to assist in meeting patient needs after providing the following minimum information to the Credentialing Specialist or their designee who will use available resources to verify credentials and identity.

    a. Proof of deployment by a City, County, State, and/or Federal agency, if deployed by an agency
    b. Copy of license, DEA certificate/furnishing license, and photo identification
    c. Copy of BLS, ACLS, PALS card(s)
    d. Signed copy of the Clinic's HIPAA non-disclosure document

3. Volunteer non-medical staff will be accepted to serve at the Clinic to assist in meeting patient access and Clinic operations needs after providing the following minimum information to the Human Resources Director or their designee who will use available resources to verify credentials and identity.

    a. Proof of deployment by a City, County, State, and/or Federal agency, if deployed by an agency
    b. Copy of BLS, ACLS, PALS card(s), if applicable
    c. Signed copy of the Clinic's HIPAA non-disclosure document

4. Community members, not affiliated with City, County, State, and/or Federal agencies may report to the Clinic for the purpose of volunteering in an emergency/surge situation.

5. Community volunteers will be accepted for service, based upon the Clinic's needs and the volunteers' skill set(s). Volunteers who have medical training (MD, DO, DC, DDS, NP, PA, RN, LVN, RT, PT, MA) will be asked to provide information per item 2 above. Volunteers with no medical office experience will be asked to provider information per item 3 above.

6. Volunteer provider and provider support staff will be paired with current Clinic personnel for orientation to the physical space, equipment, supplies, and documentation resources available. An EMR log in will be provided if the EMR is available. Otherwise, downtime medical record forms will be utilized.

7. Volunteer non-medical staff will be paired with current Clinic personnel for orientation to the physical space, telephone equipment, supplies, and registration resources available. An EMR log in will be provided if the EMR is available. Otherwise, downtime registration and medical record forms will be utilized.

8 Volunteers will be given assignments by the Incident Commander or their designee commensurate with their licensure and training. Care will be taken to ensure persons are not given assignments that exceed their scope of practice. Example: medical assistants will not be asked/allowed to place or remove urinary or IV catheters

9. A record of all volunteers will be maintained to include:

    a. Volunteer name, address, and cell phone number
    b. Agency sending the volunteer or an indication that the volunteer was self-directed from the community
    c. License/certification information with copies/photos of same
    d. Time in/time out and assignment

10. If credentials and identity of volunteers were not able to be checked before the volunteers were deployed, Human Resources Director will pursue that verification after the emergency/surge situation has passed.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Unscheduled Downtime of Electronic Medical Record	REVIEWED: 11/19/18
SECTION: Information Technology	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Unscheduled Downtime of Electronic Medical Record

Objective: To ensure documentation of patient care in the event of an unscheduled disruption of access to the Electronic Medical Record (EMR), practitioners and staff will document patient care using approved downtime paper forms.

Response Rating: Mandatory

Required Equipment:

Definitions:

Procedure:

1. In the event of an unscheduled disruption of access to the Electronic Medical Record, approved downtime paper forms will be utilized to document patient care.
2. Clinic Leadership or designee will report the service disruption to IT Department and/or the EMR vendor.
3. Approved downtime paper forms (including administrative and patient care documentation) will be maintained in a central location in a binder marked “Downtime Forms” as well as in an online shared folder labeled Forms.
4. Clinic Leadership or designee will access the paper forms, making sufficient copies of the appropriate documents to accommodate patients currently being examined/treated and those scheduled to be seen in the Clinic through the balance of the Clinic day.
5. Paper forms will be utilized to capture patient demographics and payor information required to successfully complete patient intake.
6. Paper forms will be provided to all practitioners and will be marked with the patient’s name, birth date, medical record number (if available), and visit date.

7. Patients requesting appointments will be listed, along with their phone number and the purpose of the visit/visit type. After the system has been restored, patients on the list will be contacted and appointments scheduled in the Electronic Medical Record scheduling application.

8. When access to the Electronic Medical Record is restored, completed paper documents will be scanned into the electronic chart.

9. After confirming the scanned documents have been placed appropriately in the Electronic Medical Record, the paper forms will be collected and given to the Administrative Medical Assistant so that they may be used to create claims. Once all claims have been created and submitted to the proper payor, they will be destroyed to protect patient privacy.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: TRANSFER OF PATIENT TO A HOSPITAL	REVIEWED: 11/19/18
SECTION: CLINICAL	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Transfer of the Patient to a Hospital

Objective: To ensure safe transport of a patient to the hospital with copies of all medical documentation.

Response Rating: Severe

Required Equipment: Patient chart, labs, pertinent paperwork, x-rays, Transfer Form, etc.

Policy: Patients requiring transport to the hospital should be informed of this decision by the practitioner. The practitioner will determine the appropriate mode of transportation based on patient condition.

The following guidelines should be followed prior to transport:

1. Call 911 as ordered by the practitioner.

2. All attempts to stabilize the patient prior to transport will be made by the practitioner and staff, in collaboration with EMS.

3. The practitioner will decide if the patient may be transported by private vehicle or ambulance.

4. Patients are to be properly prepared for transport with valuables given to family members or charge member of the ambulance.

5. Transfer Form will be completed and signed by patient or family member.

6. Copies of all test results and medical records should be made and given to the patient or charge member of the ambulance. If x-ray copying services are available, a copy of the film should be given to the patient. Original films should not be given out.

7. If being transferred by ambulance, the practitioner will provide the transport team with a verbal status report of the patient's condition.

Note: It is against Clinic policy for staff members to transport patients in private vehicles. If transport is non-emergency and all other alternatives for travel exhausted, the patient should be transported to the hospital by

a taxi or other commercial mode.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: THREATENING OR HOSTILE PATIENT	REVIEWED: 11/19/18
SECTION: SAFETY	REVISED:
EFFECTIVE:	MEDICAL DIRECTOR:

Subject: Threatening or Hostile Patient

Objective: To ensure the safety and well-being of patients, visitors, and Clinic staff

Response Rating:

Required Equipment:

Procedure:

If someone in the Clinic displays hostile behavior and/or is threatening you or others:

1. Attempt to defuse the situation by speaking calmly with the person. Do not approach the person or touch them.

2. If the person does not calm down and de-escalate their behavior, request intervention by on-site security officer. If the on-site security officer is not available, tell the person that they must leave the premises.

3. Call for the Supervisor and or the practitioner, asking for their back-up and support.

4. Call 911 if the person does not comply with your request to leave the premises.

5. Call local law enforcement's non-emergency line to report the hostile person and ask for drive-by observation during the balance of the business day.

6. Complete an Incident Report according to policy and forward to the Clinic Director, who will ensure the report is also reviewed by both the Medical and Executive Directors.

Mark Twain Health Care District
Strategic Matrix 2018

	A	B	C	D
1	**Strategic Action Item**			
2		**Person Resonsible**	**Expected Date**	**Completed**
3				
4	**Valley Springs RHC**	**Real Estate Com**		
5	Develop Budget /Operational Plan for VS RHC 1206B	Smart		10/2/2018
6	Electronic Medical Records linked to billing & compatib	Smart	12/20/2018	Completed
7	Explore leasing ancillary functions from MTMC	Smart	on going	
8	Gantt Chart From Walter	Smart		3/12/2018
9	Physical Address (Pending Name for Access Street)	Stout		6/14/2018
10				
11				
12	**MTHCD Public Image and Communication**			
13	District Name Change			
14	Public Relations Strategy			
15	In-Kind Funding			
16	Doodle Scheduling On-Line	Stout		4/28/2018
17	Explore Options as District "convener" of County Care			
18				
19	**Accounting Service**	Finance Comm		
20	Plan/Contract for New District Accounting Services			11/1/2018
21	Written Plan for reserve accounts (ex. Seismic Retrofit)	Smart & Krieg		12/20/2018
22	Storage boxes	Smart		1/1/2019
23	Financial Report Dashboard	Wood		TBD
24				
25	**District Records**			
26	Fine-Tune District Records Disaster Plan	Stout & Computer		TBD
27	Develop Record retention plan (state law) Attny	Policy Committee		1/1/2019
28	District Records-Back UP	Stout		6/14/2018
29				
30	**Committee Structure**	Reed		
31	Executive Committee			
32	Community Advisory Committee			
33				
34	**Phase II Development**	Al-Rafiq		
35	Pace Program - Welbe Health - July Open House Set up	Al-Rafiq		TBD
36	Senior Living Opportunities	Al-Rafiq		on-going
37				
38	**Explore Potential Partnerships in County**	Sellick & Reed		
39	Behavioral Health-Proposal to Follow	Sellick & Reed		
40	Veterans - On Hold	Atkinson & Radford		6/5/2018
41	Opioid Coalition	Radford		Nov. 2018
42				
43				
44				
45				

AMENDED PARCEL MAP

THOSE PORTIONS OF LOT 1 AND LOT 2 OF BLOCK 1 OF THE SAN ANDREAS TOWNSITE AND A PORTION OF THE NORTHEAST 1/4 OF SECTION 20, T.4 N., R.11 E., M.D.M.

CALAVERAS COUNTY CALIFORNIA

JANUARY, 1994

OWNER'S STATEMENT

THE UNDERSIGNED BEING THE PARTIES HOLDING A RECORD TITLE INTEREST IN THE LANDS SHOWN ON THIS MAP DO HEREBY CONSENT TO THE PREPARATION AND RECORDATION OF THIS PARCEL MAP AND DO HEREBY OFFER TO DEDICATE TO THE PUBLIC, ALL PUBLIC UTILITY EASEMENTS SHOWN HEREON.

Kathy Yarbrough

KATHY YARBROUGH ADMINISTRATOR
FOR MARK TWAIN HOSPITAL DISTRICT
P.O. BOX 307, 603 O.R. 22 O.R. 391 - 05012, AND 991 - 05013

William P Alexander

WILLIAM P. ALEXANDER SEC. PRESIDENT

TRUSTEE, THE STERLING TITLE COMPANY
(FORMERLY YOSEMITE TITLE COMPANY)
DEED OF TRUST DOC. NO. 1993-05014

ACKNOWLEDGEMENT

STATE OF CALIFORNIA } ss. On March 21 1994

BEFORE ME, Cynthia L. Hannah

COUNTY OF Calaveras } PERSONALLY APPEARED

Kathy Yarbrough

PERSONALLY KNOWN TO ME (OR PROVED TO ME ON THE BASIS OF SATISFACTORY EVIDENCE) TO BE THE PERSON(S) WHOSE NAME(S) IS/ARE SUBSCRIBED TO THE WITHIN INSTRUMENT AND ACKNOWLEDGED TO ME THAT HE/SHE/THEY EXECUTED THE SAME IN HIS/HER/THEIR AUTHORIZED CAPACITY(IES), AND THAT BY HIS/HER/THEIR SIGNATURE(S) ON THE INSTRUMENT THE PERSON(S), OR THE ENTITY UPON BEHALF OF WHICH THE PERSON(S) ACTED, EXECUTED, THE INSTRUMENT.

WITNESS MY HAND

Cynthia L. Hannah

NOTARY PUBLIC SIGNATURE

Cynthia L. Hannah

NOTARY'S PRINTED NAME

8 29 97

MY COMMISSION EXPIRES

Sterling Title Co

PRINCIPAL PLACE OF BUSINESS

ACKNOWLEDGEMENT

STATE OF CALIFORNIA } ss. On March 21 1994

BEFORE ME Cynthia L. Hannah

COUNTY OF Calaveras } PERSONALLY APPEARED

William P Alexander

PERSONALLY KNOWN TO ME (OR PROVED TO ME ON THE BASIS OF SATISFACTORY EVIDENCE) TO BE THE PERSON(S) WHOSE NAME(S) IS/ARE SUBSCRIBED TO THE WITHIN INSTRUMENT AND ACKNOWLEDGED TO ME THAT HE/SHE/THEY EXECUTED THE SAME IN HIS/HER/THEIR AUTHORIZED CAPACITY(IES), AND THAT BY HIS/HER/THEIR SIGNATURE(S) ON THE INSTRUMENT THE PERSON(S), OR THE ENTITY UPON BEHALF OF WHICH THE PERSON(S) ACTED, EXECUTED, THE INSTRUMENT.

WITNESS MY HAND

Cynthia L. Hannah

NOTARY PUBLIC SIGNATURE

Cynthia L. Hannah

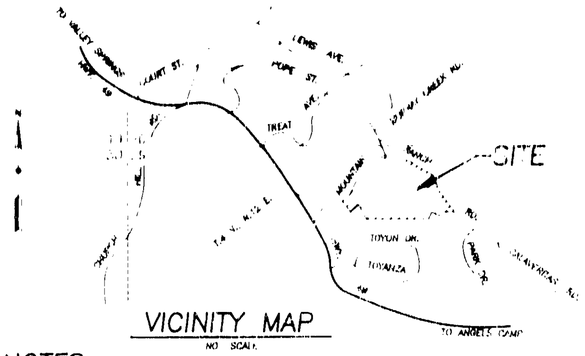
NOTARY'S PRINTED NAME

8 29 97

MY COMMISSION EXPIRES

Sterling Title Co

PRINCIPAL PLACE OF BUSINESS



VICINITY MAP
NO SCALE

NOTES:

1) ACREAGE:

THE TOTAL ACREAGE OF THIS PROJECT IS 5.0509 ACRES.

2) NUMBER OF PARCELS:

THERE ARE 5 PARCELS IN THIS PROJECT.

3) BASIS OF BEARINGS:

THE BASIS OF BEARINGS OF THIS PARCEL MAP IS THE LINE BETWEEN FOUND MONUMENTS SHOWN HEREON AS N89°10'00"E AND IS THE SAME AS SHOWN ON THAT CERTAIN RECORD OF SURVEY MAP FILED FOR RECORD IN BOOK 6 OF RECORD OF SURVEY MAPS AT PAGE 139, CALAVERAS COUNTY RECORDS.

4) IMPROVEMENTS:

ALL ENCROACHMENTS, FENCES AND/OR IMPROVEMENTS (INTERESTS) SHOWN AND REFERENCED ON THIS MAP ARE THOSE ENCOUNTERED DURING THE NORMAL AND USUAL COURSE OF SURVEYING THE LANDS DEPICTED HEREON. NO CERTIFICATION IS MADE REGARDING THE POSSIBLE EXISTENCE OF ANY OTHER ENCROACHMENTS, FENCES, AND/OR IMPROVEMENTS ON, OVER, ACROSS OR NEAR THE SUBJECT LANDS WHICH MIGHT BE DISCOVERED AND DISCLOSED BY AN A.L.T.A. SURVEY OF THESE LANDS. THE SURVEY AND ACREAGE SHOWN HEREON MAY BE AFFECTED BY ANY RIGHTS OR CLAIMS ARISING FROM SAID UNDISCOVERED INTERESTS.

5) RECORD TITLE:

THE RECORD TITLE INFORMATION UPON WHICH THIS PARCEL MAP RELIES WAS PROVIDED BY THE STERLING TITLE COMPANY, P.O. BOX 307, SAN ANDREAS, CALIFORNIA 95249, IN IT'S "PRELIMINARY REPORT NO. 6734J / AMENDED REPORT NO. 2, ISSUED WITH AN EFFECTIVE DATE OF JULY 1, 1993 AT 7:30 A.M. THE SUBJECT DEEDS FOR SUBJECT REAL PROPERTIES SHOWN HEREON ARE 51 O.R. 101, 603 O.R. 22 O.R. 391 - 05012, AND O.R. 991 - 05013 CALAVERAS COUNTY RECORDS. REFERENCE IS HEREBY MADE TO SAID PRELIMINARY REPORT P.O. 6734J / AMENDED REPORT NO. 2 FOR ANY PROVISIONS, EXCLUSIONS, LIMITATIONS, EXCEPTIONS AND/OR STIPULATIONS AFFECTING SAID SUBJECT REAL PROPERTY CONTAINED THEREIN, AS IF PARTICULARLY SET FORTH HEREON.

6) EASEMENTS:

A) THE LOCATION DESCRIPTION OF THAT CERTAIN EASEMENT FOR "ONE ASSEMBLY OF ANCHORS, GUYS, AND FIXTURES" TO THE PACIFIC TELEPHONE AND TELEGRAPH COMPANY AS PER 65 O.R. 187 IS NOT DEFINED SUFFICIENTLY TO BE DEPICTED HEREON.

7) WAIVER PROVISIONS, SUBDIVISION MAP ACT:

THE PARCEL MAP HAS BEEN PREPARED PURSUANT TO SECTION 66428 OF THE SUBDIVISION MAP ACT.

8) THIS AMENDED PARCEL MAP SUPERCEDES THAT CERTAIN PARCEL MAP FILED FOR RECORD ON OCTOBER 19, 1993, IN BOOK 8 OF PARCEL MAPS AT PAGE 121, ET SEQ., IN THE OFFICE OF THE CALAVERAS COUNTY RECORDER AND IS BEING FILED TO ABANDON AND RE-ESTABLISH PRIVATE ROAD AND PUBLIC UTILITY EASEMENTS. REVISED FROM P.M. 8 121, AND SHOWN HEREON.

9) THE MEASURED DISTANCES SHOWN HEREON ARE DISCHARGED FROM THE MEASURED DISTANCES SHOWN ON P.M. 8 121.

PREPARED FOR:

MARK TWAIN HOSPITAL DISTRICT
"OR MOUNTAIN RANCH ROAD
SAN ANDREAS, CA 95249

PREPARED BY:

SIERRA ENGINEERING ASSOCIATES, LTD.
1350 E. SAINT CHARLES STREET
SAN ANDREAS, CA 95249
(209) 754-4237

SURVEYOR'S STATEMENT

THIS MAP WAS PREPARED BY ME OR UNDER MY DIRECTION AND IS BASED UPON A FIELD SURVEY IN CONFORMANCE WITH THE REQUIREMENTS OF THE SUBDIVISION MAP ACT AND LOCAL ORDINANCES, AT THE REQUEST OF THE MARK TWAIN HOSPITAL DISTRICT IN JULY 1993. I HEREBY STATE THAT ALL MONUMENTS SHOWN ON THIS MAP ARE OF THE CHARACTER AND OCCUPY THE POSITIONS INDICATED, AND THAT THEY ARE SUFFICIENT TO ENABLE THE SURVEY TO BE RETRACED. (SEE NOTE 2)

REGISTERED PROFESSIONAL LAND SURVEYOR ROGER K. PITTO No. 4626 STATE OF CALIFORNIA

ROGER K. PITTO L.S. 4626
(EXPIRES 9/30/94)

4-8-94
DATE:

COUNTY SURVEYOR'S STATEMENT

I HAVE EXAMINED THIS MAP CONFORMS WITH THE REQUIREMENTS OF THE SUBDIVISION MAP ACT AND LOCAL ORDINANCES.

REGISTERED PROFESSIONAL ENGINEER BERNARD T. PEDERSEN No. 30759 Exp. 3-31-96 CIVIL STATE OF CALIFORNIA

Bernard T. Pederson

BERNARD T. PEDERSEN R.C.E. 30759
CALAVERAS COUNTY SURVEYOR

4/11/94
DATE:

DIRECTOR OF PUBLIC WORKS STATEMENT

ALL OFFERS OF DEDICATION FOR PUBLIC UTILITY EASEMENTS THAT APPEAR ON THIS MAP ARE HEREBY ACCEPTED.

Bernard T. Pederson

BERNARD T. PEDERSEN R.C.E. 30759
DIRECTOR OF PUBLIC WORKS, CALAVERAS COUNTY

4/11/94
DATE:

RECORDER'S STATEMENT

FILED THIS 13th DAY OF April, 1994, AT 1:53 P.M., IN BOOK 8 OF PARCEL MAPS AT PAGE 122 AT THE REQUEST OF THE CALAVERAS COUNTY SURVEYOR. # 1994 006351

KAREN ZARGI
CALAVERAS COUNTY RECORDER

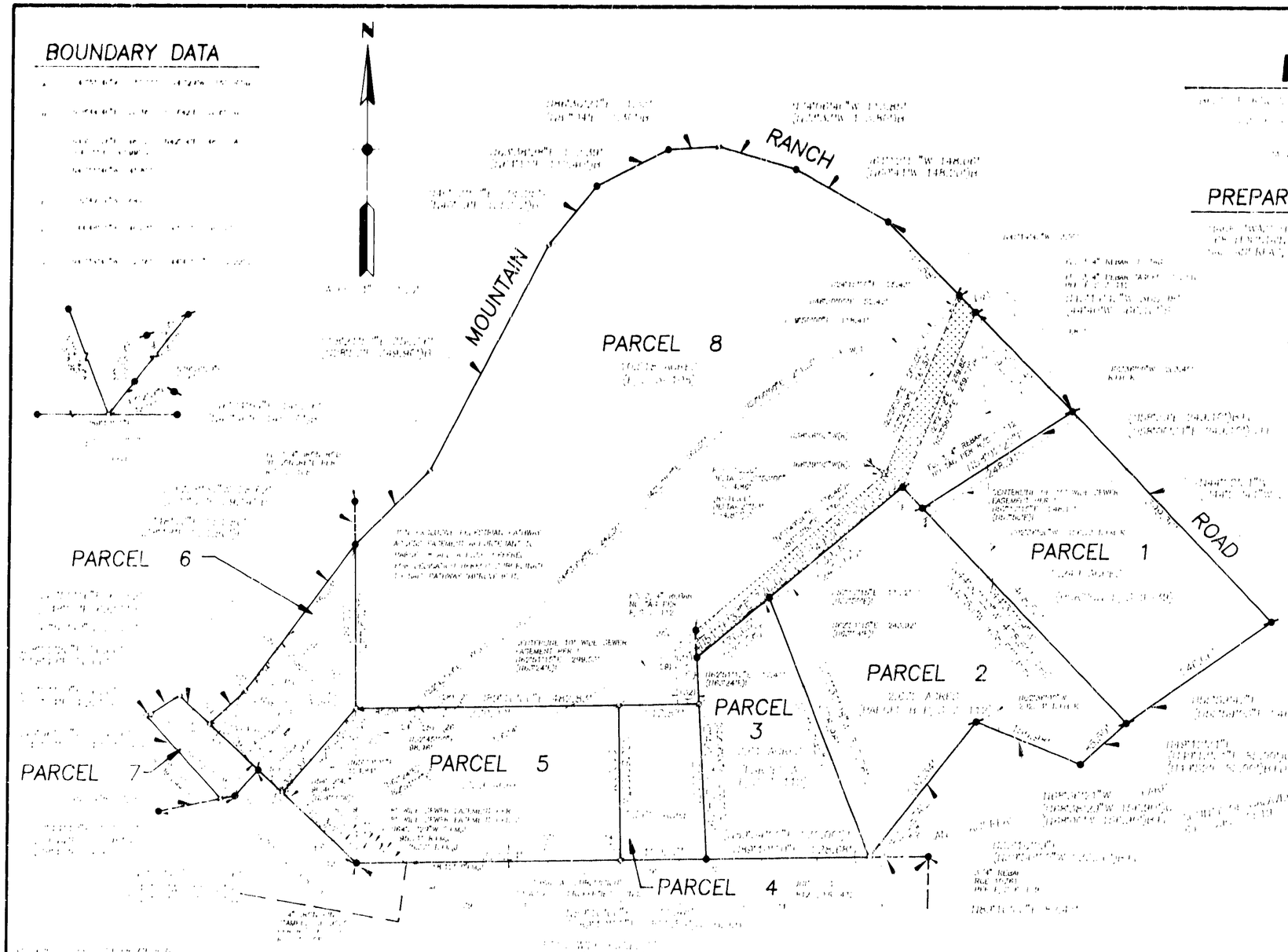
BY:

AMENDED PARCEL MAP

BOUNDARY DATA

PREPARED FOR:

PREPARED BY:



LEGEND

EASEMENT DATA

MARK TWAIN
HEALTH CARE DISTRICT

P. O. Box 95
San Andreas, CA 95249
(209) 754-4468 Phone
(209) 754-2537 Fax

Agenda Item:	**Financial Reports (as of February, 2019)**
Item Type:	**Action**
Submitted By:	**Rick Wood, Accountant**
Presented By:	**Rick Wood, Accountant**

BACKGROUND:
The DRAFT February 28, 2019 financial statements are attached. This presentation provides a comparison against the three previously completed years, the previous month, and a Year-to-Date comparison to the 2018/2019 budget.

- Eight months into the current fiscal year, with the exception of the items related to the revenues from the new lease, the District appears on track with the Budget.
- An item not currently on the P&L, the "Minority Interest" for February was positive for the second month in a row. Y-T-D Interest from operations to the District is still negative – ($88,223.00), but Y-T-D interest from investments to the District was at a positive $67,000.50 leaving a negative "Net" of ($21,222.50).
- Like the revenue section, expenses are tracking well compared to Budget.
- One new item this month is the expenses associated with the Valley Springs Clinic being broken out at the bottom of the statement. As this continues to grow, we will add a separate page for this report.
- The Balance Sheet shows a strong cash position, and the expected growing debt related to the new clinic.
- We did open an investment account with CalTRUST, and deposited $250,000 – but won't see an actual statement until the end of the month. A "DRAFT" "Investment & Reserves Report" is included for your review.

Mark Twain Health Care District
Profit & Loss
Through February 28, 2019

Revenues	Actual 2015/2016	Actual 2016/2017	Actual 2017/2018	Actual 28-Feb	Year-to-date 2018/2019	Budget 2018/2019	Actual vs Budget
District Taxes	905,711	935,421	999,443	82,667	661,698	992,000	66.70%
Rental Revenue	319,089	319,039	313,039	26,587	212,693	728,633	29.19%
Land Rental Revenue	5,777	5,777	5,296	481	3,851	5,777	66.67%
MOB Rental Revenue	214,814	217,159	219,794	18,216	149,449	227,181	65.78%
Lease Interest Income	3,698	1,982	2,428	0	0	397,712	0.00%
Intrest and Other Income	2,696	4,423	5,045	2,542	15,932	120,000	13.28%
Total Revenue	**1,451,785**	**1,483,801**	**1,545,045**	**130,493**	**1,043,624**	**2,471,303**	**42.23%**

Expenses	Actual 2015/2016	Actual 2016/2017	Actual 2017/2018	Actual 28-Feb	Year-to-date 2018/2019	Budget 2018/2019	Actual vs Budget
Salaries, wages				19,055	137,194	220,000	62.36%
Payroll Expense	33,587	68,794	235,531	1,531	5,559	16,184	34.35%
Benefits			663			5,300	0.00%
Insurance	14,889	16,578	17,043	1,250	13,651	20,000	68.25%
Legal Fees	44,309	15,195	20,179		11,052	60,000	18.42%
Audit	10,790	13,945	18,090		13,635	11,500	118.57%
Operational Consulting	262,634	392,908	332,287		29,348	60,000	48.91%
Accounting Services	805	1,304	1,141	1,865	46,537	70,000	66.48%
Community Education & Marketing	11,949	10,895	5,488	0	1720	20,000	8.60%
Medical office rent	215,243	220,659	226,237	19,332	154,655	233,024	66.37%
Depreciation and amortization	85,769	35,556	26,582	2,032	16,244	36,045	45.07%
Valley Springs Rental		11,198	57,593	0	1,654	5,000	33.08%
Board Stipends				400	1900	6,000	31.67%
Dues & Subscriptions	12,343	12,554	14,731	0	11,865	19,000	62.45%
Outside Training/Conferences	2,906	1,920	3,030	0	9,821	15,000	65.48%
Travel, Meals & Lodging	7,983	6,758	17,363	385	4,943	15,000	32.96%
Office Supplies & Expense	1,365	4,310	19,685	1,289	13,473	30,000	44.91%
Other Misc Expenses	10,958	65,595	28,745	14	3,325	5,000	66.49%
Utilities	559,265	387,974	0	0	7,777	675,000	1.15%
Grants & Sponsorships	154,969	74,159	47,413	0	58,407	635,000	9.20%
Valley Springs Clinic				37,804	46,439	50,000	92.88%
Debt Service						88,772	0.00%
Total Expenses	**1,429,764**	**1,340,302**	**1,071,801**	**84,957**	**589,200**	**2,295,825**	**25.66%**
Excess of revenues over expenses	**22,021**	**143,499**	**473,244**	**45,537**	**454,424**	**175,478**	**258.96%**

Valley Spring Clinic Expenses		
Marketing	406	547
Office Supplies & Expenses	140	2,644
OP Consultant	3,848	6,162
IT/EMR	15,411	19,086
Physcian/Provider Recruiting	18,000	18,000
Total - Valley Springs Clinic Expenses	**37,804**	**46,439**

Mark Twain Healthcare District

BALANCE SHEET

As of February 28, 2019

	TOTAL
ASSETS	
Current Assets	
Bank Accounts	
100.30 Umpqua Bank Checking	511,678.20
100.40 Money Market - Umpqua	2,299.75
100.50 Stockton Bank of	559,777.79
100.60 Five Star Bank	49,999.67
100.70 Five Star Bank - MMA	1,034,166.30
100.80 Five Star Bank - Valley Springs Checking	16,332.41
Total Bank Accounts	**$2,174,254.12**
Accounts Receivable	
1200 Accounts Receivable	103,219.63
Total Accounts Receivable	**$103,219.63**
Other Current Assets	
101.00 Umpqua Investments	720,909.94
115.05 Due From Calaveras County	65,990.18
130.00 Prepaid Expenses	
130.20 Prepaid Malpractice	5,394.61
Total 130.00 Prepaid Expenses	**5,394.61**
Total Other Current Assets	**$792,294.73**
Total Current Assets	**$3,069,768.48**
Fixed Assets	
150.00 Land and Land Improvements	0.00
150.10 Land	1,189,256.50
150.20 Land Improvements	150,307.79
Total 150.00 Land and Land Improvements	**1,339,564.29**
151.00 Buildings and Improvements	0.00
151.10 Building	2,123,677.81
151.20 Building Improvements	2,276,955.79
151.30 Building Service Equipment	168,095.20
Total 151.00 Buildings and Improvements	**4,568,728.80**
152 CIP	923,845.28
152.1 CIP Consulting Services	4,646.25
152.10 Fixed Equipment	698,156.25
152.92 CIP - VS Clinc Land Costs	1,089,498.49
160.00 Accumulated Depreciation	-5,334,391.00
Total Fixed Assets	**$3,290,048.36**
Other Assets	
170.00 Minority Interest in MTMC	14,510,261.00
180.00 Bond Issue Costs	
180.10 Bond Issue Costs	141,088.00
180.20 Accumulated Amortization	-141,088.00

	TOTAL
Total 180.00 Bond Issue Costs	**0.00**
180.30 Intangible Assets	0.00
180.50 Land Lease Legal Fees	28,081.11
180.55 Accumulated Amortization-LLLF	-26,782.11
180.60 Capitalized Lease Negotiations	378,050.49
Total 180.30 Intangible Assets	**379,349.49**
Total Other Assets	**$14,889,610.49**
TOTAL ASSETS	**$21,249,427.33**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
2000 Accounts Payable	25,906.93
Total Accounts Payable	**$25,906.93**
Other Current Liabilities	
200.00 Accts Payable & Accrued Expenes	
200.10 Other Accounts Payable	5,692.34
200.40 Accrued Utilities	35,719.52
Total 200.00 Accts Payable & Accrued Expenes	**41,411.86**
210.00 Deide Security Deposit	2,275.00
211.00 Valley Springs Security Deposit	1,000.00
220.10 Due to MTSJH - Rental Clearing	26,365.58
226 Deferred Rental Revenue	38,393.35
24000 Payroll Liabilities	5,893.81
Total Other Current Liabilities	**$115,339.60**
Total Current Liabilities	**$141,246.53**
Long-Term Liabilities	
250.00 Notes Payable - Long Term	
250.10 USDA Loan - VS Clinic	2,104,488.54
Total 250.00 Notes Payable - Long Term	**2,104,488.54**
Total Long-Term Liabilities	**$2,104,488.54**
Total Liabilities	**$2,245,735.07**
Equity	
290.00 Fund Balance	648,149.41
291.00 PY - Minority Interest MTSJH	19,720,638.00
3000 Opening Bal Equity	0.03
3900 Retained Earnings	-1,485,827.71
3901 CY - Minority Interest MTSJH	-312,469.50
Net Income	433,202.03
Total Equity	**$19,003,692.26**
TOTAL LIABILITIES AND EQUITY	**$21,249,427.33**

Lori L. Hack, MBA

PRINCIPAL and CEO, SUBJECT MATTER EXPERT

Lori Hack is CEO of Object Health, LLC, and is a nationally recognized expert in health care program development and evaluation. Having more than 25 years of managed care experience, Ms. Hack served as CEO of Alta Bates Medical Group negotiating shared services contracts with payers and providers for eight years. Most recently she has developed community-based care delivery organizations in the Bay Area and beyond using health information technology strategies and services. She has prepared community clinics and providers for PCMH and ACO operations and certifications. Ms. Hack has experience with hospital and health plan operations and most recently on state level initiatives for clinical integration activities for EHR implementation, Business Intelligence Analysis and operational workflow planning and implementation. She has extensive experience in compliance, privacy and security of health information and payer and provider contracting. Finally, Ms. Hack has coordinated public and private sector boards, work groups and national conferences to successfully achieve milestones, deliverables using consensus driven coordination and techniques.

AREAS OF EXPERTISE

- Managed Care CEO
- ACO Planning and Implementation
- Data Analysis and Evaluation
- Process Improvement and Analysis
- Health IT Planning
- Provider and Health Plan Contracting

EDUCATION

M.B.A., University of Southern California, 1992

Bachelors of Arts, Psychology, University of California, 1985

WORK HISTORY

RELEVANT EXPERIENCE

Object Health, Principal and CEO, 2007–Present. Serves as principal and CEO of Object Health, a management consulting group that assists health care organizations and communities with leveraging health information to improve operational efficiencies and clinical health outcomes. Provides ACO and PCMH consulting, clinical integration consulting for large clinics, multi-specialty groups and hospitals. Provider strategic planning, grant support and operations for Blue Shield of CA grants. As Chair of the Board of the California eHealth Collaborative, supported local HIE implementation efforts at the County and regional level. Served as private sector liaison to the California Privacy and Security Advisory Board under the direction of California's Secretary of Health and Human Services. Previously served as lead consultant for privacy and security efforts for the Long Beach Health Network, which received a Federal grant to develop a HIE in the Greater Long Beach area. Currently she is advising the San Joaquin Community Health Information Exchange.

Object Health is also actively involved in the implementation of electronic health records through their work with CalHIPSO and HITEC LA, supporting more than 1100 Eligible Providers in achieving Meaningful Use Incentive funds.

Works with community clinics for the implementation of Patient Centered Medical Home and ACO preparations.

CalRHIO, Interim CEO, 2005–2007. Served as Interim CEO for the startup of the organization and as liaison to state and federal programs. Previously responsible for the development and implementation of the new 501(c)(3) organization, including all aspects of organization and board development, strategic planning, operations, budget and fundraising. Additionally, coordinated efforts on a statewide and

national basis with the leaders in health care IT to support the mission and achieve the goals of the organization. Developed a strategy to support health information exchange in California in conjunction with national efforts and communication of the vision and mission to stakeholders within the California as follows:

- Responsible for creating and supporting the vision, mission, and goals as a voting board member
- Developed stakeholder engagement process and support in the implementation of goals and objectives for CalRHIO
- Oversaw the development of the budget, start-up operations and all aspects of the legal and business development working in conjunction with the CFO, Business and Finance Committee and legal team
- Provided presentations for public information, government relations and consumers for fundraising, education and recruitment purposes
- Developed support through fundraising efforts either directly or indirectly from grants, state and federal funding, public and private donations
- Provided staff oversight for communications, project development, implementation, and stakeholder support.

Health Technology Center, Executive Director, 2002- 2005. Responsible for operations, fundraising, research, and Partnership support for not for profit 501c(3) technology research organization. Provided management of Partnership relations and development, research methodology and integrity, strategic planning and new product development.

HSS, Inc, Vice President, Operations, 1999-2002 Provided executive management of operations, client installations, marketing and finances for physician reimbursement consulting and software programs for Hospitals, IPAs and Health plans. Utilized an ASP model software solution to health plans, medical groups and Hospitals, developed payment mechanisms in preparation for pay for performance programs.

Alta Bates Medical Group, Executive Director, 1992-1999 As Executive Director of Alta Bates Medical Group, was responsible for the strategic planning, network expansion and operations of the organization. The IPA grew from an initial group of 120 physicians to over 800 with multiple partnerships and networks serving more than 120,000 capitated patients. Developed relationships with physicians, payors and delivery system leadership to advance the reputation and performance of the medical group.

- Assisted in the growth of the IPA from $12 Million in annual revenue to $77 Million
- Provided strategic planning for contracting, compensation, finances, and network expansion for physician group
- Work with vendors to support early adoption of electronic medical record in physician offices
- Negotiated payer, provider and MSO contract on behalf of IPA physicians, enhancing revenue by 20%
- Promoted IPA to top rated group in the state for service and clinical quality, improved financial performance in less than two years
- Responsible for all aspects of IPA operations growing from 25 to 150 employees
- Coordinated the merger of operations to the EBMN and application for a Knox-Keene license until Sutter Connect was available for use by the IPA.

Antelope Valley Medical Center, Director, Managed Care, 1989-1992 Served in the capacity of contract negotiator overseeing staff that managed more than 70% of the revenue of the district hospital as well as management of day to day operations and contracting for the IPA operations.

- Managed and negotiated all managed care and MediCal contracts on behalf of district hospital
- Provided strategic planning for contracting, compensation, finances, and network expansion
- Negotiated payer, provider and MSO contract on behalf of IPA,
- Provided support to IT infrastructure implementation of on line messaging with IPA and department staff
- Participated in budget cycle and strategic planning for service line growth in cardiovascular and laparoscopic surgery

OTHER PROFESSIONAL EXPERIENCE

Prior to her roles in provider management and contracting, Ms. Hack served in provider contracting, eligibility and claims customer services roles for CIGNA HealthPlan and Care America HealthPlan (now Blue Shield of California).

PUBLICATIONS & SPEAKING ENGAGEMENTS & PROFESSIONAL ASSOCIATIONS

HFMA since 1994; National IPA Coalition, Chair of the Board, 1995-1997, member since 1993; Women in Health Care Administration, 1992–2000; AHIMA RHIO Best Practices Advisory Committee 2006–2007; OpenHII Founding Chair, 2006; CCHIT Privacy Expert Panel, 2007, 2008; HISPC California Co-Lead, 2006, California eHealth Collaborative, 2009 to current

Speaker: national and international speaker, most recently with CHIA, ACHE, HIMSS Bay Area, HFMA, Society for Health Care Planning and Marketing, Physician Forum, Gingrich Center for Health Transformation Harvard Business School, Abu Dhabi Global Medical Forum, Florida Health Information Network, eHI Initiative, World Health and Technology Congress, and other venues within HealthTech, the National IPA Coalition and client retreats.

Kim, K. K., Browe, D. K., Logan, H. C., Holm, R., Hack, L., & Ohno-Machado, L. (2013). Data governance requirements for distributed clinical research networks: triangulating perspectives of diverse stakeholders. *Journal of the American Medical Informatics Association*. Online first 12/3/13. doi: 10.1136/amiajnl-2013-002308.

Kim, KK, Hack, L. California Trust Framework: A Brief Report (Jan. 30, 2014). California Health eQuality, University of California Davis.http://www.ucdmc.ucdavis.edu/iphi/Programs/cheq/cheqresources.html

Kim, KK, Gordon, D, Hack, L. Health Information Exchange Case Study: Redwood MedNet (Jan. 30, 2014). California Health eQuality, University of California Davis.

Lori L. Hack, Object Health, William Henning Md, Natalie Martin, Chris Chan Md, Kathy Thunholm, (2014), EPrescribing analysis for providers serving Medicaid population in Southern California.

EDM Symposium. Online, http://network.bepress.com/explore/medicine-and-health-sciences/public-health/health-services-research

AMENDED AND RESTATED BYLAWS OF THE

DESIGNATED PROCEDURES OVERSIGHT COMMITTEE

1. NAME; PURPOSE; DEFINITION OF "DESIGNATED PROCEDURES"

(a) The name of the committee shall be the Sacramento Designated Procedures Oversight Committee ("**Oversight Committee**"), which shall act as an oversight body related to aspects of the provision of certain medical procedures, including elective clinical sterilizations, at the following Hospitals: Methodist Hospital of Sacramento, Sierra Nevada Memorial Hospital, Woodland Memorial Hospital, and Mark Twain Medical Center (each a "**Hospital**" and collectively the "**Hospitals**"). In this limited but important role, the Oversight Committee is designed and designated to act as a separate body to oversee the governance, operations, management and financial results related solely to the "Designated Procedures" (as defined below) performed at the Hospitals. The objective of the Oversight Committee is for there to be certain separation between the governance of each Hospital as a whole, and the direct governance over the provision of the Designated Procedures for purposes of Catholic doctrine and theology.

(b) "**Designated Procedures**" means those medical procedures that may be performed at one or more of the Hospitals that are designated from time to time by the board of directors of Dignity Community Care, a Colorado nonprofit corporation ("**Dignity Care**"), to be under the independent governance and oversight of this Oversight Committee for the purposes described in the Amended and Restated Bylaws of Dignity Care ("**Dignity Care Bylaws**") and these Bylaws. Initially, Designated Procedures shall be limited to a "direct sterilization" that consists of an elective medical procedure, the primary purpose of which is to render the patient permanently incapable of reproducing; provided, however, that a medical procedure that induces sterility does not constitute "Designated Procedures" when its direct effect is the cure or alleviation of a present and serious pathology, and a simpler treatment is not available. Future changes or modifications to the Ethical and Religious Directives for Catholic Health Care Services promulgated and as amended from time to time by the United States Conference of Catholic Bishops (the "**ERDs**") and/or to the Dignity Health Statement of Common Values, as adopted by Dignity Care and amended from time to time, (the "**Statement of Common Values**") applicable to the Hospitals may result in the classification of one or more additional medical procedures as Designated Procedures subject to the supervision of this Oversight Committee. Dignity Care shall give written notice to the Oversight Committee when one or more medical procedures are designated as Designated Procedures and under the supervision of this Oversight Committee. Subject to Section 8 below, these Bylaws should be amended when and as any such additional medical procedures are designated as Designated Procedures by Dignity Care. However, this definition shall include, and the role of this Oversight Committee shall extend (as of the effective date specified in Dignity Care's notice) to, any such additional medical procedures so designated pending the amendment or modification of these Bylaws.

2. SCOPE OF AUTHORITY; DUTIES AND RESPONSIBILITIES

(a) The authority vested in the Oversight Committee relates solely to the Designated Procedures at the Hospitals. The Oversight Committee's scope of authority does not extend, and cannot be extended unilaterally by the Oversight Committee, to any other operations, activities, procedures or services performed at the Hospitals. Any authority not specifically delegated to the Oversight Committee shall remain with the board of directors of Dignity Care, the respective hospital community boards of the Hospitals (each a "**Hospital Community Board**" and collectively the "**Hospital Community Boards**"), and/or the board of directors of the subsidiary of Dignity Care that operates a Hospital (each such subsidiary, a "**Hospital Subsidiary**" and each such board of a Hospital Subsidiary a "**Subsidiary Board**"), as applicable to the Oversight Committee. The Oversight Committee does not have the authority to alter the scope of its authority set forth in this Section 2 or to change the definition of Designated Procedures as set forth in Section 1(b) above.

(b) Subject to the foregoing, the Oversight Committee shall carry out the following duties and responsibilities related to the Designated Procedures:

(i) Assuring that facility managers who have direct line responsibility for, or related to, the provision of Designated Procedures are employees of Dignity Care or the Hospital Subsidiary, as applicable, but in any case, are not employees of System Corporation, which is the corporation that coordinates and operates the Catholic health care system with which Dignity Care operates in an alliance (the "**System Corporation**"), Dignity Health, a California nonprofit public benefit corporation ("**Dignity Health**"), or any other subsidiaries, affiliates, hospitals, other health facilities and activities, and other entities of Dignity Health or the System Corporation that are governed by the ERDs (collectively the "**System Affiliates**").

(ii) Planning and making necessary arrangements with System Corporation's executive or senior management and the president with responsibility for each Hospital and other senior management so that each Hospital may effectively conduct the scope, extent, volume and type of the Designated Procedures anticipated to be performed at each such Hospital.

(iii) Evaluating, overseeing, and receiving information and reports on, and recommending or directing actions to be taken by management with respect to, the operations and quality of care of the Designated Procedures performed at the Hospitals.

(iv) Requiring the Hospitals to (A) maintain separate, segregated accounting of all revenues arising from, and costs and expenses (direct and indirect) incurred or reasonably allocable to, those Designated Procedures operated and performed at each such Hospital, and (B) regularly report to the Oversight Committee on the net revenues, expenses (direct and indirect), earnings (EBIDTA), and/or net income or loss realized from the Designated Procedures operated and performed at each such Hospital.

(v) At least annually, meeting to review and assure that the segregated revenues, costs and expenses related to the Designated Procedures performed at each Hospital are being accurately identified, segregated, and reported to the Oversight Committee.

(vi) To the extent net income (i.e., segregated net revenues exceed segregated costs and expenses (direct and indirect) for the Designated Procedures) is realized for an entire fiscal year (or portion thereof) from the performance of the Designated Procedures at a Hospital, following the end of such fiscal year, donating such net income as a gift, donation or grant to be used for furthering the charitable purposes of Dignity Care or the Hospital Subsidiary, as applicable, to one or more nonprofit entities organized and operated exclusively for charitable purposes and exempt from income tax under Section 501(c)(3) of the Internal Revenue Code, as amended, and the equivalent provisions of state law, that operate in the communities served by such Hospital and that do not directly or actively provide or advocate for activities, services or procedures that are inconsistent with the ERDs. The Oversight Committee may make the gifts, donations or grants described in this Section at such times and in such amounts as the Oversight Committee, in its discretion, deems appropriate, but in no event shall the aggregate gifts, donations and grants related to any fiscal year exceed the net income for such fiscal year.

(vii) Not more than one hundred twenty (120) days following the end of each fiscal year, the Oversight Committee shall issue an annual report to the board of directors of Dignity Care and to the Hospital Community Board or Subsidiary Board of each Hospital, as applicable, regarding the Oversight Committee's performance of its responsibilities as described in this Section 2, including a report on the amount of net income, if any, donated pursuant to Section 2(b)(vi) during such fiscal year (the "**Annual Report**").

(viii) On an annual basis, concurrent with the delivery of the annual report described in Section 2(b)(vii) above, the Oversight Committee shall prepare and deliver a written certification (the "**Annual Certification**"), signed and dated by the Chair of the Oversight Committee, to the board of directors of Dignity Care and the Subsidiary Board, if applicable, which certifies the following:

(A) The Oversight Committee has not amended these Bylaws in any manner that violates or otherwise modifies the structure or authorities of, and the restrictions or limitations on, the Oversight Committee as contained in that certain Ministry Alignment Agreement by and between Catholic Health Initiatives, a Colorado nonprofit corporation and Dignity Health, the Dignity Care Bylaws, or these Bylaws;

(B) The composition of the members of the Oversight Committee complies with the requirements and restrictions of Section 3 of these Bylaws; and

(C) All gifts, donations or grants (if any) of any Hospital's net income realized from the performance of Designated Procedures made during the preceding fiscal year through the date of the written certification were contributed to one or more health care related tax-exempt charities that satisfy the requirements and restrictions contained in Section 2(b)(vi) of these Bylaws. For this purpose, the written certification shall include the name and amount of the gift, donation or grant to each such health care related tax exempt charity.

3. COMPOSITION OF THE OVERSIGHT COMMITTEE

(a) Size and Qualifications of Members. Subject to the requirements and limitations of this Section 3, the Oversight Committee shall consist of nine (9) individuals (the **"Authorized**

Number of Members"), who shall be representative of the communities served by the Hospitals or are interested or have some background, knowledge or experience in the oversight and/or delivery of health care services and the provision of quality care in a hospital or clinical setting. At all times, a majority of the Oversight Committee shall consist of individuals representative of the communities served by the Hospitals.

(b) Composition. Subject to Section 3(c) below, the Oversight Committee shall be comprised of (A) one (1) member from each Hospital Community Board and/or Subsidiary Board, if any, of the Hospitals that are under the supervision of the Oversight Committee, who shall at all times constitute a minority of the members of the Oversight Committee, and (B) other members (i.e., with a least one (1) member from each Hospital) satisfying the qualifications set forth in Section 3(a) above, who shall at all times constitute a majority of the members of the Oversight Committee. When a Hospital Community Board or Subsidiary Board governs more than a single Hospital, then the number of members from such Hospital Community Board or Subsidiary Board on the Oversight Committee may be up to (but not more than) the number of Hospitals governed by such Hospital Community Board or Subsidiary Board, provided that the other members shall at all times constitute a majority of the Oversight Committee.

(c) Limitations on Participation in Other Governance.

(i) In no event may (A) members of Hospital Community Boards or Subsidiary Boards comprise a majority of the members of the Oversight Committee, or (B) members of the Oversight Committee make up a majority of the members of any Hospital Community Board or Subsidiary Board.

(ii) At no time may any member of the Oversight Committee (A) be a woman religious, or (B) contemporaneously serve as a member of Catholic Health Care Federation, which is a public juridic person and the sponsor of System Corporation, a member of the board of directors of Dignity Care, a member of the board of directors of the System Corporation, or a member of the board of directors or governing body of Dignity Health or any other System Affiliate that is governed by the ERDs.

4. IDENTIFICATION, APPOINTMENT AND REMOVAL OF MEMBERS

(a) Initial Appointment and Term. The initial members of the Oversight Committee, who comply with the requirements of Sections 3(b) and (c) above, have been designated by Dignity Health prior to the Effective Date of the Ministry Alignment between Dignity Health and Catholic Health Initiatives and are named in Exhibit A to these Bylaws. The initial members of the Oversight Committee shall serve for a term commencing on January 1, 2019 and expiring on June 30, 2021.

(b) Vacancies and Subsequent Appointments.

(i) A vacancy on the Oversight Committee shall be deemed to exist (A) upon a member's death or resignation (as provided in Section 4(e) below), (B) upon removal of a member (as provided in Section 4(d) below, (C) upon the application of the term limit set forth in Section 4(c) below to a member, (D) if a member who is serving by reason of being a member of

a Hospital Community Board or Subsidiary Board ceases to be a member of such Board, (E) without further action by reason of a member's failure to attend (either in person, by conference call or by alternative means) two (2) consecutive meetings of the Oversight Committee, or (F) upon an increase in the Authorized Number of Members.

(ii) When a vacancy exists (A) if the vacancy arises with respect to a person whose position on the Oversight Committee results from being a member of a Hospital Community Board or Subsidiary Board, then such Hospital Community Board or Subsidiary Board shall provide the Oversight Committee with a slate of one (1) or more candidates to serve as a member of the Oversight Committee, and (B) if the vacancy arises with respect to any other person serving on the Oversight Committee, then Dignity Care's senior management shall provide the Oversight Committee with a slate of one (1) or more candidates to serve as a member of the Oversight Committee, who shall meet the requirements set forth in Sections 3(b) and (c) above.

(iii) Following the initial appointments described in Section 4(a) above, the Oversight Committee shall be self-perpetuating. Any vacancy or vacancies that occur on the Oversight Committee shall be filled by individuals identified in the slates of candidates provided pursuant to Section 4(b)(ii) above and appointed by the majority vote of the then remaining Oversight Committee members.

(c) Term. Except as provided in Section 4(a), each Oversight Committee member's term shall begin on July 1 of the first year for which he or she is appointed and continues until the last day of June in the last year for which he or she is appointed or until his or her replacement is selected and takes office, whichever is later, unless the member ceases to continue to serve (by reason of resignation, removal or otherwise) prior to the expiration of his or her term. An Oversight Committee member shall serve for a term of three (3) years. Thereafter, such member will be eligible for appointment for up to five (5) consecutive 3-year terms (i.e., up to 15 years); provided, however, that, upon the affirmative vote of the Oversight Committee, any such term may be shorter (but not to exceed two years) or longer (not to exceed six months) as is deemed necessary to allow for the staggering of terms, or to permit a member to serve the maximum number of consecutive years allowed under these Bylaws, as determined by the Oversight Committee. No individual may serve more than a maximum of fifteen (15) consecutive years on this Oversight Committee; provided, however, that he or she will again be eligible for selection under these Bylaws after the conclusion of a hiatus of at least a one (1) year period ("**Hiatus Period**").

(d) Removal. The Oversight Committee, by a majority vote of its Authorized Number of Members, may remove, with or without cause, any person as a member of the Oversight Committee.

(e) Resignation. Any Oversight Committee member may resign at any time by giving written notice of the resignation to the Chair of the Oversight Committee. Any resignation shall take effect on the date of receipt of that notice, or thereafter, at any future time specified in the notice of resignation.

5. OFFICERS

(a) Officers. The officers of the Oversight Committee shall be: a Chair, a Vice Chair, a Secretary, and such other officers and/or assistant secretaries as may be designated by the Oversight Committee from time to time. Such officers shall be appointed by, and serve at the pleasure of, the Oversight Committee. Officers shall serve for a term of up to three (3) years and may serve in office for consecutive terms up to the term limit set forth in Section 4(c) above. Other than an assistant secretary, a person may not serve as an officer of the Oversight Committee if he/she is not a member of such Oversight Committee. Upon a vacancy with respect to any officer prior to the expiration of his/her term, the Oversight Committee may designate another member of the Oversight Committee to serve in that capacity at any time and from time to time for the remainder of such term.

(b) Chair. The Chair shall, if present, preside at meetings of this Oversight Committee, set the agenda for such meetings, and exercise and perform such other powers and duties as may be, from time to time, assigned by the Oversight Committee.

(c) Vice Chair. The Vice Chair shall preside at meetings of the Oversight Committee in the absence of the Chair, and perform such other duties and responsibilities as may be, from time to time, assigned by the Oversight Committee. If both the Chair and Vice Chair are unable to attend any duly called meeting, the other members of the Oversight Committee in attendance at such meeting may designate a temporary Chair for such meeting by majority vote of the members in attendance.

(d) Secretary; Assistant Secretary. The Secretary shall: (A) keep the minutes of all meetings of the Oversight Committee, (B) see that all notices are duly given in accordance with the provisions of these bylaws or as required by law, (C) keep records of names and addresses of the Hospital presidents, Oversight Committee members and officers, and (D) in general, perform all of the duties incident to the office of Secretary, subject to the control of the Oversight Committee, and have such other powers and perform such other duties as may be prescribed by the Oversight Committee. The assistant secretaries, if any, shall perform the above duties at the direction of, or in the absence of, the Secretary.

6. MEETING PROCEDURES

(a) Meeting Locations. Meetings of the Oversight Committee shall be held at a meeting space provided for such purpose by a Hospital or at such other location that is convenient for the members of the Oversight Committee, as determined from time to time by the Chair.

(b) Frequency. The Oversight Committee shall meet at least once per calendar year, and at such other times as determined by the Chair, by the executive associated with System Corporation and/or Dignity Care who is assigned responsibility for administration of the Oversight Committee (the "**Responsible Executive**"), or by any two (2) members of the Oversight Committee by written request delivered to the Chair and the Responsible Executive describing the purpose and subject matter of the requested meeting.

(c) Notice. All notices shall be delivered personally or by telephone or electronic mail to each Oversight Committee member or sent by first-class mail, charges prepaid, addressed to each person's address as it is shown in the records of the Oversight Committee. One

copy of all notices given shall be delivered to the Secretary to keep in the Oversight Committee's records. All notices shall be effective upon receipt. If the notice of a meeting is mailed, it shall be deposited in the United States mail at least four days before the time of the holding of the meeting. If the notice of a meeting is delivered personally, by telephone or electronic mail, it shall be so delivered at least 48 hours before the holding of the meeting. Attendance at a meeting of the Oversight Committee by a member of the Oversight Committee shall constitute waiver of any objection to the notice of the meeting.

(d) Voting. Each member of the Oversight Committee shall be entitled to one (1) vote with respect to each matter acted on by the Oversight Committee. Unless otherwise required by these Bylaws, any approval granted, or action taken, by the Oversight Committee shall require the affirmative vote of a majority of the Oversight Committee members present at a meeting at which a quorum is present. Attendance at a meeting of the Oversight Committee by proxy shall not be permitted.

(e) Attendance. A member of the Oversight Committee shall cease to serve on the Oversight Committee upon such member's failure to attend two (2) consecutive meetings of the Oversight Committee.

(f) Quorum. The presence of a majority of the Authorized Number of Members of the Oversight Committee shall constitute a quorum, which shall be required for the Oversight Committee to transact business or otherwise act at a meeting of the Oversight Committee. A meeting at which a quorum is initially present may continue notwithstanding the withdrawal of Oversight Committee members, if any action taken is approved by at least a majority of the required quorum for that meeting.

(g) Telephonic and Electronic Communication Meetings. Any member of the Oversight Committee may participate in a meeting of the Oversight Committee by means of teleconference, videoconference or other similar means as long as all persons participating in the meeting can hear each other, and a member's participation in a meeting pursuant to this provision shall constitute his or her presence in person at such meeting for purposes of establishing a quorum.

(h) Reporting. Minutes or other written record of all meetings of the Oversight Committee shall be made and maintained. The results of all meetings of the Oversight Committee shall be reported to the Hospital Community Boards and the Subsidiary Boards, if any, as a part of the Annual Report.

7. COORDINATION AND SUPPORT

(a) Policy. The board of directors of Dignity Care shall adopt, and may from time to time amend, a policy and procedure that will establish processes and procedures for the management and administration of the Oversight Committee, including the timing of annual meetings of the Oversight Committee and the submission of Annual Report and Annual Certification (the "**Oversight Committee Policy**"). In the event of any conflict between the provisions of these Bylaws and the Oversight Committee Policy, the provisions of these Bylaws shall control.

(b) Commitment to Support. As may be detailed in the Oversight Committee Policy, the Responsible Executive shall, along with other necessary senior management, plan and make necessary arrangements to provide whatever support may be necessary from time to time to ensure the Oversight Committee is able to carry out the purpose, duties and responsibilities described in Section 2 above.

(c) Liaisons. As may be detailed in the Oversight Committee Policy, the Responsible Executive, the senior ranking operations executive with management responsibility for multiple facilities in a defined geographic area (e.g., a Senior Vice President Operations over a Service Area) who has the largest number of Hospitals subject to oversight by the Oversight Committee, and the president of each Hospital (or his/her designee) shall serve as a liaison to the Oversight Committee and shall attend meetings of the Oversight Committee, and shall ensure that such Hospitals may effectively conduct the scope, extent, volume and type of the Designated Procedures anticipated to be performed at the Hospitals.

(d) Resources.

(1) Finance. The Hospitals, the System Corporation and/or Dignity Care shall commit sufficient accounting and finance personnel to assist the Oversight Committee in (A) its preparation of reports detailing revenues, costs and expenses (direct and indirect) incurred or reasonably allocable to those Designated Procedures operated and performed at the Hospitals, and (B) its determination of the net revenues, expenses, earnings (EBIDTA), and/or net income or loss realized from the Designated Procedures operated and performed at such Hospitals.

(2) Legal. The Hospitals, System Corporation and/or Dignity Care shall commit sufficient legal personnel, as necessary, to assist the Oversight Committee in interpreting and meeting its responsibilities as described in these Bylaws, including Section 2 above, and in the Dignity Care Bylaws.

8. AMENDMENT OR TERMINATION OF BYLAWS

These Bylaws may only be revised, amended or restated by the action of the board of directors of Dignity Care.

Exhibit A

INITIAL MEMBERS OF THE OVERSIGHT COMMITTEE

1. Lori Aldrete
2. Bill Alger
3. Marian Bell-Holmes
4. Julius Cherry
5. Nancy Guerland
6. Beth Hassett
7. Crin Stanford