MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

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22 ***CLOSED SESSION 3:00***

MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

Quality Committee Meeting
Friday, June 30, 2023, 1:00 p.m.
George M. Medak Conference Room, Suite 207
MCH Medical Office Building, 29099 Hospital Road, Lake Arrowhead, CA 92352
Or
Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 234 601 921 58
Passcode: MWdfbE
Download Teams | Join on the web
Or call in (audio only)
+1 951-384-1117,,605686207# United States, Riverside
Phone Conference ID: 605 686 207#

Members:	Cheryl Moxley, Committee Chairperson	Barry Hoy, Committee Member
	Mark Turner, Chief Executive Officer	Julie Atwood, Director of Human Resources
	Terry Peña, Chief Operating Officer	Leslie Plouse, Quality Director
	Don Larsen, MD, Community Member	Gerry Hinkley, Community Member

OPEN SESSION	1:00 p.m.
CALL TO ORDER	Cheryl Moxley, Committee Chairperson
PREVIOUS MINUTES	Cheryl Moxley, Committee Chairperson Action Probable
PUBLIC COMMENTS	Government Code Section 54954.3 Sections A & B

The public has the right to address the legislative body on any item of interest to the public.
A time restraint may be implemented at the discretion of the Committee Chairperson.

CLOSED SESSION - AGENDA ITEMS
(According to section: (54956.9)

1.	Hospital Acquired Harm	Leslie Plouse, Quality Director Information Only
2.	Event Reports – Level of Harm	Leslie Plouse, Quality Director Information Only
3.	Complaints	Leslie Plouse, Quality Director Information Only

4. USACS Dashboard — Leslie Plouse, Quality Director
   Information Only

RETURN TO OPEN SESSION

1. Closed Session Report — Cheryl Moxley, Committee Chairperson

2. Public Report of Decisions — Cheryl Moxley, Committee Chairperson

OPEN SESSION – AGENDA ITEMS

1. Performance Improvement — Leslie Plouse, Quality Director
   Information Only
   a. Fall & Injury Reduction
   b. Behavioral Health
   c. Meds to Beds
   d. Breast Cancer Screening
   e. Colon Cancer Screening

2. Patient Surveys — Leslie Plouse, Quality Director
   Information Only

3. Regulatory — Leslie Plouse, Quality Director
   Information Only
   a. Regulatory Activities
   b. Regulatory Updates

ADJOURNMENT

San Bernardino Mountains Community Hospital Quality Committee Meetings

Attendance Matrix - 2023

Committee Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Cheryl Moxley	√	√	√	√	A							DARK
Barry Hoy	√	√	√	√	√							
Terry Peña	√	√	√	√	E							
Mark Turner	√	√	√	√	√							
Julie Atwood	√	√	√	√	√							
Leslie Plouse	√	√	√	√	√							
Don Larsen	√	√	√	√	√							
Gerry Hinkley	√	√	√	√	√							
Comment:												

√ Present E Excused A Absent

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
1.0 Members Present: Absent: Recording Secretary: Guests:	Barry Hoy, Committee Member Mark Turner, Member, Chief Executive Officer Julie Atwood, Member, Director of Human Resources Leslie Plouse, Member, Quality Director Dr. Don Larsen, Community Member Gerry Hinkley, Community Member Cheryl Moxley, Committee Chairperson Terry Peña, Member, Chief Operating Officer/Chief Nursing Officer Kristi McCasland, Executive Assistant Kieth Burkart, Board President Cheryl Robinson, Board Vice President Yvonne Waggener, Chief Financial Officer Barry Smart, Board Treasurer Kim McGuire, Community Development Director Peter Venturini, Foundation Board President	**Quorum present**
2.0 Call to Order:	Hoy called the meeting to order at 1:03 p.m.	**The meeting was called to order**
3.0 Previous Minutes	On a motion made and seconded, the Quality Committee Meeting Minutes of April 28, 2023 were approved as written.	**On a motion made and seconded, the Quality Committee Meeting Minutes of April 28, 2023 were approved as written** **M (Hoy) / S (Larsen) / C**
4.0 Public Comment:	There was no public comment noted at this time.	**None**
5.0 Adjourn to Closed Session:	The Quality Committee Adjourned to “Closed Session” at approximately 1:04 p.m.	**None**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	CLOSED SESSION ATTENDEES: Barry Hoy, Committee Member Mark Turner, Member, Chief Executive Officer Julie Atwood, Member, Director of Human Resources Leslie Plouse, Member, Quality Director Dr. Don Larsen, Community Member Gerry Hinkley, Community Member Kristi McCasland, Executive Assistant Kieth Burkart, Board President Cheryl Robinson, Board Vice President Yvonne Waggener, Chief Financial Officer Barry Smart, Board Treasurer	
6.0 Return to Open Session:	The Committee returned to "Open Session" at approximately 1:09 p.m.	**None**
6.1 Closed Session Report:	Per Hoy, the following items were reported on during "Closed Session" – Hospital Acquired Harm; Harm Events; Complaints; and USACS Dashboard.	**Information only**
7.0 Agenda Items 7.1 Performance Improvement (PI)	Plouse reported on the following PI Projects: • Fall/Injury Reduction: The committee is looking at risk assessment tools that would be specific to the clinical departments. This item has been put on hold until we find out what tools are imbedded in the new EMR system. Policies will be revised once the risk assessment tools are selected/implemented. • Behavioral Health Program Development: As of March, we are at 100% on the suicide prevention documentation process outcome and 80% on the safety attendant training process outcome; April numbers are pending. Action items were reviewed in detail.	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	• IEHP Performance Improvement Projects: a. Meds to Beds: Our target for 2023 is that 100% of IEHP members who are discharged from an IP setting are offered the Meds to Beds program. In April 2023, we were at 100%. b. Breast Cancer Screening: Our target for 2023 is that 55.15% of female IEHP patients ages 52-74 receive a mammogram; as of April 2023, we are at 42.86%. c. Colon Cancer Screening: Our target for 2023 is that 48.75% of IEHP/MediCal patients ages 45-75 receive a screening for colorectal cancer; as of April 2023, we are at 35.44%.	
7.2 Patient Surveys	Patient Satisfaction Surveys (Inpatient & ED) – • Inpatient: In April 2023, there were two responses, with a 50% top box score (88.19 mean score). No verbatim comments received for April. • ED: In April 2023, there were seven responses with an 80.77% top box score (94.33 mean score). No verbatim comments were received for April. • Physical Therapy: For Q1 2023, there were 117 responses received. Out of those responses, 113 gave the rating of 9-10 (promoter) and 4 gave the rating of 7-8 (neutral) for an overall score of 96.6%.	**Information only**
7.3 Regulatory Activity/Updates	Regulatory Activities and Updates -- • SNF Life Safety Survey 5/4/2023: Plan of correction submitted and approved; progress reports will begin in June 2023. • SNF CMS Recertification Survey 4/17/2023-4/20/2023: Plan of correction submitted and approved; progress reports will begin in June 2023. • TJC Lab Triennial Reaccreditation Survey 5/3/2022-5/5/2022:	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	Critical Results documentation in April (overall) was 97%; Policies uploaded and current as of April was 97%. • CDPH Complaint Investigation 7/22/2022: investigation ongoing	
8.0 Final Adjournment:	There being no further business to discuss, the meeting was adjourned at approximately 1:30 p.m.	**Meeting adjourned**

MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

Human Resources Committee Meeting
Friday, June 30, 2023, 1:30 p.m.
George M. Medak Conference Room, Suite 207
MCH Medical Office Building, 29099 Hospital Road, Lake Arrowhead, CA 92352
Or
Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 234 601 921 58
Passcode: MWdfbE
Download Teams | Join on the web
Or call in (audio only)
+1 951-384-1117,,605686207# United States, Riverside
Phone Conference ID: 605 686 207#

Members:	Kieth Burkart, President	Barry Smart, Committee Member
	Mark Turner, Chief Executive Officer	Don Larsen, Committee Member
	Terry Peña, Chief Operating Officer	Julie Atwood, Director of Human Resources

OPEN SESSION — 1:30 p.m.

CALL TO ORDER — Kieth Burkart, Committee Chairperson

PREVIOUS MINUTES — Kieth Burkart, President
Action Probable

PUBLIC COMMENTS — Government Code
Section 54954.3 Sections A & B

The public has the right to address the legislative body on any item of interest to the public.
A time restraint may be implemented at the discretion of the Committee Chairperson.

AGENDA ITEMS

1. Hospital Week — Julie Atwood, Director of Human Resources
Information Only
2. Annual Salary & Benefits Review — Julie Atwood, Director of Human Resources
Information Only
3. Turnover — Julie Atwood, Director of Human Resources
Information Only

ADJOURNMENT

San Bernardino Mountains Community Hospital Human Resource Committee Meetings

Attendance Matrix - 2023

Committee Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Kieth Burkart	FACILITIES	MARKETING	√	FACILITIES	MARKETING		FACILITIES	MARKETING		FACILITIES	MARKETING	DARK
Barry Smart			√									
Julie Atwood			√									
Terry Peña			√									
Mark Turner			√									
Don Larsen			√									
Gerry Hinkley			√									
Comment:												

√ Present E Excused A Absent

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
1.0 Members Present: Absent: Recording Secretary: Guests:	Keith Burkart, Committee Chairperson Barry Smart, Committee Member Mark Turner, Chief Executive Officer Don Larsen, Community Member Terry Peña, Chief Operating Officer/Chief Nursing Officer Julie Atwood, Human Resource Director Kristi McCasland, Executive Assistant Cheryl Robinson, Board Member Cheryl Moxley, Board Member Barry How, Board Member Leslie Plouse, Quality Director Yvonne Waggener, Chief Financial Officer Kim McGuire, Community Development Director Gerry Hinkley, Community Member	**Quorum present**
2.0 Call to Order:	Burkart called the meeting to order at 1:29 p.m.	**The meeting was called to order**
3.0 Previous Minutes	On a motion made and seconded the Human Resources Committee Meeting Minutes of September 15, 2022, and the Special Human Resources Committee Minutes of October 20, 2022 were approved as written.	**On a motion made and seconded, the Human Resources Committee Meeting Minutes of September 15, 2022, and the Special Human Resources Committee Minutes of October 20, 2023 were approved as written.** **M (Turner) / S (Smart) / C**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
4.0 Public Comment:	There was not public comment at this time.	**None**
5.1 New Manager Introduction: Delacey Foster, Dietary Manager	Atwood reported that we have 1 new manager at Mountains Community Hospital. Introductions and backgrounds were reviewed for Delacey Foster, Dietary Manager.	**Information Only**
5.2 2022 Turnover	Atwood reported that we currently have 253 employees; 71% of which live on the mountain (Crestline to Green Valley Lake); and 30% who live in Big Bear or down the hill. In 2022, our turnover was 14%. Atwood reported that moving forward turnover would reported to the Board on quarterly basis.	**Information Only**
5.3 Work Injuries	Atwood reported that in 2022 we had 10 reportable injuries, with 14 days lost and 182 days on the job with restrictions. Turner noted that our insurance providers would be giving a Workers Comp presentation at tomorrow's Department Managers meeting.	**Information Only**
5.4 Rest & Meal Periods	Atwood reported that beginning January 1, 2023; we were no longer exempt from the CA law regarding employee rest and meal periods. Employees who do not get their full 30 minute meal period will be paid an hour of time. Employees scheduled to work 10 or 12 hours are granted (2) meal periods, however, they can choose to waive one of them.	**Information Only**
6.0 Final Adjournment:	There being no further business to discuss, the meeting was adjourned at approximately 1:43 p.m.	**Meeting adjourned**

MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

Finance Committee Meeting
Friday, June 30, 2023, 1:45 p.m.
George M. Medak Conference Room, Suite 207
MCH Medical Office Building, 29099 Hospital Road, Lake Arrowhead, CA 92352
Or
Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 234 601 921 58
Passcode: MWdfbE
Download Teams | Join on the web
Or call in (audio only)
+1 951-384-1117,,605686207# United States, Riverside
Phone Conference ID: 605 686 207#

Members:	Barrick Smart, Committee Chairperson	Barry Hoy, Committee Member
	Yvonne Waggener, Chief Financial Officer	Terry Peña, Chief Operating Officer
	Mark Turner, Chief Executive Officer	Don Larsen, MD, Community Member
	Gerry Hinkley, Community Member	

OPEN SESSION	1:45 p.m.
CALL TO ORDER	Barry Smart, Committee Chairperson
PREVIOUS MINUTES	Barry Smart, Committee Chairperson Action Probable
PUBLIC COMMENTS	Government Code Section 54954.3 Sections A & B

The public has the right to address the legislative body on any item of interest to the public.
A time restraint may be implemented at the discretion of the Committee Chairperson.

AGENDA ITEMS

1.	Financial Statements	Yvonne Waggener, Chief Financial Officer Action Probable
2.	Capital Purchases	Yvonne Waggener, Chief Financial Officer Action Possible
3.	Investments	Yvonne Waggener, Chief Financial Officer Action Possible
4.	Investment Account at Cal Bank & Trust	Yvonne Waggener, Chief Financial Officer Barry Smart, Committee Chairperson Action Possible

5. FY24 Proposed Operating Budget — Yvonne Waggener, Chief Financial Officer
   Action Probable

ADJOURNMENT

San Bernardino Mountains Community Hospital Finance Committee Meetings

Attendance Matrix - 2023

Committee Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Barry Smart	√	√	CANCELLED	√	√							DARK
Barry Hoy	√	√		√	√							
Yvonne Waggener	√	√		√	√							
Mark Turner	√	√		√	√							
Terry Peña	√	√		√	E							
Don Larsen	√	√		√	√							
Gerry Hinkley	√	√		√	√							
Comment:												

√ Present E Excused A Absent

MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

FINANCE COMMITTEE MEETING MINUTES

May 25, 2023

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
1.0 Members Present: Absent: Recording Secretary: Guests:	Barrick Smart, Committee Chairperson Barry Hoy, Committee Member Yvonne Waggener, Member, Chief Financial Officer Mark Turner, Member, Chief Executive Officer Don Larsen, Community Member Gerry Hinkley, Community Member Terry Peña, Member, Chief Operating Officer/Chief Nursing Officer Kristi McCasland, Executive Assistant Kieth Burkart, Board President Cheryl Robinson, Board Vice President Julie Atwood, Human Resources Director Kim McGuire, Community Development Director Leslie Plouse, Quality Director Peter Venturini, Foundation Board President	**Quorum present**
2.0 Call to Order:	Smart called the meeting to order at 1:51 p.m.	**The meeting was called to order**
3.0 Previous Minutes:	On a motion made and seconded, the Finance Committee Meeting Minutes of April 28, 2023 were approved.	**On a motion made and seconded, the Finance Committee Meeting Minutes of April 28, 2023 were approved as written** **M (Hoy) / S (Turner) / C**
4.0 Public Comment:	There was no public comment noted at this time.	**None**
5.0 Agenda Items: 5.1 Financial Statements	Waggener presented the FY23 Financial Statements as of ten (10) months ended April 30, 2023. Comparative statistics and selected financial indicators were reviewed with the committee.	**A motion was made and seconded to recommend to the Board to accept the Financial**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	Waggener noted that our new General Surgeon, Dr. Beshoy Nashed, has received insurance credentialing from IEHP, Aetna, Signa, Medi-Cal, Medi-Care and UHC, so we should see a bump in our surgery statistics moving forward. (Dr. Nashed still needs insurance credentialing from Blue Cross, Blue Shield and Regal.)	**Statements as of Ten (10) months ending April 30, 2023.** **M (Hoy) / S (Larsen) / C**
5.2 Capital Purchases	Waggener presented the FY23 Capital Purchases as of nine (10) months ended April 30, 2023. Updates on FY23 purchases were reviewed. Waggener noted that the MedSurg Pyxis machine was included on the FY20 & FY21 capital budgets, but the MedSurg unit could not be purchased until the MedSurg Nurses Station construction was complete. Because this capital item straddled multiple years, it fell off the radar and was not carried forward to the FY23 capital budget. The total for the MedSurg Pyxis machine was $82,146.	**A motion was made and seconded to recommend to the Board to approve the $82,146 capital expenditure for the MedSurg Pyxis machine.** **M (Hoy) / S (Hinkley) / C**
5.3 Investments	Waggener presented and reviewed the LAIF and UBS statements as of April 30, 2023.	**Information only**
5.4 Investment Account at Cal Bank & Trust	Smart reported that Cal Bank & Trust asked if we would consider having an investment account with them like the one we have at UBS. Smart & Waggener met with their investment arm (LPL Financial), and they sent us a proposal, which is not a big difference from UBS. Smart will review their proposal in depth, and bring this item back to next month's Finance committee for discussion/consideration.	**Information only**
6.0 Adjournment:	No further business to discuss, the meeting was adjourned at approximately 2:43 p.m.	**Meeting adjourned**

MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

SPECIAL FINANCE COMMITTEE MEETING MINUTES

June 20, 2023

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
1.0 Members Present: Absent: Recording Secretary: Guests:	Barry Hoy, Committee Member Yvonne Waggener, Chief Financial Officer Mark Turner, Chief Executive Officer Don Larsen, Community Member Gerry Hinkley, Community Member Barrick Smart, Committee Chairperson Terry Peña, , Chief Operating Officer/Chief Nursing Officer Kristi McCasland, Executive Assistant Kieth Burkart, Board President Cheryl Robinson, Board Vice President Cheryl Moxley, Board Secretary Kim McGuire, Community Development Director	**Quorum present**
2.0 Call to Order:	Hoy called the meeting to order at 5:00 p.m.	**The meeting was called to order**
3.0 Public Comment:	There was no public comment noted at this time.	**None**
4.0 Agenda Items: 4.1 FY24 Proposed Operating Budget	Waggener presented the FY24 Operating Budget Assumptions and reviewed the gross patient service revenue (by department), deductions from revenue, other operating revenue, operating expenses, non-operating revenue/expenses and the FY24 proposed operating budget vs. actual estimated FY23 budget. Category line items were reviewed and discussed in detail. For FY24 we are projecting a net loss of ($1,418,426). Waggener reported that the Senior Management Team would continue to look at the proposed budget numbers to finalize them for review/approval at the regular Finance Committee and Regular Board of Directors meetings on June 30, 2023.	**The FY24 Proposed Operating Budget will be taken to the regular Finance Committee and Regular Board of Directors Meetings on June 30, 2023 for review/approval.**
6.0 Adjournment:	No further business to discuss, the meeting was adjourned at approximately 6:04 p.m.	**Meeting adjourned.**

Mountains Community Hospital
Key Financial Indicators

	AUDITED							BENCHMARKS	
	06/30/17	06/30/18	06/30/19	06/30/20	06/30/21	06/30/22	05/31/23	FAR WEST CAH	CA CAH
LIQUIDITY									
Days cash on hand - All sources	**161**	**240**	**344**	**523**	**490**	**490**	**463**	**173**	**222**
Cash	909,787	944,823	625,817	15,242,086	8,242,632	4,168,498	4,408,354		
Board Designated	8,505,612	14,339,180	21,636,014	20,160,931	29,289,726	35,548,549	37,293,815		
Total	9,415,399	15,284,003	22,261,831	35,403,017	37,532,358	39,717,047	41,702,169		
Days gross revenue in gross AR	58	57	55	49	62	52	54		
Days net revenue in net AR	**41**	**33**	**43**	**33**	**41**	**37**	**29**	**59**	**41**
Days expense in AP	**32**	**23**	**25**	**29**	**29**	**42**	**30**		
Current ratio	**1.6**	**2.3**	**1.6**	**2.1**	**1.8**	**1.8**	**1.6**		
Cash to debt	**91%**	**154%**	**236%**	**303%**	**443%**	**498%**	**559%**		
CAPITAL STRUCTURE									
Long-term debt to capitalization	**38%**	**28%**	**24%**	**25%**	**16%**	**14%**	**13%**		
PROFITABILITY									
Total margin	**12%**	**26%**	**19%**	**17%**	**29%**	**14%**	**7%**		
OTHER									
Paid full time equivalents (FTE's)	**165.66**	**177.25**	**183.31**	**176.66**	**185.49**	**182.08**	**192.68**		
BENCHMARK - FAR WEST	The Industry Benchmark is from the Optum 2022 Almanac of Hospital Financial and Operating Indicators. The Benchmark Average is for Critical Access Hospital in the Far West Region.								
BENCHMARK - CA	The California Benchmark is from the Flex Monitoring Team Data Summary Report #26, CAH Financial indicators Report: Summary of Indicators Medians by State, May 2022.								
Total Margin Goal	Based on Year-To-Date Budget								

Mountains Community Hospital
Comparative Statistics

	Patient Days				Average Daily Census				ER Visits		Surgery	
	Acute	Swing	Hospital	SNF	Acute	Swing	Hospital	SNF	Month	Day	Endo	Surg
Jul-21	86	-	86	593	2.8	-	2.8	19.1	896	29	18	24
Aug-21	86	3	89	620	2.8	0.1	2.9	20.0	835	27	8	13
Sep-21	74	28	102	600	2.5	0.9	3.4	20.0	727	24	18	21
Oct-21	83	32	115	620	2.7	1.0	3.7	20.0	708	23	18	12
Nov-21	96	2	98	600	3.2	0.1	3.3	20.0	723	24	13	16
Dec-21	121	36	157	620	3.9	1.2	5.1	20.0	682	22	14	22
Jan-22	196	2	198	620	6.3	0.1	6.4	20.0	810	26	2	14
Feb-22	59	1	60	560	2.1	0.0	2.1	20.0	572	20	1	9
Mar-22	34	-	34	573	1.1	-	1.1	18.5	601	19	15	22
Apr-22	49	-	49	553	1.6	-	1.6	18.4	669	22	7	17
May-22	57	-	57	589	1.8	-	1.8	19.0	714	23	10	25
Jun-22	75	-	75	583	2.5	-	2.5	19.4	716	24	12	16
	1,016	104	1,120	7,131	2.8	0.3	3.1	19.5	8,653	24	136	211
	Patient Days				Average Daily Census				ER Visits		Surgery	
	Acute	Swing	Hospital	SNF	Acute	Swing	Hospital	SNF	Month	Day	Endo	Surg
Jul-22	45	7	52	589	1.5	0.2	1.7	19.0	841	27	18	24
Aug-22	46	28	74	605	1.5	0.9	2.4	19.5	814	26	20	19
Sep-22	50	14	64	585	1.7	0.5	2.1	19.5	760	25	3	7
Oct-22	30	38	68	594	1.0	1.2	2.2	19.2	786	25	-	1
Nov-22	80	56	136	562	2.7	1.9	4.5	18.7	802	27	-	6
Dec-22	47	4	51	558	1.5	0.1	1.6	18.0	786	25	-	12
Jan-23	46	39	85	585	1.5	1.3	2.7	18.9	712	23	-	9
Feb-23	44	46	90	532	1.6	1.6	3.2	19.0	565	20	-	11
Mar-23	56	45	101	584	1.8	1.5	3.3	18.8	497	16	-	9
Apr-23	54	27	81	535	1.8	0.9	2.7	17.8	602	20	-	14
May-23	81	43	124	513	2.6	1.4	4.0	16.5	692	22	-	9
	579	347	926	6,242	1.7	1.0	2.8	18.6	7,857	23	41	121
Budget May-23	78	16	94	608	2.5	0.5	3.0	19.6	744	24	-	15

Mountains Community Hospital
Comparative Statistics

	Lab	Radiology Exams						PT	Rural Health Clinics				
	Tests	X Ray	CT	Mammo	DXA	US	Total	Visits	LA Med	LA Dent	LA Tele	RS Med	Total
Jul-21	7,369	736	264	84	19	107	1,210	712	482	215	210	120	1,027
Aug-21	8,120	709	255	77	18	120	1,179	734	535	244	224	155	1,158
Sep-21	7,871	657	243	75	18	80	1,073	746	528	266	234	150	1,178
Oct-21	7,535	659	249	100	15	127	1,150	714	433	205	239	96	973
Nov-21	7,463	620	254	79	24	124	1,101	710	453	243	225	141	1,062
Dec-21	6,673	562	229	51	18	73	933	590	385	167	237	59	848
Jan-22	7,426	689	250	38	7	82	1,066	566	455	278	236	73	1,042
Feb-22	6,098	606	238	49	13	91	997	577	421	216	196	123	956
Mar-22	6,849	559	183	58	8	110	918	807	533	265	285	130	1,213
Apr-22	6,141	592	213	101	23	133	1,062	711	389	263	270	116	1,038
May-22	6,597	620	204	84	15	117	1,040	678	476	316	256	113	1,161
Jun-22	6,794	660	189	74	17	103	1,043	642	514	292	246	115	1,167
	84,936	7,669	2,771	870	195	1,267	12,772	8,187	5,604	2,970	2,858	1,391	12,823
	Lab	Radiology Exams						PT	Rural Health Clinics				
	Tests	X Ray	CT	Mammo	DXA	US	Total	Visits	LA Med	LA Dent	LA Tele	RS Med	Total
Jul-22	7,502	632	276	52	9	107	1,076	642	480	259	221	89	1,049
Aug-22	7,644	635	256	74	23	100	1,088	792	506	291	236	177	1,210
Sep-22	6,523	584	238	51	12	119	1,004	615	395	245	240	140	1,020
Oct-22	6,566	594	206	94	19	102	1,015	722	413	247	244	126	1,030
Nov-22	6,815	575	184	99	23	83	964	715	379	196	213	102	890
Dec-22	5,970	592	203	78	19	93	985	635	337	204	235	97	873
Jan-23	5,784	577	191	37	8	94	907	623	374	227	223	88	912
Feb-23	4,897	488	153	46	13	63	763	526	322	183	196	74	775
Mar-23	3,813	450	148	19	5	62	684	378	278	108	198	54	638
Apr-23	6,309	574	204	55	11	92	936	678	361	264	199	91	915
May-23	6,521	611	210	64	7	97	989	811	485	284	219	106	1,094
	68,344	6,312	2,269	669	149	1,012	10,411	7,137	4,330	2,508	2,424	1,144	10,406
Budget May-23	6,000	739	204	82	25	113	1,163	681	460	260	240	140	1,100

Through May 2023

Description	Actual	Budget	Variance	YTD Actual	YTD Budget	Variance	FY Budget	Remaining
Revenue:								
Gross Patient Service Revenue	5,111,334	5,259,965	-148,631	53,604,891	57,508,818	-3,903,927	62,680,783	-9,075,892
Deductions from Revenue:								
Contractual Discounts	3,310,029	3,444,901	-134,872	33,644,817	37,582,911	-3,938,094	40,969,812	-7,324,995
Bad Debt	70,000	106,000	-36,000	711,384	1,157,000	-445,616	1,261,000	-549,616
Charity Care	15,340	0	15,340	75,372	0	75,372	0	75,372
Supplemental Reimbursement	-1,554,736	-1,000,000	-554,736	-9,448,403	-7,100,000	-2,348,403	-7,852,000	-1,596,403
Net Patient Service Revenue	3,270,702	2,709,064	561,638	28,621,721	25,868,907	2,752,814	28,301,971	319,750
Other Operating Revenue	31,335	23,960	7,375	280,603	263,560	17,043	352,520	-71,917
Total Revenue	3,302,037	2,733,024	569,013	28,902,325	26,132,467	2,769,858	28,654,491	247,834
Expenses:								
Salaries and Wages	1,518,392	1,553,200	-34,808	15,913,471	16,727,890	-814,419	18,248,010	-2,334,539
Employee Benefits	329,148	339,910	-10,762	3,387,033	3,568,760	-181,727	3,911,160	-524,127
Professional Fees	190,154	151,580	38,574	2,434,701	1,677,380	757,321	1,866,780	567,921
Supplies	208,110	265,625	-57,515	2,716,863	2,787,480	-70,617	3,131,975	-415,112
Purchased Services	118,793	84,050	34,743	1,394,754	1,111,635	283,119	1,255,185	139,569
Rent	14,032	9,915	4,117	168,250	109,065	59,185	122,280	45,970
Repairs & Maintenance	78,288	71,740	6,548	795,732	750,635	45,097	906,495	-110,763
Utilities	264,339	42,325	222,014	783,495	504,175	279,320	547,500	235,995
Insurance	39,414	38,960	454	433,969	428,545	5,424	467,500	-33,531
Depreciation Expense	124,474	139,730	-15,256	1,367,685	1,511,580	-143,895	1,651,310	-283,625
Other Operating Expenses	116,931	104,995	11,936	1,716,573	1,687,275	29,298	1,876,535	-159,962

Through May 2023

Description	Actual	Budget	Variance	YTD Actual	YTD Budget	Variance	FY Budget	Remaining
Total Expenses	3,002,076	2,802,030	200,046	31,112,526	30,864,420	248,106	33,984,730	-2,872,204
Income (Loss) from Operations	299,961	-69,006	368,967	-2,210,201	-4,731,953	2,521,752	-5,330,239	3,120,038
Non-Operating Rev (Exp):								
District Tax Revenue	245,000	245,000	0	2,695,000	2,695,000	0	2,940,000	-245,000
Investment Income	66,006	0	66,006	830,824	0	830,824	0	830,824
Interest Expenses	-36,020	-36,020	0	-409,734	-409,735	1	-445,765	36,031
Non Capital Grants & Contr	0	0	0	953,369	722,500	230,869	970,000	-16,631
Other Non-Operating Revenue	40,091	37,490	2,601	421,422	412,540	8,882	450,180	-28,758
Other Non-Operating Expense	-31,290	-26,075	-5,215	-298,551	-303,130	4,579	-331,890	33,339
Gain/Loss On Disp of Property	0	0	0	0	0	0	0	0
Non-Operating Revenue/Expense	283,788	220,395	63,393	4,192,330	3,117,175	1,075,155	3,582,525	609,805
Net Income (Loss)	583,749	151,389	432,360	1,982,130	-1,614,778	3,596,908	-1,747,714	3,729,844

May 2023

Description	Beginning Balance	Ending Balance	Variance
Assets:			
Cash & Cash Equivalents	4,168,497	4,408,354	239,857
Receivables: Patient - Net	2,875,476	2,518,081	-357,395
Receivables: Other	198,586	-240,077	-438,662
Receivables: Foundation	0	6,151	6,151
Inventory	569,588	675,066	105,478
Prepaid Expenses & Deposits	477,555	510,045	32,490
Total Current Assets	8,289,702	7,877,621	-412,082
Assets Limited As To Use	36,015,367	37,608,945	1,593,578
Capital Assets - Net	16,208,340	17,180,035	971,695
Other Assets	1,982,928	1,982,928	0
Total Assets	62,496,338	64,649,529	2,153,191
Liabilities:			
Long-Term Debt - CP	509,000	533,200	24,200
AP & Accrued Expenses	1,536,352	1,225,801	-310,551
Patient Credit Balances	583,417	684,197	100,780
Accrued Interest	183,248	138,877	-44,372
Accrued Payroll	1,183,246	1,244,730	61,484
Deferred Revenue	40,294	45,199	4,905
Est Third-Party Settlements	649,088	954,032	304,944
Total Current Liabilities	4,684,645	4,826,036	141,391
Long-Term Debt	7,979,957	7,461,067	-518,890
Deferred Inflows-Leases	2,008,540	2,008,540	0
Total Liabilities	14,673,142	14,295,643	-377,499
Net Assets	47,823,196	50,353,886	2,530,690
Total Liabilities & Net Assets	62,496,338	64,649,529	2,153,191

FY 2023 Capital Budget & Asset Additions as of 05/31/23						
Department	Item Description	Budget	Complete	Actual	Funding	
Facilities	Front of House	498,000		504,921	507,000	Grants & Donations
Facilities	Gift Shop	165,600				
Facilities	Front of House & Gift Shop Soft Costs & Furniture	152,600				
Facilities	RHC LA Interior Remodel/Retrofit	200,000		68,546	50,000	County
Facilities	Touchless Bathrooms	60,000		74,402	200,000	Federal COVID Relief
Facilities	Hallway Flooring MOB	20,000				
Environmental Services	Hand Hygiene Monitoring	50,000	X	35,135		
Surgery	Surgery Cabinetry	23,000	X	26,550		
Facilities	Hospital & MOB Flooring	307,000		362,543	258,000	ARP Ship Grant
Facilities	Patient Transfer Vehicle	125,000			125,000	Foundation
Emergency/Surgery	Stryker Gurneys	95,000	X	94,572	150,000	Ahmanson Grant
Facilities	Education Center	-			327,000	Donations
Facilities	Minor Use Permit (Parking Structure, Education Center, Acute Care Wing)	200,000		46,139		
Facilities	Parking Structure	-				
Facilities	New Acute Care Wing	-				
Anesthesia	Anesthesia Monitor	30,000				
Dietary	A/C Project	81,000		845		Approved Aug 2022
Emergency	Radio System (Wearable Alert Notifiers)	TBD				
Emergency	Slit Lamp	10,000				
Facilities	Chemistry Analyzers (2) Construction	25,000		17,470		
Facilities	ER Exam Lights	50,000		433		
Facilities	Extension to Bio Hazard Cage	6,000				
Facilities	Fire Suppression (Server Room)	65,000				
Facilities	Front of House & Med Surg HVAC	306,000		296,044		
Facilities	Med Surg Nursing Station (Pyxis)	135,000		169,269		
Facilities	Med Surg Windows	150,000				
Facilities	MOB A/C Units	25,000		5,400		
Facilities	MOB Electrical Panel	15,000				
Facilities	MOB Repairs on Pop-Outs	75,000				
Facilities	Nurses' Call System	250,000				
Facilities	OR Doors	15,000				
Facilities	Parking Lot Expansion	50,000				
Facilities	Parking Lot Slurry & Restripe	38,000	X	37,565		
Facilities	Pharmacy Relocation (Includes Hood)	496,800		75,661		
Facilities	Seismic NPC3 (Anchor Equipment) & SPC 4D	100,000		68,671		
Facilities	SNF Nurses' Station	15,000				

FY 2023 Capital Budget & Asset Additions as of 05/31/23						
Department	Item Description	Budget	Complete	Actual	Funding	
Facilities	Storage Containers	74,000				
Facilities	Surgery Water Filtration System Contruction	20,000				
Facilities	Utility Vehicle	25,000				
Information Tech	Cisco Firewalls	28,000				
Information Tech	EHR	TBD		312,654		
Laboratory	Centrifuge	9,000	X	8,369		
Laboratory	Chemistry Analyzer Interface	19,000		18,318		
Laboratory	Coagulation Analyzer	67,000				
Laboratory	Microscope	15,000	X	14,817		
Med Surg	Accuvein Vein Finder	6,000				
Respiratory	EKG Machine	13,000				
RHC Dental	Air Compressor	9,000				
RHC Dental	Autoclave	12,000	X	10,644		
RHC Dental	Exam Chair	17,000	X	16,499		
Surgery	Cardiac Monitors (2)	23,000				
Surgery	EGD & Colonscopy Scopes	55,000				
Surgery	Electrosurgical Unit with Smoke Evacuator	37,000	X	36,282		
		4,263,000		**2,301,747**	**1,617,000**	
Not Budgeted						
Facilities	Entrance Doors Near ED	NA		22,259		
Facilities	Physical Therapy Doors	NA	X	7,714		
Facilities	Sprinklers	NA	X	9,217		
Information Tech	Phone System Upgrade	NA	X	8,520		
Laboratory	Blood Bank Fridge	NA	X	11,787		
Med Surg	Pyxsis machines	NA	X	82,146		
Radiology	Windows 10 Upgrade to Ultrasound Machine	NA	X	6,007		
Skilled Nursing Facility	Hepa Air Filtration	NA	X	15,111		
Skilled Nursing Facility	Shed	NA	X	7,902		
	Total	**4,263,000**		**2,472,410**		

San Bernardino Mountains Community Hospital District
FY2024 Operating Budget

	FY23 (ESTIMATED)	FY24 (PROPOSED)	DIFFERENCE
Revenue:			
Gross Patient Service Revenue	58,626,856	65,148,058	6,521,202
Deductions From Revenue			
Contractual Discounts	36,902,718	41,944,608	5,041,890
Bad Debt	785,384	983,000	197,616
Charity Care	75,372	72,000	(3,372)
*Supplemental Reimbursement	(9,639,448)	(8,254,000)	1,385,448
Total Deductions From Revenue	28,124,026	34,745,608	6,621,582
Net Patient Service Revenue	30,502,830	30,402,450	(100,380)
Other Operating Revenue	369,563	424,648	55,085
Total Revenue	30,872,393	30,827,098	(45,295)
Expenses:			
Salaries and Wages	17,383,591	19,351,540	1,967,949
Employee Benefits	3,718,433	3,948,200	229,767
Professional Fees	2,882,344	2,683,885	(198,459)
Supplies	3,061,358	3,257,650	196,292
Purchased Services	1,365,059	976,710	(388,349)
Rent	181,466	199,220	17,754
Repairs and Maintenance	951,592	858,579	(93,013)
Utilities	836,820	648,560	(188,260)
Insurance	472,924	547,648	74,724
Depreciation	1,492,415	2,173,200	680,785
Other Operating	1,905,833	2,010,594	104,761
Total Expenses	34,251,835	36,655,786	2,403,951
Loss From Operations	(3,379,442)	(5,828,688)	(2,449,246)
Non-Operating Revenue (Expense):			
District Tax Revenue	3,000,000	3,096,000	96,000
Investment Income	880,824	914,400	33,576
Interest Expense	(445,765)	(522,182)	(76,417)
Non Capital Grants and Donations	1,166,168	952,000	(214,168)
Other Non-Operating Revenue	459,062	432,570	(26,492)
Other Non-Operating Expense	(327,311)	(353,580)	(26,269)
Total Non-Operating Revenue (Expense)	4,732,978	4,519,208	(213,770)
Net Income (Loss)	1,353,536	(1,309,480)	(2,663,016)

MOUNTAINS COMMUNITY HOSPITAL
The Heart of Mountain Healthcare

"Mountains Community Hospital makes possible essential quality medical services to the residents and visitors of the local mountains."

DISTRICT BOARD OF DIRECTORS MEETING
Friday, June 30, 2023, 2:15 p.m.
George M. Medak Conference Room, Suite 207
MCH Medical Office Building, 29099 Hospital Road, Lake Arrowhead, CA 92352
Or
Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Meeting ID: 234 601 921 58
Passcode: MWdfbE
Download Teams | Join on the web
Or call in (audio only)
+1 951-384-1117,,605686207# United States, Riverside
Phone Conference ID: 605 686 207#

Members:	Kieth Burkart, President	Cheryl Robinson, Vice President
	Barrick Smart, Treasurer	Cheryl Moxley, Secretary
	Barry Hoy, Trustee	
Staff Members:	Mark Turner, Chief Executive Officer	Terry Peña, Chief Operating Officer
	Walter Maier, M.D., MEC Treasurer	Yvonne Waggener, Chief Financial Officer
	Julie Atwood, Human Resources Director	Kristi McCasland, Executive Assistant

OPEN SESSION	2:15 p.m.
CALL TO ORDER	Kieth Burkart, President
PRESIDENTS COMMENTS	Kieth Burkart, President Action Possible
BOARD MEMBER REPORTS	All Board Members
PUBLIC COMMENTS	Government Code Section 54954.3 Sections A & B

The public has the right to address the legislative body on any item of interest to the public.
A time restraint may be implemented at the discretion of the Board President.

PREVIOUS MINUTES approval	Kieth Burkart, President Action probable
CONSENT AGENDA	Kieth Burkart, President Action Probable

(Motion will be made to include all items listed)

1. Approval of Quality Committee minutes, meeting held May 25, 2023
2. Approval of Human Resources Committee minutes, meeting held March 16, 2023
3. Approval of Finance Committee minutes, meeting held May 25, 2023
4. Approval of the attached Policies and Procedures that was sent June 21, 2023
5. Approval of the attached list of Policies and Procedures ADDENDUM that was sent June 27, 2023

AGENDA ITEMS

1. Corporate Compliance Program	Mark Turner, Chief Executive Officer Michael Onusko, Interim Compliance Officer Action Possible
2. Resolution 2023-11 – Special Tax Levies for FY2023-24	Mark Turner, Chief Executive Officer Action Probable
3. Agreement for Collection of Special Taxes, Fees & Assessments for FY2023-24	Mark Turner, Chief Executive Officer Action Probable
4. CEO Report	
a. Construction and Land Use approval update	Information Only
b. General Surgeon Onboarding update	Information Only
5. COO/CNO Report	Terry Peña, Chief Operating Officer Information only
6. Quality Committee Report Report of Meeting held June 30, 2023	Cheryl Moxley, Chairperson Information only
7. Human Resources Committee Report Report of Meeting held June 30, 2023	Kieth Burkart, Chairperson Information only
8. Finance Committee Report Report of Meeting held June 30, 2023	Barry Smart, Chairperson
a. Financial Statements	Action Probable
b. Capital Purchases	Action Possible
c. Investments	Action Possible
d. Investments Account at Cal Bank & Trust	Action Possible
e. FY24 Proposed Operating Budget	Action Probable
9. Board Education	Kieth Burkart, President Action Possible
10. Discussion Topic Suggestions	Kieth Burkart, President Information only

ADJOURN TO CLOSED SESSION

CLOSED SESSION AGENDA ITEMS

(Closed session pursuant to Govt. Code Section 54954.5

1.	Hearings Subject matter: Staff Privileges Re: Credentialing Recommendations Closed session pursuant to Cal. Health & Safety § 32155	Walter Maier, M.D., MEC Treasurer Action Probable
2.	Medical Executive Committee Report Subject Matter: Report of Medical Executive Committee Meeting minutes Closed session pursuant to Cal. Health & Safety § 32155	Walter Maier, M.D., MEC Treasurer Information only

RETURN TO OPEN SESSION

1.	Closed Session Report	Kieth Burkart, President
2.	Public Report of Decisions	Kieth Burkart, President

NEXT BOARD-ATTENDED MEETINGS — Thursday, July 27, 2023 at 1:00 p.m.
(Days & times are subject to change so please refer to the posted agenda for exact times)

FINAL ADJOURNMENT

San Bernardino Mountains Community Hospital Board of Directors Meetings

Attendance Matrix - 2023

Board Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Kieth Burkart	√	√	√	√	√							DARK
Cheryl Robinson	√	√	√	√	√							
Cheryl Moxley	√	√	√	√	A							
Barry Smart	√	√	√	√	√							
Barry Hoy	√	√	√	√	√							
Staff Members												
Mark Turner	√	√	√	√	√							
Terry Peña	√	√	√	√	E							
Yvonne Waggener	√	√	√	√	√							
Julie Atwood	√	√	√	√	√							
Kim McGuire	√	√	√	√	√							
Kristi McCasland	√	√	√	√	√							
Bijan Motamedi, M.D.	E	√	√	√	√							
Comment												

√ Present E Excused A Absent

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
1.0 Call to Order:	Kieth Burkart, Board President, called the Board of Directors meeting to order at approximately 2:43 p.m.	**The meeting was called to order**
2.0 Board Members Present: Members Absent: Recording Secretary Staff Members Present: Guests:	Kieth Burkart, Board President Cheryl Robinson, Vice President Barrick Smart, Board Treasurer Barry Hoy, Board Trustee Cheryl Moxley, Board Secretary Terry Peña, Chief Operating Officer/Chief Nursing Officer Kristi McCasland, Executive Assistant Mark Turner, Chief Executive Officer Yvonne Waggener, Chief Financial Officer Julie Atwood, Human Resources Director Bijan Motamedi, M.D., Chief of Staff Kim McGuire, Community Development Director Leslie Plouse, Quality Director Don Larson, MD, Community Member Gerry Hinkley, Community Member Peter Venturini, Foundation Board President	**Quorum present**
3.0 President's Comments:	None	**None**
4.0 Board Member's Reports:	Moxley and Hoy reported that they learned a lot and enjoyed the networking opportunities at the Annual HASC conference.	**Information only**
5.0 Public Comments:	None	**None**
6.0 Previous Minutes:	On a motion made and seconded the Minutes from the Board of Directors meeting of April 28, 2023 were approved as written.	**On a motion made and seconded the Minutes from the Board of Directors meeting of**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
		April 28, 2023 were approved as written. **M (Robinson) / S (Smart) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**
7.0 Consent Agenda:	The following Consent Agenda items were reviewed: 1. Approval of Quality Committee minutes, meeting held April 28, 2023 2. Approval of Marketing Committee minutes, meeting held February 16, 2023 3. Approval of Finance Committee minutes, meeting held April 28, 2023 4. Approval of the attached list of Policies and Procedures (Revised List) that was sent May 17, 2023 *(see list attached to the May Board Packet)*.	**On a motion made and seconded, the Consent Agenda items were approved as presented.** **M (Robinson) / S (Smart) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**
8.0 Agenda 8.1 Resolution 2023-09 – Establishing Appropriations Limits for FY2023-2024	Waggener reviewed Resolution 2023-09 noting that we are required to establish appropriations limits by resolution each year. • **RESOLUTION NO. 2023-09** **RESOLUTION OF THE BOARD OF DIRECTORS OF THE SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT ESTABLISHING APPROPRIATIONS LIMITS FOR FISCAL YEAR 2023-2024** See Resolution 2023-09 for entire text.	**On a motion made and seconded, the following resolution was accepted as presented:** **RESOLUTION NO. 2023-09** **RESOLUTION OF THE BOARD OF DIRECTORS OF THE SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT ESTABLISHING APPROPRIATIONS LIMITS FOR FISCAL YEAR 2023-2024** **M (Robinson) / S (Hoy) / C**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
		4 Ayes / 0 Nays / 0 Abstain / 1 Absent
8.2 CEO Report a. Construction and Land Use Approval Update	Turner reported on the progress of the construction projects: • Med/Surg Nurses Station / Front of the House project: We are getting close to closing out these projects. The only thing remaining is to get the paperwork pulled together and signed off by the inspectors on June 6. The furniture and artwork have been received. • Pharmacy Project: HCAI has approved the plans and we have placed notices inviting bids. The job walk is scheduled for June 6, and the deadline for contractor to submit their bids is mid-July. It is estimated this project will take 1 year to complete. • Laboratory Project: The larger analyzer has been installed and vented out; we are awaiting receipt/installation of the seismic kit. The smaller unit will be installed in June 2023. • Gift Shop Project: Once the smaller analyzer is moved out of the space (June) we can begin work on the Gift Shop Project. We are awaiting bids from our current contractor. • Hospital Van: An order has been placed for a Ford Transit van. It is estimated the van will be received in about 3-7 months once the build is complete. • Land Use Approval (Acute Wing): The application for land use approval was submitted and is going through the county approval process now.	**Information only**
b. General Surgeon Onboarding Update	Turner reported that Dr. Nashed was credentialed with IEHP as of June 1, and that he is still awaiting insurance credentialing from a couple other plans. Dr. Nashed has completed 2 of his 6-proctored procedures with Dr. Martin; Dr. Walker will proctor the other four procedures.	**Information only**
c. ATC Cell Tower Buyout	Turner reported that ATC got back with us and is again offering $850k buyout for the cell tower. The offer was sent to the ad hock team to review. This item will be brought back to the Board in June for their	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	consideration.	
8.3 COO/CNO Report	Peña no present (Excused).	**Information only**
8.4 Quality Committee Report a. Report of meeting held May 25, 2023	Hoy reported on the Quality Committee meeting: 1. Performance Improvement: a. Fall/Injury Reduction: The committee is looking at risk assessment tools that would be specific to the clinical departments. This item has been put on hold until we find out what tools are imbedded in the new EMR system. Policies will be revised once the risk assessment tools are selected/implemented. b. Behavioral Health Program Development: As of March, we are at 100% on the suicide prevention documentation process outcome and 80% on the safety attendant training process outcome; April numbers are pending. Action items were reviewed in detail. c. IEHP Performance Improvement Projects: 1) Meds to Beds: Our target for 2023 is that 100% of IEHP members who are discharged from an IP setting are offered the Meds to Beds program. In April 2023, we were at 100%. 2) Breast Cancer Screening: Our target for 2023 is that 55.15% of female IEHP patients ages 52-74 receive a mammogram; as of April 2023, we are at 42.86%. 3) Colon Cancer Screening: Our target for 2023 is that 48.75% of IEHP/MediCal patients ages 45-75 receive a screening for colorectal cancer; as of April 2023, we are at 35.44%. 2. Patient Satisfaction Surveys (Inpatient & ED): a. Inpatient: In April 2023, there were two responses, with a 50% top box score (88.19 mean score). No verbatim comments received for April.	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	b. ED: In April 2023, there were seven responses with an 80.77% top box score (94.33 mean score). No verbatim comments were received for April. c. Physical Therapy: For Q1 2023, there were 117 responses received. Out of those responses, 113 gave the rating of 9-10 (promoter) and four gave the rating of 7-8 (neutral) for an overall score of 96.6%. 3. Regulatory Activities and Updates: a. SNF Life Safety Survey 5/4/2023: Plan of correction submitted and approved; progress reports will begin in June 2023. b. SNF CMS Recertification Survey 4/17/2023-4/20/2023: Plan of correction submitted and approved; progress reports will begin in June 2023. c. TJC Lab Triennial Reaccreditation Survey 5/3/2022-5/5/2022: Critical Results documentation in April (overall) was 97%; Policies uploaded and current as of April was 97%. d. CDPH Complaint Investigation 7/22/2022: investigation ongoing	
8.5 Marketing Committee Report a. Report of meeting held May 25, 2023	Robinson reported on the Marketing Committee meeting: 1. Fundraising: • YTD, the Foundation has raised $89,000 – this includes the Le Grand Picnic tickets and sponsorships we sold the past few days for LGP. Last year at this time, we had raised $31,000. • Total cash and investments around $2.4MM. • The Foundation President will sign a check for $290,000 for the hospital's wish list items tomorrow. • The Summit Circle dinner was held on April 15, and there were 140 attendees. Overall, it was a great event. • The "Back to the Future" themed LeGrand Picnic is scheduled for July 23, 2023. A save the date email was sent and the event information was added to the hospitals website. The committee is working on décor, auction items, advertising, scripts, ordering the	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	tables/chairs and gathering volunteers. The Foundation received their sellers permit for this event to be able to charge sales tax. 2. Naming opportunities: • There were 125 naming opportunities identified, the next step will be to value each space. Gift Map will help with giving us comparative values. 3. Grant Update: • Received a $7,500 grant from JE Fehsenfeld Foundation • Requested a $100k grant from San Manuel Band of Mission Indians, which is pending. • The final report for the Ahmanson Foundation is due August 31st • Requested a $15k grant from the Mountain Small Business Grant Program, which is pending. • Working schedule a call to learn more about the IE Community Foundation and their endowment fund program and other grant opportunities. • Connected with a grant writer for SAC Health and Loma Linda, who also writes grants for Bear Valley on occasion. We are going to keep an eye out for opportunities to partner. 4. Marketing: • Hospital & Nurses Week was promoted through social media posts. • New Mover Cards were developed and sent to new homeowners who closed escrow between 12/1/2022-3/31/2023 (approximately 400 new homeowners). • Working with HR on a staff recruitment campaign that focuses on work life balance. • Out of 4,300 national entries in the Healthcare Advertising Awards, there were only 14 that were given awards for "COVID Marketing Campaign", of which Mountains Community Hospital won two of those 13 awards.	

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	• Social media posts are being done on Instagram, Facebook and LinkedIn, please follow us and share our posts. 5. Upcoming Events: • Rural Dental Open House – 5/11 • Auxiliary Meeting – 5/11 • Locals Day at SkyPark – 5/18 • Running Springs Farmers Market – 5/20 • Game of Skate in Crestline – 5/20 • Auxiliary Officer Installation – 6/12 (tentative) • Volunteer/New Employee Orientation – 6/19 • New waiting room/registration area ribbon cutting – TBD • Sheriff's Dept. BBQ mixer – TBD • Le Grand Picnic – 7/23 • Rose Memorial – 8/12 • Foundation Board Meeting – 8/31 • Ted Roy Charity Foundation Golf Tournament – 9/15 • First Friday at the Lake House – TBD • Breast Cancer Walk – 10/7 • Lake Arrowhead Chamber Mixer – 10/12 • Foundation Board Meeting – 10/19	
8.6 Finance Committee Report a. Report of meeting held May 25, 2023	Smart reported on the Finance Committee meeting: 1. Financial Statements: The FY23 Financial Statements as of Ten (10) months ended April 30, 2023. Comparative statistics and selected financial indicators were reviewed with the committee.	**On a motion made and seconded, the Financial Statements as of Ten (10) months ending April 30, 2023 were accepted as presented.** **M (Smart) / S (Hoy) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	2. Capital Purchases: The FY23 Capital Purchases as of Ten (10) months ended April 30, 2023. Updates on FY23 purchases were reviewed. It was noted that the MedSurg Pyxis machine was included on the FY20 & FY21 capital budgets, but the MedSurg unit could not be purchased until the MedSurg Nurses Station construction was complete. Because this capital item straddled multiple years, it fell off the radar and was not carried forward to the FY23 capital budget. The total for the MedSurg Pyxis machine was $82,146. 3. Investments: LAIF and UBS statements for months ending April 30, 2023 were presented and reviewed. 4. Investment Account with Cal Bank & Trust: Smart reported that Cal Bank & Trust asked if we would consider having an investment account with them like the one we have at UBS. Smart & Waggener met with their investment arm (LPL Financial), and they sent us a proposal, which is not a big difference from UBS. Smart will review their proposal in depth, and bring this item back to next month's Finance committee for discussion/consideration.	**On a motion made and seconded, the Board approved the $82,146 unbudgeted capital expenditure for the MedSurg Pyxis machine.** **M (Smart) / S (Hoy) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**
8.7 Board Education	None	**None**
8.8 Discussion Topic Suggestions:	None	**None**
9.0 Adjourn to Closed Session:	The Board adjourned to "Closed Session" at approximately 3:18 p.m.	**Information only**
10.0 Return to Open Session:	The Board returned to "Open Session" at approximately 3:35 p.m.	**Information only**
10.1 Closed Session Report:	Per Kieth Burkart, the following items were reported on during "Closed Session": • Medical Staff Reports of May 25, 2023 and Credentialing from the May 23, 2023 Medical Executive Committee meeting.	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
11.0 Public Report of Decisions 11.1 Hearings; Staff Privileges; Credentialing Recommendations	The Board accepted the Medical Staff Report of May 25, 2023, and Credentialing from the May 23, 2023 Medical Executive Committee meeting. Approvals were as follows: • **New Appointments**: o NILOFAR FIROOZNIA, MD – Tele-Radiology/Mammography (SOL) o MICHAEL F. MCCONNELL, DO - Tele-Radiology/Mammography (SOL) • **Provisional Extensions**: o MEGHA N. GUPTA, MD – Tele-Radiology • **Advancement from Provisional Staff/Regular Staff**: o CHRISTIAN J. INGUI, MD – Tele-Radiology o DAVID N. ISHIMITSU, MD – Tele-Radiology • **Reappointments**: o KEVIN J. EWERT, DDS – General Dentist - MCH Rural/Dental Clinic o CHOON S. KOO, MD – Pathology o WALTER M. MAIER, MD – Family Practice • **Changes in Staff Status**: None • **Revision/Increase of Privileges**: None • **Terminations/Resignations**: o ROBERT REUTER, MD – Radiology/Tele-Radiology – (OnRad) • **Revision of Privileges**: None • **Leave of Absence Requests:** None	**On a motion made and seconded, the Medical Staff Reports of May 25, 2023, and Credentialing from the May 23, 2023 Medical Executive Committee meeting were accepted as recommended by the MEC.** **M (Robinson) / S (Hoy) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**
12.0 Next Board-Attended Meetings:	Due to a conflict in scheduling, the next Regular Board-Attended meeting will be on Friday, June 30, 2023 at 1:00 p.m. Meeting to be held in the George M Medak Conference Room (Suite 207) in the Medical Office Building.	**Information only**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
13.0 Final Adjournment:	There being no further business to discuss, the Board of Directors meeting adjourned at approximately 3:35 p.m.	**Meeting adjourned**

By: _____

Cheryl Moxley, Secretary of the Board

By: _____

Kristi McCasland, Recording Secretary

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
1.0 Call to Order:	Kieth Burkart, Board President, called the Board of Directors meeting to order at approximately 6:05 p.m.	**The meeting was called to order**
2.0 Board Members Present: Members Absent: Recording Secretary Staff Members Present: Guests:	Kieth Burkart, Board President Cheryl Robinson, Vice President Cheryl Moxley, Board Secretary Barry Hoy, Board Trustee Barrick Smart, Board Treasurer Kristi McCasland, Executive Assistant Mark Turner, Chief Executive Officer Yvonne Waggener, Chief Financial Officer Kim McGuire, Community Development Director Don Larsen, Community Member Gerry Hinkley, Community Member	**Quorum present**
3.0 President's Comments:	Burkart commented that the budget is looking good as a start.	**None**
4.0 Board Member's Reports:	None	**None**
5.0 Public Comments:	None	**None**
6.0 Agenda 6.1 Resolution 2023-10 – Authorizing Signers for all Accounts at California Bank & Trust	Turner reported that they are looking to add Waggener as a signer on all accounts at California Bank & Trust. Turner noted that the hospital has processes in place to prevent any conflicts with having her as a signer. • **RESOLUTION NO. 2023-10** **RESOLUTION OF THE BOARD OF DIRECTORS OF THE SAN BERNARDINO MOUNTAINS COMMUNITY**	**On a motion made and seconded, the following resolution was accepted as presented:** **RESOLUTION NO. 2023-10** **RESOLUTION OF THE BOARD OF DIRECTORS OF THE**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
	HOSPITAL DISTRICT AUTHORIZING SIGNERS FOR ALL ACCOUNTS HELD AT CALIFORNIA BANK & TRUST. See Resolution 2023-10 for entire text.	**SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT AUTHORIZING SIGNERS FOR ALL ACCOUNTS HELD AT CALIFORNIA BANK & TRUST.** **M (Hoy) / S (Robinson) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**
6.2 MCH Organizational Chart	Turner reported that the MCH Organizational Chart was updated to move the Privacy and Compliance Officer to have a direct line to the Chief Executive Officer, and a dotted line to the Board. He noted that a consultant, Michael Onusko, is filling the position in the interim while he works to revamp our Corporate Compliance program. Once the programs is up and running, the position will be filled by someone internally. He noted that Onusko will be making a Corporate Compliance presentation at the June 30, 2023 Regular Board Meeting.	**On a motion made and seconded, the changes to the MCH Organizational Chart were accepted as presented.** **M (Robinson) / S (Hoy) / C** **4 Ayes / 0 Nays / 0 Abstain / 1 Absent**
6.3 FY24 Proposed Operating Budget	Hoy reported on the Special Finance Committee meeting: Waggener presented the FY24 Operating Budget Assumptions and reviewed the gross patient service revenue (by department), deductions from revenue, other operating revenue, operating expenses, non-operating revenue/expenses and the FY24 proposed operating budget vs. actual estimated FY23 budget. Category line items were reviewed and discussed in detail. For FY24 we are projecting a net loss of ($1,418,426). The Senior Management Team would continue to look at the proposed budget numbers to finalize them for review/approval at the regular Finance Committee and Regular Board of Directors meetings on June 30, 2023.	**The FY24 Proposed Operating Budget will be taken to the regular Finance Committee and Regular Board of Directors Meetings on June 30, 2023 for review/approval.**

TOPIC	DISCUSSION/CONCLUSION/RECOMMENDATION	ACTION/FOLLOW-UP
8.0 Adjourn to Closed Session:	The Board adjourned to "Closed Session" at approximately 6:14 p.m.	**Information only**
9.0 Return to Open Session:	The Board returned to "Open Session" at approximately 6:30 p.m.	**Information only**
10.1 Closed Session Report:	Per Kieth Burkart, the following items were discussed during "Closed Executive Session": • Executive Session: Personnel Issues: CEO Compensation	**Information only**
11.0 Public Report of Decisions	No reportable actions taken.	**Information only**
12.0 Next Board-Attended Meetings:	Due to a conflict in scheduling, the next Board-Attended meetings will be on Friday, June 30, 2023 at 1:00 p.m. Meeting to be held in the George M. Medak Conference Room, 29099 Hospital Road, Suite 207, Lake Arrowhead, CA 92352.	**Information only**
13.0 Final Adjournment:	There being no further business to discuss, the Board of Directors meeting adjourned at approximately 6:31 p.m.	**Meeting adjourned**

By: _____

Cheryl Moxley, Secretary of the Board

By: _____

Kristi McCasland, Recording Secretary

Board of Directors Meeting - June 30, 2023
Policy Review/Approval

Board Approvals: (37 Documents)

I. New Policies / Forms / Attachments: (8)

a. Infection Control (IC) Policies: (1)
Infection Control Risk Assessment (ICRA) Matrix of Precautions for Construction & Renovation (Attachment) - IC

b. Provision of Care, Treatment and Services (PC) Policies: (4)
Suicide Prevention (Policy) - PC
C.A.S.E. (Creating A Safe Environment) Checklist (Form) - PC
SAFE-T Protocol with Columbia Risk and Protective Factors (Form) - PC
Safety Attendant Monitoring Log (Form) - PC

c. Rights of the Individual (RI) Policies: (1)
Abuse, Suspected Dependent Adult/Elder Abuse (Policy) - RI

d. Skilled Nursing Facility: (2)
SNF Receipt of Information on Admission (Form) - SNF
Emergency Operations Manual Addendum: 1135 Waiver Request for SNF (Attachment) - Skilled Nursing Facility

II. Updated Policies / Forms / Attachments: (8)

a. Medical Staff (MS) Policies: (3)
Privileges, Psychology (Form) - MS
Medical Staff Application Processing (Policy) - MS
Privileges, Otolaryngology (Form) - MS

b. Rights & Responsibilities of the Patient (RI) Policies: (1)
Grievances / Complaints, Customer (Policy) - RI

c. Nutrtional Services Department Policies: (1)
Standard Diets (Policy) - Nutritional Services Department

d. Perioperative Services Department Policies: (2)
Perioperative COVID Testing Procedure (Policy) - Perioperative Services Department
Perioperative Management of Confirmed Case of COVID-19 (Policy) - Perioperative Services Department

e. Rural Health Clinic Policies: (1)
Testing-Diagnostic and Laboratory (Policy) - Rural Health Clinic

III. Trienniel Renewal Only (no / minor changes): (21)

a. Leadership (LD) Policies: (2)
Practitioner Roster (Policy) - LD / MS
Disclosure of Adverse Outcome(s) to Patients Families (Policy) - LD

b. Medication Management (MM) Policies: (1)
Medication Errors and Adverse Reactions (Policy) - MM

c. Medical Staff (MS) Policies: (5)
Medical Staff Application Missing Letter (Form) - MS
Privileges, Internal Medicine (Form) - MS
Privileges, Oral Surgery (Form) - MS
Privileges, Ophthalmology (Form) - MS
Reappointment Application- Medical Staff & Allied Health Professional

d. Provision of Care, Treatment & Services (PC) Policies: (1)
Patient Lifts: HoverJack/Matt, Hoyer and Standing Lifts (Policy) - PC

e. Rights & Responsibilities of the Patient (RI) Policies: (1)
Code of Ethics (Policy) - RI

f. Nutritional Services Department Policies: (2)
COVID -19 Staffing (Policy) - Nutritional Services Department
Special Function Request for Food and Beverages (Policy) - Nutritional Services Department

g. Perioperative Services Department Policies: (7)

Cleaning of Instruments (Policy) - Perioperative Services Department
Disposable Items-Resterilization (Policy) - Perioperative Services Department
Shelf Life of Supplies (Policy) - Perioperative Services Department
Heat Sealer (Policy) - Perioperative Services Department
Labeling/Lot Numbers (Policy) - Perioperative Services Department
Perioperative Services Dress Code (Policy) - Perioperative Services Department
Scope of Service, Sterile Processing Department (Policy) - Perioperative Services Department

h. Purchasing Department Policies: (1)

Dispensing Medical Supplies to the Public (Policy) - Purchasing Department

i. Respiratory Services Policies: (1)

Ventilation, Mechanical (Policy) - Respiratory Department

Board of Directors Meeting - June 30, 2023
Policy Review/Approval
ADDENDUM

In addition to the previous list of policies which was emailed on 6/21/2023, the policies listed below will be reviewed/approved at the June 30, 2023 Board of Directors Meeting.

Board Approvals: (5 Documents)

I. New Policies / Forms / Attachments: (1)

a. **Human Resources (HR) Policies:** (1)
Employee Referral Incentive Program (Policy) - HR

II. Updated Policies / Forms / Attachments: (2)

a. **Human Resources (HR) Policies:** (1)
Workplace Violence (Policy) - HR/LS

a. **Enviornmental Services Department Policies:** (1)
Scrubs Policy (Policy) - EVS / IC

III. Trienniel Renewal Only (no / minor changes): (2)

a. **Human Resources (HR) Policies:** (1)
Dress Code (Policy) - HR

b. **Enviornmental Services Department Policies:** (1)
Hazardous Pharmaceutical Waste - RCRA & NIOSH Disposal (Policy) - EVS

MOUNTAINS COMMUNITY HOSPITAL The Heart of Mountain Healthcare	Employee Referral Incentive Program (Policy) - HR	HR - Human Resources
ORIGINATION DATE: 01/25/2023	DATE APPROVED: Not Approved Yet	VERSION: 1

POLICY The Mountains Community Hospital (MCH) Employee Referral Incentive Program is designed to supplement recruiting efforts for hard-to-fill and high-demand vacant staff positions. The recruitment results should advance MCH's employment goals and initiatives.

I. REFERRAL INCENTIVE ELIGIBILITY

A. This policy applies to all eligible MCH employees.
B. The Employee Referral Incentive Program provides eligible staff with lump-sum compensation that is outside of base salary and wages. This lump-sum payment is subject to local, state and federal tax withholdings.
C. To be eligible for an employee referral incentive, the recipient employee must be an active employee both on the date the referral is made and on the date the payment is processed.
D. The following individuals are not eligible for the employee referral incentive:
    1. Directors, Managers, and supervisors who are involved in recruitment for their assigned department. Referral of applicants to other departments, however, is acceptable.
    2. Officers and Human Resources personnel.
    3. Immediate family members of the new employee.

II. POSITION ELIGIBILITY

A. A list of approved vacant positions and/or specific jobs is managed by MCH Human Resources.
B. Human Resources will determine applicable jobs for the Employee Referral Incentive Program based on market demand studies and length of position openings.
C. All eligible positions will be posted with a "Hard-to-Fill" or "High Demand" designation.
D. Incentive payments associated with these designations will be paid at the amounts found in the chart below, once all requirements are met.

DESIGNATION	INCENTIVE AMOUNT
HARD TO FILL	**$300**
HIGH DEMAND	**$500**

E. Specific position designations may be revoked at any time by the Human Resources department when the position is filled or is no longer in high-demand or hard-to-fill. If the designation is revoked, it will be removed from the job posting.

III. PROCEDURE

A. The referred applicant will submit an application to the Human resources department for a qualified position.
B. The referred applicant must mark that they were referred to this position by a current employee and they must list the employee's name.
C. Only one eligible referring employee can be listed.
D. The employee referral incentive cannot be split between multiple employees.
E. The referring employee must submit an Employee Referral Incentive Validation form to Human Resources no later than 14 days after the referred applicant submitted their application to MCH.
F. The referring employee must be the same person listed on the candidate's application.
G. There is no guarantee that the referred candidate will be hired. Hiring will depend on the availability of the specified open position and the necessary skills, knowledge and experience of the candidate.
H. All candidates will be evaluated for employment consistent MCH's policies and procedures.
I. If hired, the referred new employee must complete 180 days of employment and be in good standing within their assigned department.
J. The employee referral incentive payment is a one-time payment issued to the referring employee once the new hire meets all of the above-described requirements.

IV. GENERAL GUIDELINES

A. A referred candidate will not be considered a new hire if they have worked for MCH in the past 12 months.
B. Eligible referring employees may receive more than one incentive payment for different positions if the referred applicants meet the program requirements and are hired.
C. Incentive payments will occur after confirmation that all requirements outlined in this policy have been met. The confirmation will be communicated to the referring employee by the Human Resources department only.

MOUNTAINS COMMUNITY HOSPITAL The Heart of Mountain Healthcare

Employee Referral Incentive Validation Form

Referring Employee Information

FIRST AND LAST NAME: _____

DEPARTMENT: _____

TELEPHONE: _____

EMAIL: _____

Referred Candidate Information

FIRST AND LAST NAME: _____

POSITION REFERRED FOR: _____

TELEPHONE: _____

EMAIL: _____

WHY/HOW IS THIS CANDIDATE QUALIFIED FOR THIS POSITION: _____

_____

_____

_____

_____

I have read and understand the Employee Referral Incentive Program policy. I understand that I will be contacted by Human Resources when, and if, my referral meets all of the requirements set forth in the policy.

_____ _____

Signature *Date*

MOUNTAINS COMMUNITY HOSPITAL The Heart of Mountain Healthcare	Scrubs Policy (Policy) - EVS / IC	EVS, IC - Infection Prevention & Control
ORIGINATION DATE: 08/26/2020	DATE APPROVED: 09/17/2020	VERSION: 1

POLICY: For purposes of this policy, Mountains Community Hospital (MCH), which includes all off campus-licensed facilities, including but not limited to the Rural Health Clinic Lake Arrowhead, Rural Health Clinic Dentist and Rural Health Clinic Running Springs.

PRINCIPLES: Hospital-provided and vendor laundered scrubs that are provided by our current contracted vendor are for authorized personnel to wear during their shift(s). These scrubs are not to leave the MCH Property for any reason. They should be removed prior to leaving and placed in an "Orange Scrub Bag" located throughout the various departments. This will ensure they are laundered properly and sent back to our facility timely.

The use of hospital provided and laundered scrub uniforms are based on the following rationale supported by the Center for Disease Control to:

- Reduce the bioburden in "clean" or "restricted" areas of the hospital
- Provide changes of hospital laundered clothing to those employees at greatest risk of blood and body fluid contamination in their daily work, while preventing the transport of contaminated items into the community.

PROCEDURE:

A. Normal Operation

Hospital laundered scrubs will be made available for the Surgery Department and will be located in the Surgical Office.

1. ~~**COVID-19 Operation**~~New Hires
   a. Once hired, OR Manager will send sizes to EVS Manager to order
      1) Turnaround time is usually 3-4 weeks depending on the size
   b. We should have enough on hand to begin their orientation
2. Additional attire in any Operating Room or any Invasive Procedure Units must adhere to the following guidelines:
   - Hospital laundered warm-up jackets may be worn provided they are clean, lint-free, and not worn anywhere outside the surgical area.
     - If worn outside the surgical area they must be removed prior to entering.
   - Due to their high lint content, fleece jackets, sweatshirts and sweaters may "NOT" be worn in any Operating Room, PACU or Invasive Procedure Suite(s). High-lint

materials harbor bacteria. As personnel move around, the friction frees bacteria with subsequent shedding into the environment;

3. Scrubs do not provide protection from blood or body fluids. Personal protective equipment (e.g., polytetrafluoroethylene (PTFE) must be worn over scrubs when splashes to skin or clothing are anticipated.
4. Hospital-provided scrubs, which are visibly soiled or wet, must be changed. If the scrub attire becomes contaminated with blood or body fluids, a clean pair of scrubs will be provided to the employee. If the garment is soiled, it should be removed in such a way to avoid exposure to the skin. The employee is to contact his/her supervisor to obtain additional scrubs. Each employee is allowed to have his/her weekly allotment of scrubs.

B. During a Pandemic; i.e. COVID-19

~~1.~~5. Hospital laundered scrubs will ~~also~~ be made available for the following departments and will be located in ~~the Infusion area~~a designated area other than the Surgery Office.

- Emergency Department
- Medical Surgical
- Skilled Nursing
- Laboratory
- Radiology
- Rural Health Clinic(s)

~~2.~~6. All staff with the exception of Surgery will retrieve their scrubs from the ~~Infusion~~Designated Area and sign them out accordingly.

~~3.~~7. At the end of their shift, they will place all soiled scrubs into "Orange Bags" located throughout the facility.

~~4.~~8. All Personnel authorized to wear hospital-laundered scrubs will adhere to the Policy set forth above.

~~5.~~9. Additional attire in any Operating Room or any Invasive Procedure Units must adhere to the following guidelines:

- ~~Warm~~Hospital laundered warm-up jackets may be worn provided they are clean, ~~and~~ lint-free~~;~~, and not worn anywhere outside the surgical area.
  - If worn outside the surgical area they must be removed prior to entering.

- Due to their high lint ~~content,~~count fleece jackets, sweatshirts and sweaters may ~~NOT~~"NOT" be worn in any Operating Room, ~~Labor and Delivery~~PACU or Invasive Procedure ~~Suites~~Suite(s).
  - High-lint materials harbor bacteria. As personnel move around, the friction frees bacteria with subsequent shedding into the environment;

~~6.~~10. Scrubs do not provide protection from blood or body fluids. Personal protective equipment (e.g., ~~gortex gown~~polytetrafluoroethylene (PTFE) must be worn over scrubs when splashes to skin or clothing are anticipated.

~~7.~~11. Hospital-provided scrubs, which are visibly soiled or wet, must be changed. If the scrub attire becomes contaminated with blood or body fluids, a clean pair of scrubs will be provided to the employee. If the garment is soiled, it should be removed in such a way ~~so as~~ to avoid exposure to the skin. The employee is to contact his/her supervisor to obtain additional scrubs. Each employee is allowed to have his/her weekly allotment of scrubs.

ATTACHMENT: Scrub Do's and Don't (Attachment) - EVS

REFERENCES:

- Belkin, N.L. Use of Scrubs and Related Apparel in Health Care Facilities, Association for Professionals in Infection Control and Epidemiology, Inc.; American Journal Infection Control 1997; 25:401-4.
- Belkin, N.L. Home Laundering of Soiled Surgical Scrubs: Surgical Site Infections and the Home Environment, Association for Professionals in Infection Control and Epidemiology, Inc.; Practice Forum, 2/01, 29:1.

MOUNTAINS COMMUNITY HOSPITAL The Heart of Mountain Healthcare	Anti-Violence in the Workplace (Policy) - HR	HR - Human Resources
ORIGINATION DATE: 06/01/2006	DATE APPROVED: 01/21/2021	VERSION: 4

PURPOSE: To create an environment, free of workplace violence.

POLICY: Mountains Community Hospital ~~has adopted a Zero Tolerance Policy against~~(MCH) maintains a zero tolerance policy on workplace violence. ~~Consistent with this policy, acts~~ Act and/or threats of physical violence, including ~~intimidation, harassment, and~~ but not limited to, intimidation and/or coercion, which ~~involve or affect MCH or which occur on MCH property will not be tolerated~~involves any staff, vendors, contractors, volunteers, physicians or any agent of MCH are not acceptable.

~~**POLICY:**~~

~~A. Acts or threats of violence include conduct which is sufficiently severe, offensive, or intimidating to alter the employment conditions at MCH or to create a hostile, abusive, or intimidating work environment or tone for several MCH employees and it Medical Staff. Examples of workplace violence include, but are not limited to, the following:~~

~~1. All threats or acts of violence occurring on MCH premises, regardless of the relationship between MCH and the parties involved in the incident.~~

~~2. All threats or acts of violence occurring off MCH premises by someone who is acting in the capacity of a representative of MCH.~~

~~3. All threats or acts of violence occurring off MCH premises involving an employee of MCH if the threats or acts affect the legitimate interest of MCH.~~

~~4. Any acts or threats resulting in the conviction of an employee or agent of MCH, or of an individual performing service for MCH on a contract or temporary basis, under any criminal code provision relating to violence or threats of violence which adversely affect the legitimate interests and goals of MCH.~~

~~B. Specific examples of conduct that may be considered threats or acts of violence include, but are not limited to, the following:~~

~~1. Hitting or shoving an individual.~~

~~2. Threatening an individual or his/her family, friends, associates, or property with harm.~~

~~3. The intentional destruction or threat of destruction of MCH property.~~

~~4. Harassing or threatening phone calls.~~

~~5. Harassing surveillance or stalking.~~

~~6. The suggestion or intimation that violence is appropriate.~~

~~7. Unauthorized possession or inappropriate use of firearms or weapons.~~

~~C. MCH prohibition against threats and act of violence applies to all persons involved in MCH operations, including but not limited to MCH personnel, contract, and temporary~~

~~workers and anyone else on MCH property. Violations of this policy by any individual on MCH property, or by any individual acting off MCH property when his/her actions affect the company's business interests will lead to disciplinary action (up to and including termination) and/or legal action as appropriate. No provision of this policy shall alter the at-will nature of the employment relationship at MCH.~~

~~D. Possession while on duty or bringing onto MCH property of unauthorized material, such as explosives, weapons (including, but not limited to, firearms and knives), or other similar items, is strictly prohibited.~~

~~E. Every employee and every person on MCH property is required to report incidents of threats or acts of physical violence or any other violation of this policy of which he/she is aware. The report should be made to the Human Resource Department, the reporting individual's immediate supervisor, or another supervisory employee if the immediate supervisor is not available. Nothing in this policy alters any other reporting obligation established in MCH policies or in state, federal or other applicable law.~~

PROCEDURE(S):

1. MCH is committed to maintaining an environment that is safe, secure and free of intimidation, threats, and violence.
   a. Employees will have an opportunity to be actively involved in the development, implementation, and review of the workplace violence policy, including participation in the identification, evaluation and correction of workplace violence hazards, and associated training curriculum.

2. MCH will provide proper training to all necessary employees, in regards to recognizing and appropriately responding to such incidents.
   a. Training will include:
      - How to recognize the potential for violence, factors contributing to the escalation of violence and how to counteract them.
      - When and how to seek assistance to prevent or respond to violence.
      - Strategies to avoid physical harm.
      - How to report violent incidents to law enforcement.
      - Resources available to employees for coping with incidents of violence. Resources will include, but are not limited to, critical incident stress debriefing (CISD) and the employee assistance program.

- Appropriate response to hazard identification and evaluation procedures, corrective measures, general and personal safety measures.
- How to communicate concerns about workplace violence, after action reports and how to participate in the review and revision of the workplace violence plan.
- How to recognize individuals, including staff, patients and visitors, who may initiate violent acts or disruptive behavior while in the facility.
- How to recognize a person's mental status, including conditions, which may cause the patient to be non-responsive to instruction, act or behave unpredictably, disruptively, uncooperatively, or aggressively.

b. Clinical staff will be training regarding treatment and medications related to psychiatric conditions.

c. Training shall include an opportunity for interactive questions and answers with a person who is knowledgeable about the Workplace Violence Prevention Policy.

3. Training for all employees shall occur upon adoption of the Workplace Violence Prevention Policy and within the 90-day probationary period thereafter.

4. Training shall occur when "new" work equipment or work practices are introduced and/or when a new or previously unrecognized workplace violence hazard has been identified.
   a. This training may be limited to only addressing new information needed.

5. Employees who are assigned to respond to codes, the notification of violent incidents or whose work assignments involve confronting and controlling person(s) exhibiting aggressive or violent behavior will be trained upon adoption of the policy and every year after.
   a. New employees who are at additional risk for experiencing workplace violence, such as security personnel will be trained prior to their initial assignment (If contracted, in accordance with their company's policy /protocols).

6. Training records shall be maintained
   a. Training records will include a brief curriculum summary, instructor qualifications, names, and job titles of attendees.

7. The Safety Officer in collaboration with Human Resources shall ensure compliance related to the Workplace Violence Prevention Policy.
   a. Responsibilities include but are not limited to:

i. Ensuring Managers are trained in workplace violence prevention and emergency procedures as well as applicable laws and regulations (AB 508) Management of Assaultive Behavior (MAB).
ii. Ensuring that all staff, vendors, contractors, volunteers, physicians or any agents of MCH adhere to the Workplace Violence Prevention Policy.

8. Employees shall communicate events that constitute workplace violence, using the proper reporting methods.
   a. Report any incidents to Management immediately.
   b. Document workplace violence by using our QRR system.
      i. Separate form for workplace violence concerns.
      ii. Reports of workplace violence will be kept for a minimum of 5 years.
   c. Communicate any known history or witnessed acts of violence involving a patient at shift change (handoff). Including transfers to another unit or to another facility.
   d. Report any acts of violence by visitors, staff members, or other person(s) to Management, Security, House Supervisor, Charge Nurse or Administrator on Call (AOC).
   e. Acts of violence that result in illness, injury (serious or not) or death must be reported to Law Enforcement within 8 hours.
      i. Incidents with firearms or other dangerous weapon(s), including common objects used as a weapon, will be reported to local law enforcement.
      ii. Reports to outside agencies must include:
         1. Hospital name, site address, hospital representative's contact information, date, time and location of the incident, the number of employees and types of injuries sustained, what agencies were notified and responded, continuing threats, corrective actions, and an incident identifier.
         2. No employee or patient names or any medical information will be disclosed unless requested by the outside agency.
      iii. MCH supports that there will be no reprisal to employees that report workplace violence within all MCH properties, to any outside agencies including law enforcement.
   f. All reports of workplace violence shall be entered into the QRR system and a report will be ran by the Director of Quality to be investigated by the appropriate manager(s), administrator, Safety Officer, and/or designee.

9. Post incident response shall include an investigation, recognition of contributing factors, recommendations for corrective action(s) and a CISD conducted by Incident Commander (IC) or designee.

a. All documentation will be stored in our QRR system for a minimum of 5 years.

10. The EOC Ad Hoc Safety and Security team shall review the Workplace Violence Prevention Policy annually.
    a. The annual review shall include patterns of workplace violence. This will include but not limited to; staffing patterns, the risk of violence, security systems, alarms, emergency response, security personnel availability, facility issues and risks associated with certain departments.
    b. Environmental and community based risk factors.
    c. MCH facility and property evaluations, including but not limited to buildings, vehicles and outdoor areas.
        i. Risks include isolated workstations, poor lighting, poor visibility, lack of physical barriers/egress, impediments to accessing alarms (panic buttons), lack of security and points of entry.
    d. All recommended corrective action(s).

REFERENCES: **https://www.dir.ca.gov/title8/3342.html**

Mountains Community Hospital

Compliance Overview

This overview is meant to summarize the basics of the Mountains Community Hospital Compliance Program and information that the board and board committee members should be aware of in their role as a healthcare board member. Should you have any questions regarding the material or questions related to compliance in general, please contact Michael Onusko, Corporate Compliance Officer for Mountains Community Hospital. His contact information is located at the end of this document.

Board Responsibilities for Compliance

The government has made it clear that boards of Trustees, board committees, and board members in general have a responsibility for corporate compliance. Over the years, it has become more important for board members and committee members to make sure they are well informed about compliance activities at the organizations they oversee. In fact, the government has taken a strong stance that board members can also be held liable or accountable for issues if it is determined that they played a role in the decision-making process. The Office of the Inspector General (OIG), the Department of Health and Human Services, and several other groups partnered to develop practical guidance for board members related to their individual responsibilities and roles. A copy of the document follows this overview. Board members should familiarize themselves with this document as well as the "Yates Memo" that was released in 2015 which is also included for reference.

What is a Compliance Program?

- A compliance program is the name for a process that helps us ensure that all individuals know and follow federal and state laws and regulations that relate to their job.
- An effective compliance program is a key factor in achieving a culture of integrity by promoting ethical and compliant behavior to combat fraud, waste, and abuse.
- It reflects an organization's good faith effort to comply with applicable statutes, regulations, and other federal or state program requirements.

An Effective Compliance Program

- The Office of the Inspector General (OIG) has identified seven elements for an effective compliance program.
- Mountains Community Hospital has designed their program to incorporate the seven elements required for an effective compliance program:

- Designate a Compliance Officer
- Establish a Code of Conduct and written policies
- Provide training and education
- Conduct auditing and monitoring
- Establish a Compliance Hotline
- Develop response mechanisms
- Establish processes for remediation of problems

- In recent years, some auditors have added an eighth element related to routine risk assessment of the compliance program to ensure it is complete and up-to-date

Why should organizations have a Compliance Program?

- To provide standards and procedures for employees to follow
- To maintain and promote integrity and ethical behavior
- To demonstrate commitment to act in compliance with legal and ethical responsibilities
- To fulfill obligations of various federal regulations governing health care

Keep in mind, that programs cannot simply be 'window dressing' or a collection of papers on a shelf. Federal and state agencies want to know that an organization has an active program that is part of the everyday culture that is promoted and enforced consistently across all areas of the organization

Code of Ethical Conduct for Mountains Community Hospital

Mountains Community Hospital is committed to complying with all legal, professional and ethical obligations that apply to our various business practices, and to establishing and maintaining a corporate culture that enables all of us to fulfill all related legal, professional and ethical obligations. Employees, staff, and providers of Mountains Community Hospital and its affiliated entities are expected to know and adhere to all legal requirements that pertain to their area of responsibility.

The Mountains Community Hospital Board of Directors has adopted a Corporate Compliance Program to ensure that Mountains Community Hospital and all its entities operate in full compliance with applicable laws and ethical principles. The program is intended to demonstrate, in the clearest possible terms, Mountains Community Hospital's absolute commitment to the highest standards of ethics and compliance with all applicable laws, policies, rules and regulations. The Corporate Compliance Officer and the Mountains Community Hospital Audit and Compliance Committee, representing all major compliance areas, provide program direction and ensure Mountains Community Hospital has a risk-based process that (1) builds compliance consciousness into daily operations, (2) monitors the effectiveness of compliance activities and (3) communicates instances of noncompliance to appropriate senior management for corrective action.

Mountains Community Hospital

Mountains Community Hospital provides a hotline as an anonymous way for employees to report suspected wrong-doing, including fraud, waste and abuse; violations of federal and state laws; and any other unethical behaviors.

Mountains Community Hospital is committed to investigating all reports promptly. Confidentiality and anonymity are protected to the extent allowed by law. The Corporate Compliance Officer reports results of investigations to the Mountains Community Hospital Board of Trustees and the President and CEO of Mountains Community Hospital and ensures that corrective action plans are implemented as soon as possible.

Organizational Ethics

Mountains Community Hospital has an ethical responsibility and obligation to the patients and the community it serves. Guided by its statement of mission, vision and values, Mountains Community Hospital has established and implemented an organizational ethics policy and committee to provide a moral framework for its business and patient care operations. The organization's guiding principle is simple: Do the right thing. All clinical decisions are based on patient care needs. When faced with a tough ethical decision, review the following checklist:

- Does the action comply with Mountains Community Hospital policies and procedures and/or policies and procedures at our affiliated entities?
- Is the action legal?
- How would the action look to your family and friends, our patients and the general public if it were published on the front page of the newspaper?
- Would the action make you feel bad if you did it?
- Are you being fair and honest?
- Is the action consistent with Mountains Community Hospital's Code of Conduct?
- Is the action wrong? Are you unsure? If so, ask until you get an answer.

Ethical behavior is the responsibility of every Mountains Community Hospital employee and those of our affiliated entities. Each one of us has a personal obligation to report any activity that appears to violate applicable laws, regulations, rules, policies, procedures or standards of ethical conduct.

Defining Fraud Waste and Abuse- FWA

- Fraud- *the intentional deception or misrepresentation that is designed to obtain an unauthorized benefit.* A false statement made or submitted by an individual or entity who knows the statement is false and knows that the false statement could result in some otherwise unauthorized benefit to the individual or entity. The false statements could be verbal or written.

Mountains Community Hospital

- Waste- *generally means over-utilization of services that result in unnecessary cost. Considered to be caused by reckless action or misuse of resources.* Any services that are either not documented or poorly documented or do not follow medical necessity guidelines are considered improper payments. This is referred to as 'waste' of government funds.
- Abuse- *an act that is inconsistent with accepted sound medical, business, or fiscal responsibility.* Refers to practices by individuals and entities which ultimately cause undue cost to the healthcare system.

Hotlines-

Mountains Community Hospital utilize a confidential disclosure program as indicated by OIG guidance. For this reason, we maintain an organizational hotline. When a call or inquiry is received, we must act upon the findings and have established strict non-retaliation policies to protect employees who report problems in good faith.

Having a hotline may be the best front-line defense against individuals filing a qui-tam (whistleblower) lawsuit. Ultimately, whistleblowers may turn out to be:

- Past or present employees
- Patients
- Physicians
- Contractors
- Private citizens

Compliance and Privacy
Hot-Line
1-844-706-5282 OR
https://mchcares.ethicspoint.com

Mountains Community Hospital

MOUNTAINS COMMUNITY HOSPITAL Compliance Key Contacts

Corporate Compliance Officer -

Michael Onusko, CHC

724-984-1989 Cell

Michael.onusko@mchcares.com

Mountains Community Hospital

Administrative Policy and Procedure Manual

MANUAL SECTION: Corporate Compliance

POLICY NUMBER:

SUBJECT: Corporate Compliance Plan

REVISION REVIEW DATES:

POLICY:

It is the policy of Mountains Community Hospital to maintain a Corporate Compliance Plan that applies to the Board of Directors, Employees, Volunteers, Medical/Dental Staff members, independent contractors and others involved with the health system.

- A copy of the Corporate Compliance Plan is attached
- A copy of the Annual/New Employee Compliance Plan Education Certification is attached
- Record of Interaction Appendix A

Mountains Community Hospital
Corporate Compliance Plan

Introduction

Mountains Community Hospital, in working to fulfill its mission and goals, wishes to demonstrate and further its strong commitment to conducting its affairs in accordance with applicable federal and state laws and regulations. A Corporate Compliance Plan is a formal program that is designed to assist our employees in meeting these goals.

Mountains Community Hospital has adopted this Corporate Compliance Plan (the "Plan") to assist employees in achieving the following objectives:

- To ensure that all employees conduct themselves according to the appropriate standards of business and professional conduct established by the hospital,
- To identify and eliminate criminal or unethical conduct,
- To ensure compliance with the directives of federal and state regulatory agencies,
- To encourage the reporting of compliance related violations,
- To develop a centralized source for distributing information on health care compliance issues.
- To communicate our commitment to compliance to employees, contractors, and vendors, and
- To develop a program that best fits the needs of Mountains Community Hospital.

In order to achieve these objectives, Mountains Community Hospital has adopted a Corporate Compliance Plan which has the following features:

- The designation of a Corporate Compliance Officer,
- The designation of a Committee to provide Compliance oversight,
- The development of compliance initiatives throughout the organization,
- Education and training designed to assist employees in understanding compliance issues,
- The use of audits and/or other techniques to monitor compliance and assist in the reduction of non-compliant behavior,
- Written standards of conduct that promote Mountains Community Hospital's commitment to compliance, and
- A mechanism for employees to report non-compliance and for the reports to be investigated and reviewed.

Employees are encouraged to use this document as a compliance resource. It has been designed with the employee in mind, with an attempt to make the document "user friendly." If you have any questions about this Plan or compliance issues, you may contact your supervisor, individuals are available to assist you with any compliance matter.

Compliance at Mountains Community Hospital

I. Compliance Oversight Committee

Oversight of the Corporate Compliance Plan is provided by the Finance Committee. This committee is comprised of members of the Mountains Community Hospital Board of Directors.

The Corporate Compliance Officer is appointed by the CEO of Mountains Community Hospital. The CCO is responsible for directing compliance activities and developing policies and standards. The CCO will have direct access to the CEO and Board of Directors.

II. Corporate Compliance Plan Applicability

This plan provides a mechanism for reporting misconduct or suspect behavior without fear of repercussions. Not all violations need to be reported. Many minor violations are inadvertent. In such cases, an employee may want to approach his or her co-worker, discuss the incident and instruct him or her on the proper manner of conduct.

Serious violations or repeated minor violations must be reported. Examples of serious misconduct that must be reported are; theft of our suspicion of theft of hospital property, falsifying medical or business records, soliciting or accepting kickbacks, discussing confidential patient information when not required, violating safety or environmental regulations, stealing hospital trade secrets, unlawful manufacturing, trafficking or possession of drugs, Medicare and Medicaid fraud and abuse, submitting false claims, Civil Rights violations including harassment and discrimination, OSHA noncompliance, antitrust violations, violations involving taxation, breach of confidentiality, and conflict of interest violations.

If you have any doubt as to whether a certain type of conduct should be reported, please ask your supervisor, department manager, or Corporate Compliance Officer. These individuals are always available to assist you with any compliance related questions. Remember, it is better to ask the questions than to allow possible misconduct to continue.

Ill. Training and Education

The key to a successful compliance program is participation by all employees. There are a number of important and complex issues that define compliance. Education and training will be provided to all employees to help define these complex issues. The goal of the education and training sessions will be to increase understanding and awareness among all employees. A wide variety of training techniques will be used to keep employees informed and up-to-date on compliance related issues.

A. New Employees - Initial Training and Education

All new employees of Mountains Community Hospital are required to attend employee orientation. At this employee orientation session, new employees will receive a copy of the Hospital's Corporate Compliance Plan and receive training and education regarding the Plan. Orientation to the Plan may also be provided in the new employee's department by their supervisor.

Upon completion of this initial training and education, each new employee must sign a certification that they have read and understand the Plan, that they have discussed the Plan with their supervisor and that they understand that Mountains Community Hospital will take appropriate disciplinary measures, which may include termination, for violating the principles of the Plan or for violating any laws or regulations applicable to compliance issues.

B. All Employees and Staff - Continuing Training and Education

Employees will receive follow-up education and training on compliance on an ongoing basis. This training will attempt to focus on problem areas that have been identified by the CCO. Employees in areas where compliance is likely to be of more concern may receive additional education and training, as needed.

Annual education and training may be conducted on the Hospital level, Department level, or a combination of both. All employee certifications will be kept for a minimum of six years by the CCO. Certifications will be maintained by Human Resources and/or the Corporate Compliance Department.

C. Board Education

Completion of the Conflict of Interest Disclosure by board members shall occur upon appointment and thereafter annually. Educational sessions for boards of Directors and/or board committees shall be completed on a regular basis per the request of the CEO.

D. Documentation

All seminars and other training and education sessions must be documented by the person(s) conducting the seminar or training session. Such documentation must record the topic, date of the session and the names of the persons in attendance. All attendees should sign an attendance roster. Records must be forwarded to the CCO and retained for not less than six years.

E. General Applicability

All employees are required to attend and participate in compliance training. Failure to comply with training requirements may result in disciplinary action.

IV. Enforcement of the Corporate Compliance Plan

A. General Procedure

Enforcement of the Corporate Compliance Plan is a shared responsibility between the Compliance Officer and every employee. Employees should strive to ensure compliance every day. Ensuring compliance means following the laws and regulations applicable to your job. In other words, ensuring compliance is no more than doing your job correctly. Enforcement of the Plan will be carried out in accordance with and subject to Mountains Community Hospital's Employee Handbook, Administrative Policy and Procedure Manual, Human Resources policy and Procedure Manual, and Medical-Dental Staff by-laws. The CCO will investigate any alleged violation of the Plan or of any policy issues in accordance with the Plan after receiving an allegation. Employees are expected to cooperate fully with the CCO and other appropriate individuals during an investigation. Failure to cooperate with an investigations and failure to make full disclosure may subject an employee to disciplinary action.

B. Violation of the Plan - Disciplinary Measures

If a violation of the Corporate Compliance Plan occurs, disciplinary action may be taken. The nature and severity of the disciplinary action will depend upon the facts and circumstances of the violation. Available disciplinary measures include counseling, oral or written warning, demotion, and suspension with pay, immediate termination, restitution, and/or civil or criminal prosecution.

Any disciplinary action to be taken will be determined by the leadership for the department, in consultation with the Corporate Compliance Officer and a representative from Human Resources. Disciplinary measures against any non-employed physician are governed by the Medical-Dental Staff bylaws. These bylaws shall take precedence in the event of a conflict with the Corporate Compliance Plan. All employees of Mountains Community Hospital are covered by the Corporate Compliance Plan, without regard to the position that they hold in the organization. Appropriate disciplinary action will be taken without regard to the position held in the organization. This Plan in no way alters the employment "at-will" state of Hospital employees.

C. Administrative and Supervisory Responsibility

All employees of Mountains Community Hospital are responsible for maintaining compliance in their daily activities. Department chairs, managers, administrators, and other individuals in administrative or supervisory positions share an additional responsibility. Because of their position in the organizations, administrative and supervisory personnel are responsible for

educating their subordinates on compliance related issues and may be held accountable for failing to detect, prevent or appropriately respond to conduct which violates this plan.

D. Applicability of the Plan to Agents and to Independent Contractors

Mountains Community Hospital will at all-time make reasonable efforts to ensure that its agents, independent contractors, and other parties with who they have a similar relationship comply with the Plan. Mountains Community Hospital will not retain nor enter into a relationship with any person or entity which is not properly licensed or who has been excluded or debarred from any federally funded health care program. This includes, but is not limited to, Medicare, Medicaid and TRICARE (Champus).

Mountains Community Hospital will require individuals and entities associated with billing and collecting to certify that they are properly licensed and that they have not been excluded or debarred from participation in a federally funded health care program. Mountains Community Hospital will take such reasonable steps to ascertain if individuals or entities have been excluded or debarred. Such steps shall include, without limitation, review of the General Services Administration's List of Parties Excluded from Federal Programs and the HHS/OIG Cumulative Sanction Report. Failure of such person or entity to comply with the standards set forth in the Corporate Compliance Plan may constitute grounds for termination of the relationship.

E. Interaction with Government Agencies

As Mountains Community Hospital attempts to comply with laws and regulations, hospital employees may need to contact a government agency or an agent of the government to request advice on a particular issue. All employees should document and retain a record of the request and response. This is extremely important if the hospital and its employees intend to rely on this guidance as proof of compliance. Employees should attempt to get the guidance in writing. If this is not possible, a log should be maintained of oral inquiries between the hospital and third parties on which the hospital intends to rely. A log has been developed to make this task easier. A copy of the log is included in Appendix A.

As an employee of Mountains Community Hospital you may be contacted by a government agency regarding an investigation being conducted by that government agency. If you receive any type of written document concerning an investigation, you must give this document to your supervisor immediately, who will in turn provide the document to the Corporate Compliance Officer. It is extremely important that Senior Administration is made aware of any investigation as soon as we are provided notice that an investigation has begun.

F. Reporting Violations to the Government

If credible evidence exists to show a violation of criminal, civil, or administrative law, and after reasonable inquiry this evidence is substantiated, Mountains Community Hospital will notify the appropriate agency and disclose the violation. Some violations may be so serious that they warrant immediate notification. The decision to report a violation is made without regard to the financial impact on the government agency or Mountains Community Hospital.

V. Reporting Violations to the Government

A. Confidential/ Anonymous Disclosure Program

Mountains Community Hospital's compliance program allows employees to report violations anonymously and/or confidentially. Every effort will be made to ensure that the identity of the employee making the report is kept confidential and no attempt will be made to determine the identity of an employee if the report is made anonymously. This approach encourages employees to report compliance violations without the fear of retaliation or harassment. Employees should report any instances of retaliation or harassment to the Corporate Compliance Officer who will conduct an investigation and take appropriate action.

B. Reporting Procedures

The Corporate Compliance Program at Mountains Community Hospital is designed to facilitate the appropriate reporting of compliance related issues. If at any time you may have questions regarding the Compliance Program or any policy or procedure, you should talk to the Corporate Compliance Officer. The CCO is specifically charged with providing clarification on hospital policy.

Not all violations need to be reported. Many minor violations are inadvertent. In such cases, you want to approach your co-worker and discuss the incident and instruct him or her on proper behavior or conduct. However, serious violations or repeated minor violations must be reported.

It is important to remember that the goal of the Compliance Program is for improper or inappropriate conduct and practices to be reported and corrected. As an employee of Mountains Community Hospital, you should feel comfortable with reporting compliance issues to your supervisor. If your supervisor is the subject of the report, you should report the issue to your manager, director, Human Resources, the Senior Administrator responsible for your department, or the Corporate Compliance Officer. Please remember, it is vital that the conduct be reported regardless of the mechanism you choose to use when making the report. An employee will not be disciplined for failing to use his or her normal reporting chain.

C. Compliance Hotline

Mountains Community Hospital will maintain a hotline in order to allow employees to report violations of the Corporate Compliance Plan. This hotline will allow for reports to be made confidentially and/or anonymously. This hotline may be used to report the violations of any Compliance concerns without regard to the nature of the violation.

Mountains Community Hospital will make every effort to keep the identity of callers anonymous; however, anonymity cannot be guaranteed and is subject to any laws to the contrary. The identity of employees who utilize the hotline and disclose their identity, or whose identity is obvious, will be maintained with strict confidentiality. Failure to maintain confidentiality is punishable by appropriate disciplinary measures, to be determined by the Senior Administrator for the department, in consultation with the Corporate Compliance Officer and a representative from Human Resources. Notice of this hotline will be posted throughout the hospital.

All calls to the Compliance Hotline will be logged and maintained by the CCO. The Compliance Hotline number is:1-844-706-5282 or **https://mchcares.ethicspoint.com**

D. False or Bad Faith Reports - Disciplinary Measures

Mountains Community Hospital actively discourages and wishes to prevent false reports and reports made in bad faith. Any employee who makes a report which the CCO determines, after an investigation, to be in bad faith, may be subject to disciplinary measures.

VI. Audits

A. Audits

The CCO may, with or without the concurrence of the Committee, contract with an independent professional organization, to review the policies, procedures, and practices of Mountains Community Hospital. Mountains Community Hospital monitors compliance on an on-going basis. Reviews conducted by an outside agency may not be necessary and are within the discretion of the CCO. In conducting the review, the auditor selected will have access to all relevant documentation and all knowledgeable personnel. All employees of Mountains Community Hospital will fully cooperate with the auditor. The auditor will provide the CCO and Committee with a written report when the audit is completed.

In the event that the auditor detects or discovers any errors or irregularities, the auditor will promptly notify the CCO. The CCO may then take such steps as the CCO deems necessary or advisable to address the issue. These steps may include contracting with another organization to review the policies, procedures and practices of Mountains Community Hospital. The auditor will report any problem(s) detected in the audit and any suggestions for addressing the problem(s). In response to compliance issues identified through such audits, the CCO will propose a corrective action plan.

VII. Hiring

Mountains Community Hospital will not employ nor contract for services with an individual whom Mountains Community Hospital knows or reasonably should have known has been convicted of a criminal offense related to a government program or listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in a government program.

Mountains Community Hospital will make reasonable inquiry into the status of every potential employee, including reviewing the General Services Administration's List of Excluded Parties from Federal Programs and the HHS/OIG Cumulative Sanctions Report. Subject to this policy, personnel functions for employees will be handled by the Human Resources Office. With regard to current employees and contractors, if, after entering into a contract or employing an individual, the contractor or individual is convicted of a health care related crime or is debarred, excluded, or otherwise sanctioned. Mountains Community Hospital will terminate its employment or other contact arrangement with the individual or contractor.

VIII. Employee Responsibility

Every employee of Mountains Community Hospital is responsible for reading and understanding this Corporate Compliance Plan, as well as any other department specific plan that the employee may be required to follow. Additional information concerning the Compliance Program at Mountains Community Hospital may also be provided to the employee and should be considered a part of the overall Compliance Program. Examples of additional information include, but are not limited to, brochures, newsletters, memoranda, notices, and postings.

IX. Communication

As employees become knowledgeable about their respective Code of Conduct and its specific application to their role within their office, department or hospital, their ability to maintain a dialogue on compliance issues is critical to their participation in, and the overall success of their compliance program.

The purpose of such a communication mechanism is three-fold, similar to the entire compliance program, i.e.:

1. to prevent,
2. to detect, and
3. to correct any criminal or ethical wrongdoing.

To **PREVENT** misconduct, there should be an opportunity for each board member, employee, and volunteer of the System to obtain consistent guidance or interpretation on a particular policy, rule, regulation, or law.

The first source of guidance for a particular employee should be his/her immediate supervisor or department head. If the immediate supervisor or department head is not available or responsive,

the next source should be the compliance officer, an administrator, or other executive level manager. A confidential call to the Compliance Hotline at: (855) 737-6788 may also be made to obtain such guidance.

A second purpose of a Compliance Hotline is to **DETECT** misconduct. If the routine channels for guidance or interpretation are not appropriate in a particular situation, e.g., the misconduct involves a supervisor or manager; an employee may be reluctant to report it. The ability to confidentially report concerns about another's conduct internally without fear of retribution assists the compliance representative in investigating and correcting situations which might not have been otherwise identified.

The third purpose of a Compliance Hotline is to **CORRECT** any misconduct and be prepared to report the corrective action to the caller. This ability to report back to the caller on the corrective actions encourages individuals to come forward with their compliance concerns.

Protections

The effectiveness of a Compliance Hotline as an exchange of information is vulnerable for three reasons that must be overcome through a proper design and allocation of resources over time. These concerns are:

1. Limited time of the compliance representatives;
2. The adequacy of the built-in protections in terms of their sufficiency to avoid retribution or retaliation; and
3. The timeliness and effectiveness of addressing the concerns raised.

Access to the Compliance Representative

Through a phased-in approach to education, training, and publication of the Compliance Hotline number, it is the intent of Mountains Community Hospital to screen all Hotline calls with prompt referral to the respective compliance representative.

The design of this program will be as follows:

1. Maintain confidentiality, if requested, for a caller to protect them from retribution by a wrongdoer or retaliation by fellow employees;
2. Allow the involved compliance representative to obtain sufficient data to investigate a concern without identifying the caller, and still respond to the caller with corrective action taken, if so requested; and
3. Make the communication mechanism available to all employees away from their workplace, at no cost to themselves to assure confidentiality.

While evaluating each call to determine if it forms a reasonable basis for further investigation, the compliance representative will also be responsible for prioritizing issues, investigating credible evidence of wrongdoing, documenting activity, reporting corrective actions when requested by a caller, and maintaining a log of all inquiries and any corresponding follow-up activity.

Retribution, retaliation, harassment, or any other improper activity against any participant in the Compliance Hotline program will not be tolerated. Such action could threaten the effectiveness of the Hotline and possibly the entire Compliance Program. Therefore, such conduct would be appropriately addressed through discipline of any such participant. Due to the complex legal, financial, and administrative issues involved in such an investigation and corrective action, the compliance representative will work closely with Corporate Compliance Officer for Mountains Community Hospital on such issues.

X. INVESTIGATION AND RESOLUTION OF SYSTEMIC PROBLEMS

If the results of an audit, Hotline call investigation, or letter from a government agency indicate a potential violation of this Compliance Plan, or a failure to comply with federal or state regulations, the compliance representative involved, pursuant to the direction of Corporate Compliance Officer of Mountains Community Hospital, will investigate the alleged conduct to determine the appropriate corrective action. These options may include the need to notify the authorities, prepare a corrective action plan, and submit any overpayments as required, if applicable. Compliance representatives will maintain records of each and every investigation, and document all such activities.

Reporting

If a compliance representative discovers misconduct that may violate either federal or state law, it may be appropriate under certain circumstances, to report the misconduct and there may be a return of certain monies, within a specified timeframe. The compliance representative will consult with Mountains Community Hospital Corporate Compliance Officer to determine any reporting or repayment obligation. Any reporting of disclosure of violations shall be coordinated with Mountains Community Hospital General Counsel or his/her designee.

At the request of the Mountains Community Hospital Corporate Compliance Officer, the compliance representative will prepare a report to include documentation of the allegation(s), a description of the investigatory efforts, copies of interview notes and key documents, a listing of the witnesses interviewed and the documents reviewed, and a summary of the disciplinary or corrective actions taken. The involved area should also be strongly considered for regular follow-up audits to confirm the effectiveness of those corrective actions. If disciplinary action is needed, it will be imposed according to the guidelines provided in the discipline policies and procedures of the involved entity.

Conclusion

Every employee must be committed to the compliance process. This will help to ensure that Mountains Community Hospital remains an institution recognized for its high moral and ethical standards. Employees are encouraged to seek out compliance information and to use this information in their daily activities.

The Corporate Compliance Plan contains various policies designed to aid Mountains Community Hospital in attaining its missions and goals, while attempting to ensure that the practices of the hospital comply with applicable laws and regulations regarding a wide variety of compliance areas and issues. The Plan is intended to be an integral part of the daily operations of Mountains Community Hospital. It is designed to be flexible enough to adapt to the changing needs of Mountains Community Hospital and to changes in laws and regulations regarding compliance issues.

Mountains Community Hospital Corporate Compliance Plan
And
Code of Conduct

Employee Statement

Each employee of Mountains Community Hospital has the responsibility to perform his or her duties in accordance with federal and state laws and regulations, as well as appropriate business, ethical, and professional standards of conduct established by the hospital. The Corporate Compliance Plan is designed to assist employees in meeting these goals.

I_____, hereby acknowledge that;
(Print Name)

1. I have been given a copy of the Corporate Compliance Plan and Code of Conduct

2. I have read and understand the Corporate Compliance Plan and/or other Plan _____(list the Plan that was reviewed),

3. I have reviewed and discussed the Corporate Compliance Plan or other Plan with my supervisor, department manager, Senior Administrator, and/or the Corporate Compliance Officer,

4. I have been given a reasonable opportunity to ask questions regarding the Corporate Compliance Plan or other Plan,

5. I understand the terms and provisions of the Plan(s),

6. I understand that disciplinary measures, including termination, may be taken against me for violating the principles of the Plan(s) or for violating any laws or regulations applicable to compliance issues, and

7. I understand that if I have any questions, at any time, regarding the Plan(s), I may ask my supervisor, department manager, Senior Administrator, and/or Corporate Compliance Officer for assistance.

Employee Signature_____ Date_____

Department_____ Phone Ext._____

Supervisor/Compliance Officer Statement

I hereby certify that I have discussed the content and application of the Plan with the employee listed above. In addition, I have discussed the following compliance topics, if any;

_____

Supervisor Signature_____ Date_____

Title_____ Department_____

(Please return this form to Human Resources when completed.)

Appendix A

Mountains
Community Hospital
Record of Interaction

I. Purpose

As Mountains Community Hospital attempts to comply with laws and regulations, hospital employees may need to contact a government agency or an agent of the government to request advice on a particular issue. All employees should document and retain a record of the request and response. This is extremely important if the hospital and its employees intend to rely on this guidance as proof of compliance. Employees should attempt to get this guidance in writing. If this is not possible, you should complete this form as evidence of oral inquiries between the hospital and the other party. This form should be kept in the department.

II. Documentation

A. Employee Name: _____ Department: _____

C. Issue: _____

_____

_____

D. Agency Contacted: _____

E. Point-of-Contact: _____ Phone Number: _____

G. Resolution of Issue: _____

_____

_____

H. Other Information: _____

_____

_____

III. Employee Signature

Employee Signature: _____ Date: _____

(Please Attach Additional Sheets if Necessary)

Mountains Community Hospital
COMPLIANCE REPORT

[APPLICABLE TIME PERIOD]

I. SUMMARY OF COMPLIANCE EDUCATION AND TRAINING ACTIVITIES

II. HOTLINE CALLS

A. Number of hot line calls:

B. Substance of allegations

C. Resulting investigations

D. Current status or disposition

III. EXCLUDED INDIVIDUAL AND ENTITY SCREENINGS

Employees/Volunteers/Associates	**Yes**	**No**
A. All applicants/individuals/groups initially screened for exclusion?		
B. All applicants/individuals/groups regularly screened thereafter for exclusion?		
C. All screenings negative? If no, explain.		

Vendors/Referring Providers/Board Members	**Yes**	**No**
D. New Vendors screened routinely for exclusion?		
E. Existing vendors screened routinely for exclusion?		
F. Referring providers screened routinely for exclusion?		
G. Board members screened routinely for exclusion?		
H. All screenings for vendors, referring, and board negative? If no, explain.		

IV. SUMMARY OF INTERNAL COMPLIANCE AUDITS FROM THE FACILITY'S ANNUAL WORK PLAN-

V. SUMMARY OF EXTERNAL COMPLIANCE AUDITS CONDUCTED PER REQUEST/INQUIRY FROM AN OUTSIDE AGENCY OR PAYER-

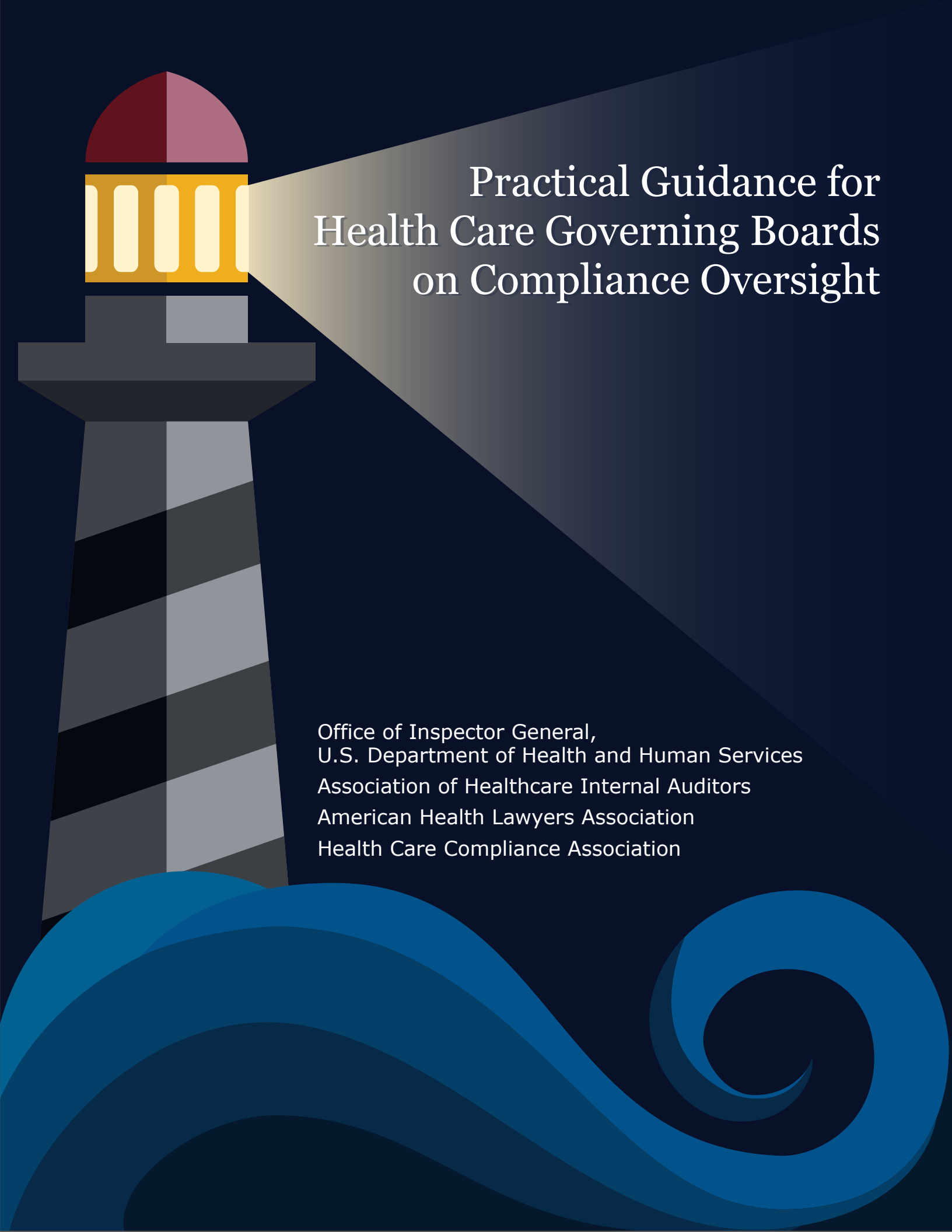
VI. SUMMARY OF ANY OTHER INTERNAL AUDITS OR INVESTIGATIONS COMPLETED OUTSIDE OF THE FACILITY'S ANNUAL COMPLIANCE WORK PLAN-

VII. SUMMARY OF ANY OTHER EXTERNAL AUDITS OR INVESTIGATIONS THAT REQUIRE COMPLIANCE INVOLVEMENT-

VIII. SUMMARY OF INTERNAL HIPAA AUDITS OR INVESTIGATIONS/ACTIVITIES COMPLETED BY COMPLIANCE-

IX. SUMMARY OF SELF-REPORTS/SELF-DISCLOSURES

X. SUMMARY OF DISCIPLINARY ACTIONS RESULTING FROM ANY OF THE FOREGOING



Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General,
U.S. Department of Health and Human Services
Association of Healthcare Internal Auditors
American Health Lawyers Association
Health Care Compliance Association

About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation's largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG's mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

The following individuals, representing these organizations, served on the drafting task force for this document:

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This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.

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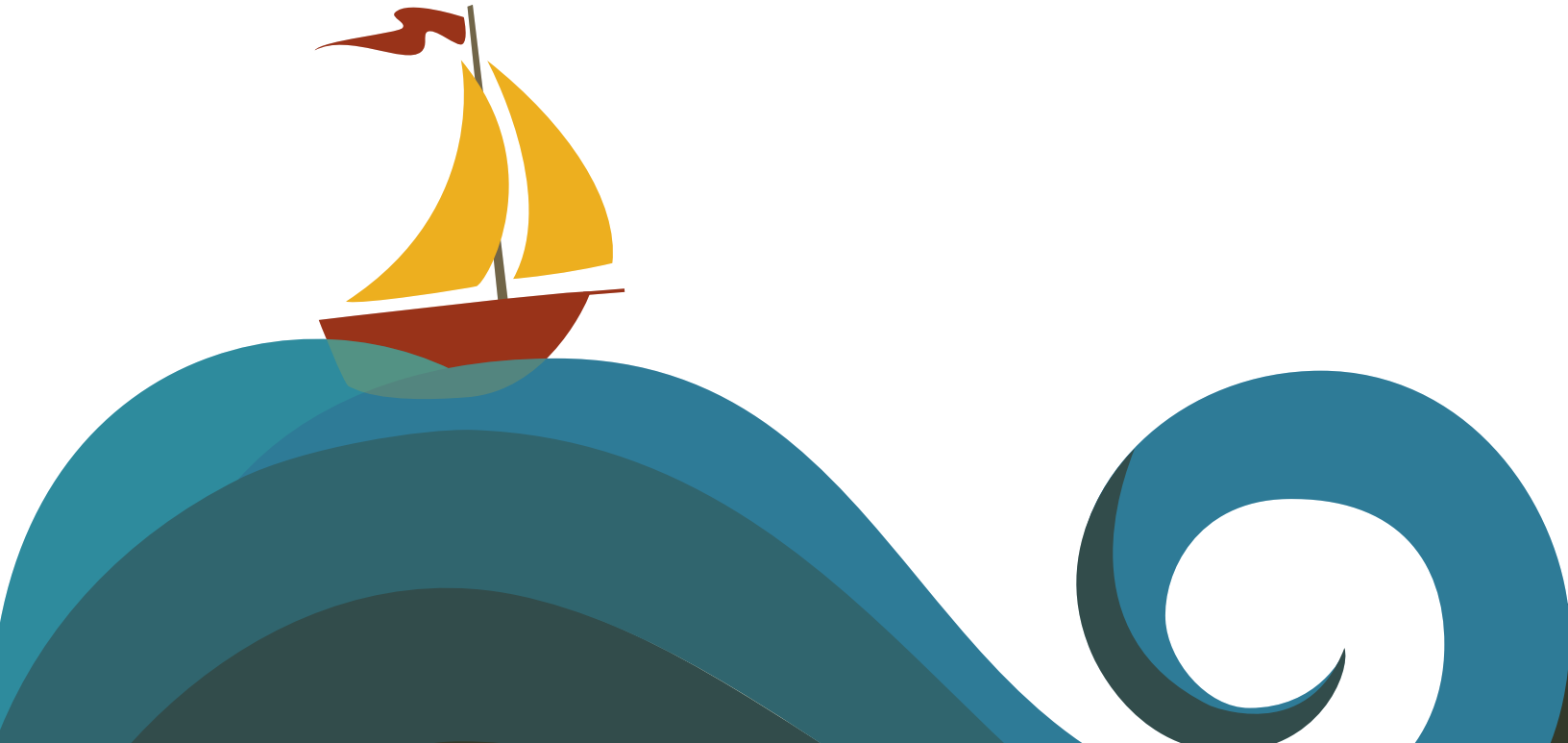

Introduction

Previous guidance[1] has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board's oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization's audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHLA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHLA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.[2] The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines),[3] OIG's voluntary compliance program guidance documents,[4] and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program."[5] The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

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2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

5 USSG Ch. 8, Intro. Comment.

promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations' compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization's compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort....

Although compliance program design is not a "one size fits all" issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to "the size of the organization."[6] In accordance with the Guidelines,

6 USSG § 8B2.1, comment. (n. 2).

OIG recognizes that the design of a compliance program will depend on the size and resources of the organization.[7] Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations.[8] Smaller organizations may meet their compliance responsibility by "using available personnel, rather than employing separate staff, to carry out the compliance and ethics program." Board members of such organizations may wish to evaluate whether the organization is "modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations."[9] The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations' compliance and ethics efforts than their larger counterparts.[10]

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management

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7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) ("The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner."); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 *Id.*

10 *Id.*

and make informed strategic decisions regarding the organizations' compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations' highest risks.

Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization's commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.[11] OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.[12] Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

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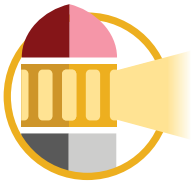
11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

12 *See* Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).

Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:



The compliance function promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

The legal function advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

The internal audit function provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional

Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

The human resources function manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

The quality improvement function promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence,[13] and performance of different functions within an organization on a periodic basis. OIG believes an organization's Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner.[14] While independent, an organization's counsel and compliance officer should collaborate to further the interests of the organization. OIG's position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;[15]

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13 Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.

14 *See* OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

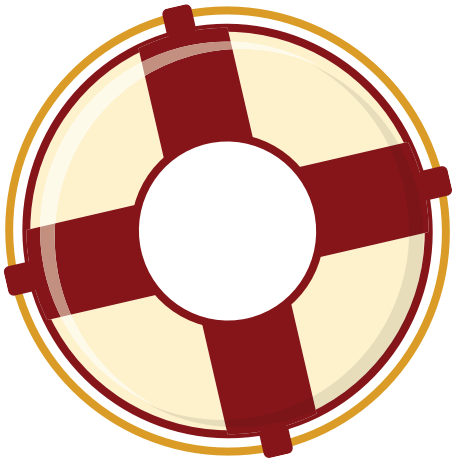
15 *See, generally, id.*

the same is true for internal audit.[16] To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

1. identifying compliance risks,
2. investigating compliance risks and avoiding duplication of effort,
3. identifying and implementing appropriate corrective actions and decision-making, and
4. communicating between the various functions throughout the process.



16 Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should "[b]e independent of physicians and line management"); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should "[b]e objective and independent of line management to the extent reasonably possible"); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

Reporting to the Board

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization's

The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts....

code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization's business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular "executive sessions" (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.

Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.

The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.

The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take

under the Guidelines is "monitoring and auditing to detect criminal conduct."[17] Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.[18]

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

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17 *See* USSG § 8B2.1(b)(5).

18 *See* USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule[19] offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

Encouraging Accountability and Compliance

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

Compliance is an enterprise-wide responsiblity.

In an effort to support the concept that compliance is "a way of life," a Board may assess employee performance in promoting and adhering to compliance.[20] An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses

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19 *See* Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html.

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule.[21] The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is "identified" or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to "identify" an overpayment.[22] However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization's compliance program may be in correcting and remediating compliance issues.

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21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is "identified" when a person "has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.") disregard or deliberate ignorance of the overpayment."); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).

Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG's Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations.[23] OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.[24] Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management's responses to identified violations of the organization's policies or Federal or State laws.

Conclusion

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization's compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to

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23 *See* OIG, *Self-Disclosure Information*, http://oig.hhs.gov/compliance/self-disclosure-info.

24 *See id.*, at 2 ("we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d).")

senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization's individual situation.

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U.S. Department of Justice

Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

September 9, 2015

MEMORANDUM FOR THE ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION
THE ASSISTANT ATTORNEY GENERAL, CIVIL DIVISION
THE ASSISTANT ATTORNEY GENERAL, CRIMINAL DIVISION
THE ASSISTANT ATTORNEY GENERAL, ENVIRONMENT AND NATURAL RESOURCES DIVISION
THE ASSISTANT ATTORNEY GENERAL, NATIONAL SECURITY DIVISION
THE ASSISTANT ATTORNEY GENERAL, TAX DIVISION
THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
THE DIRECTOR, EXECUTIVE OFFICE FOR UNITED STATES TRUSTEES
ALL UNITED STATES ATTORNEYS

FROM: Sally Quillian Yates
Deputy Attorney General

SUBJECT: Individual Accountability for Corporate Wrongdoing

Fighting corporate fraud and other misconduct is a top priority of the Department of Justice. Our nation's economy depends on effective enforcement of the civil and criminal laws that protect our financial system and, by extension, all our citizens. These are principles that the Department lives and breathes—as evidenced by the many attorneys, agents, and support staff who have worked tirelessly on corporate investigations, particularly in the aftermath of the financial crisis.

One of the most effective ways to combat corporate misconduct is by seeking accountability from the individuals who perpetrated the wrongdoing. Such accountability is important for several reasons: it deters future illegal activity, it incentivizes changes in corporate behavior, it ensures that the proper parties are held responsible for their actions, and it promotes the public's confidence in our justice system.

There are, however, many substantial challenges unique to pursuing individuals for corporate misdeeds. In large corporations, where responsibility can be diffuse and decisions are made at various levels, it can be difficult to determine if someone possessed the knowledge and criminal intent necessary to establish their guilt beyond a reasonable doubt. This is particularly true when determining the culpability of high-level executives, who may be insulated from the day-to-day activity in which the misconduct occurs. As a result, investigators often must reconstruct what happened based on a painstaking review of corporate documents, which can number in the millions, and which may be difficult to collect due to legal restrictions.

These challenges make it all the more important that the Department fully leverage its resources to identify culpable individuals at all levels in corporate cases. To address these challenges, the Department convened a working group of senior attorneys from Department components and the United States Attorney community with significant experience in this area. The working group examined how the Department approaches corporate investigations, and identified areas in which it can amend its policies and practices in order to most effectively pursue the individuals responsible for corporate wrongs. This memo is a product of the working group's discussions.

The measures described in this memo are steps that should be taken in any investigation of corporate misconduct. Some of these measures are new, while others reflect best practices that are already employed by many federal prosecutors. Fundamentally, this memo is designed to ensure that all attorneys across the Department are consistent in our best efforts to hold to account the individuals responsible for illegal corporate conduct.

The guidance in this memo will also apply to civil corporate matters. In addition to recovering assets, civil enforcement actions serve to redress misconduct and deter future wrongdoing. Thus, civil attorneys investigating corporate wrongdoing should maintain a focus on the responsible individuals, recognizing that holding them to account is an important part of protecting the public fisc in the long term.

The guidance in this memo reflects six key steps to strengthen our pursuit of individual corporate wrongdoing, some of which reflect policy shifts and each of which is described in greater detail below: (1) in order to qualify for any cooperation credit, corporations must provide to the Department all relevant facts relating to the individuals responsible for the misconduct; (2) criminal and civil corporate investigations should focus on individuals from the inception of the investigation; (3) criminal and civil attorneys handling corporate investigations should be in routine communication with one another; (4) absent extraordinary circumstances or approved departmental policy, the Department will not release culpable individuals from civil or criminal liability when resolving a matter with a corporation; (5) Department attorneys should not resolve matters with a corporation without a clear plan to resolve related individual cases, and should

memorialize any declinations as to individuals in such cases; and (6) civil attorneys should consistently focus on individuals as well as the company and evaluate whether to bring suit against an individual based on considerations beyond that individual's ability to pay.[1]

I have directed that certain criminal and civil provisions in the United States Attorney's Manual, more specifically the Principles of Federal Prosecution of Business Organizations (USAM 9-28.000 *et seq.*) and the commercial litigation provisions in Title 4 (USAM 4-4.000 *et seq.*), be revised to reflect these changes. The guidance in this memo will apply to all future investigations of corporate wrongdoing. It will also apply to those matters pending as of the date of this memo, to the extent it is practicable to do so.

1. To be eligible for <u>any</u> cooperation credit, corporations must provide to the Department all relevant facts about the individuals involved in corporate misconduct.

In order for a company to receive <u>any</u> consideration for cooperation under the Principles of Federal Prosecution of Business Organizations, the company must completely disclose to the Department all relevant facts about individual misconduct. Companies cannot pick and choose what facts to disclose. That is, to be eligible for any credit for cooperation, the company must identify all individuals involved in or responsible for the misconduct at issue, regardless of their position, status or seniority, and provide to the Department all facts relating to that misconduct. If a company seeking cooperation credit declines to learn of such facts or to provide the Department with complete factual information about individual wrongdoers, its cooperation will not be considered a mitigating factor pursuant to USAM 9-28.700 *et seq.*[2] Once a company meets the threshold requirement of providing all relevant facts with respect to individuals, it will be eligible for consideration for cooperation credit. The extent of that cooperation credit will depend on all the various factors that have traditionally applied in making this assessment (*e.g.*, the timeliness of the cooperation, the diligence, thoroughness, and speed of the internal investigation, the proactive nature of the cooperation, etc.).

This condition of cooperation applies equally to corporations seeking to cooperate in civil matters; a company under civil investigation must provide to the Department all relevant facts about individual misconduct in order to receive any consideration in the negotiation. For

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[1] The measures laid out in this memo are intended solely to guide attorneys for the government in accordance with their statutory responsibilities and federal law. They are not intended to, do not, and may not be relied upon to create a right or benefit, substantive or procedural, enforceable at law by a party to litigation with the United States.

[2] Nor, if a company is prosecuted, will it support a cooperation-related reduction at sentencing. *See* U.S.S.G. USSG § 8C2.5(g), Application Note 13 ("A prime test of whether the organization has disclosed all pertinent information" necessary to receive a cooperation-related reduction in its offense level calculation "is whether the information is sufficient ... to identify ... the individual(s) responsible for the criminal conduct").

example, the Department's position on "full cooperation" under the False Claims Act, 31 U.S.C. § 3729(a)(2), will be that, at a minimum, all relevant facts about responsible individuals must be provided.

The requirement that companies cooperate completely as to individuals, within the bounds of the law and legal privileges, *see* USAM 9-28.700 to 9-28.760, does not mean that Department attorneys should wait for the company to deliver the information about individual wrongdoers and then merely accept what companies provide. To the contrary, Department attorneys should be proactively investigating individuals at every step of the process – before, during, and after any corporate cooperation. Department attorneys should vigorously review any information provided by companies and compare it to the results of their own investigation, in order to best ensure that the information provided is indeed complete and does not seek to minimize the behavior or role of any individual or group of individuals.

Department attorneys should strive to obtain from the company as much information as possible about responsible individuals before resolving the corporate case. But there may be instances where the company's continued cooperation with respect to individuals will be necessary post-resolution. In these circumstances, the plea or settlement agreement should include a provision that requires the company to provide information about all culpable individuals and that is explicit enough so that a failure to provide the information results in specific consequences, such as stipulated penalties and/or a material breach.

2. Both criminal and civil corporate investigations should focus on individuals from the inception of the investigation.

Both criminal and civil attorneys should focus on individual wrongdoing from the very beginning of any investigation of corporate misconduct. By focusing on building cases against individual wrongdoers from the inception of an investigation, we accomplish multiple goals. First, we maximize our ability to ferret out the full extent of corporate misconduct. Because a corporation only acts through individuals, investigating the conduct of individuals is the most efficient and effective way to determine the facts and extent of any corporate misconduct. Second, by focusing our investigation on individuals, we can increase the likelihood that individuals with knowledge of the corporate misconduct will cooperate with the investigation and provide information against individuals higher up the corporate hierarchy. Third, by focusing on individuals from the very beginning of an investigation, we maximize the chances that the final resolution of an investigation uncovering the misconduct will include civil or criminal charges against not just the corporation but against culpable individuals as well.

3. Criminal and civil attorneys handling corporate investigations should be in routine communication with one another.

Early and regular communication between civil attorneys and criminal prosecutors handling corporate investigations can be crucial to our ability to effectively pursue individuals in

these matters. Consultation between the Department's civil and criminal attorneys, together with agency attorneys, permits consideration of the full range of the government's potential remedies (including incarceration, fines, penalties, damages, restitution to victims, asset seizure, civil and criminal forfeiture, and exclusion, suspension and debarment) and promotes the most thorough and appropriate resolution in every case. That is why the Department has long recognized the importance of parallel development of civil and criminal proceedings. *See* USAM 1-12.000.

Criminal attorneys handling corporate investigations should notify civil attorneys as early as permissible of conduct that might give rise to potential individual civil liability, even if criminal liability continues to be sought. Further, if there is a decision not to pursue a criminal action against an individual – due to questions of intent or burden of proof, for example – criminal attorneys should confer with their civil counterparts so that they may make an assessment under applicable civil statutes and consistent with this guidance. Likewise, if civil attorneys believe that an individual identified in the course of their corporate investigation should be subject to a criminal inquiry, that matter should promptly be referred to criminal prosecutors, regardless of the current status of the civil corporate investigation.

Department attorneys should be alert for circumstances where concurrent criminal and civil investigations of individual misconduct should be pursued. Coordination in this regard should happen early, even if it is not certain that a civil or criminal disposition will be the end result for the individuals or the company.

4. Absent extraordinary circumstances, no corporate resolution will provide protection from criminal or civil liability for any individuals.

There may be instances where the Department reaches a resolution with the company before resolving matters with responsible individuals. In these circumstances, Department attorneys should take care to preserve the ability to pursue these individuals. Because of the importance of holding responsible individuals to account, absent extraordinary circumstances or approved departmental policy such as the Antitrust Division's Corporate Leniency Policy, Department lawyers should not agree to a corporate resolution that includes an agreement to dismiss charges against, or provide immunity for, individual officers or employees. The same principle holds true in civil corporate matters; absent extraordinary circumstances, the United States should not release claims related to the liability of individuals based on corporate settlement releases. Any such release of criminal or civil liability due to extraordinary circumstances must be personally approved in writing by the relevant Assistant Attorney General or United States Attorney.

5. **Corporate cases should not be resolved without a clear plan to resolve related individual cases before the statute of limitations expires and declinations as to individuals in such cases must be memorialized.**

If the investigation of individual misconduct has not concluded by the time authorization is sought to resolve the case against the corporation, the prosecution or corporate authorization memorandum should include a discussion of the potentially liable individuals, a description of the current status of the investigation regarding their conduct and the investigative work that remains to be done, and an investigative plan to bring the matter to resolution prior to the end of any statute of limitations period. If a decision is made at the conclusion of the investigation not to bring civil claims or criminal charges against the individuals who committed the misconduct, the reasons for that determination must be memorialized and approved by the United States Attorney or Assistant Attorney General whose office handled the investigation, or their designees.

Delays in the corporate investigation should not affect the Department's ability to pursue potentially culpable individuals. While every effort should be made to resolve a corporate matter within the statutorily allotted time, and tolling agreements should be the rare exception, in situations where it is anticipated that a tolling agreement is nevertheless unavoidable and necessary, all efforts should be made either to resolve the matter against culpable individuals before the limitations period expires or to preserve the ability to charge individuals by tolling the limitations period by agreement or court order.

6. **Civil attorneys should consistently focus on individuals as well as the company and evaluate whether to bring suit against an individual based on considerations beyond that individual's ability to pay.**

The Department's civil enforcement efforts are designed not only to return government money to the public fisc, but also to hold the wrongdoers accountable and to deter future wrongdoing. These twin aims – of recovering as much money as possible, on the one hand, and of accountability for and deterrence of individual misconduct, on the other – are equally important. In certain circumstances, though, these dual goals can be in apparent tension with one another, for example, when it comes to the question of whether to pursue civil actions against individual corporate wrongdoers who may not have the necessary financial resources to pay a significant judgment.

Pursuit of civil actions against culpable individuals should not be governed solely by those individuals' ability to pay. In other words, the fact that an individual may not have sufficient resources to satisfy a significant judgment should not control the decision on whether to bring suit. Rather, in deciding whether to file a civil action against an individual, Department attorneys should consider factors such as whether the person's misconduct was serious, whether

it is actionable, whether the admissible evidence will probably be sufficient to obtain and sustain a judgment, and whether pursuing the action reflects an important federal interest. Just as our prosecutors do when making charging decisions, civil attorneys should make individualized assessments in deciding whether to bring a case, taking into account numerous factors, such as the individual's misconduct and past history and the circumstances relating to the commission of the misconduct, the needs of the communities we serve, and federal resources and priorities.

Although in the short term certain cases against individuals may not provide as robust a monetary return on the Department's investment, pursuing individual actions in civil corporate matters will result in significant long-term deterrence. Only by seeking to hold individuals accountable in view of all of the factors above can the Department ensure that it is doing everything in its power to minimize corporate fraud, and, over the course of time, minimize losses to the public fisc through fraud.

Conclusion

The Department makes these changes recognizing the challenges they may present. But we are making these changes because we believe they will maximize our ability to deter misconduct and to hold those who engage in it accountable.

In the months ahead, the Department will be working with components to turn these policies into everyday practice. On September 16, 2015, for example, the Department will be hosting a training conference in Washington, D.C., on this subject, and I look forward to further addressing the topic with some of you then.

Mountains Community Hospital
Corporate Compliance Committee Charter

Purpose

Mountains Community Hospital operates in a complex, dynamic, highly competitive, and highly regulated environment. The Corporate Compliance Committee will assist MCH's senior management in its responsibilities relating to MCH's operational compliance, including identifying, preventing and mitigating compliance risk.

Composition of Committee

The Committee consists of the Compliance Officer and other members of senior management from at least the following areas: Office of General Counsel, Finance, Nursing, Health Information Technology, Human Resources, Medical Group, and Quality. Additional members may be added upon the invitation of the Committee.

Meetings

The Committee will meet at least quarterly, and may meet more frequently as circumstances dictate. The Compliance Officer will chair the Committee and will prepare or approve an agenda in advance of each meeting. Members of the Committee will provide a report on activities and potential risks identified in their areas.

The Committee will keep minutes of its proceedings, which will be provided to the Board Finance Committee and made available to the Office of Inspector General (**OIG**) upon request. Committee meeting minutes will be reviewed and approved by the Corporate Compliance Officer.

Responsibilities and Duties

1. Support the Compliance Officer in fulfilling his/her responsibilities, including assisting in the analysis of risk areas for Mountains Community Hospital.
2. Establish and maintain the Corporate Compliance Program (**Compliance Program**) to identify, prevent and mitigate compliance risk to MCH.
3. Assess the effectiveness of the Program and identify opportunities to improve it; make recommendations to the Board, as necessary or appropriate.
4. Oversee monitoring of internal and external audits and investigations.
5. Assist the MCH Board of Directors' Finance Committee, with oversight of MCH's policies, procedures and systems in an effort to ensure that:
    a. The Board has general knowledge about compliance issues facing the healthcare industry;
    b. MCH employees, volunteers, physicians, trustees, vendors and operations comply with applicable laws and regulations;
    c. MCH, its employees and trustees act in accordance with appropriate ethical standards;
    d. MCH procedures and systems support the delivery of quality health care to patients;
    e. The Compliance Program is effective and meets the fundamental elements identified in the Federal Sentencing Guidelines and in the Office of the Inspector General's (**OIG**) program guidance;
    f. Annual work plans are developed to address areas of identified risk and to continually improve Program effectiveness; and
    g. Findings from Program audits and reviews are appropriately addressed and monitored.

RESOLUTION NO. 2023-11

RESOLUTION OF THE BOARD OF DIRECTORS OF THE SAN BERNARDINO MOUNTAINS COMMUNITY HOSPITAL DISTRICT DETERMINING, CERTIFYING, AND DIRECTING 2023-2024 SPECIAL TAX LEVIES WITHIN THE DISTRICT

WHEREAS, more than two-thirds (2/3rds) of the voters voting at a special election within the San Bernardino Mountains Community Hospital District on November 7, 1989, approved a measure authorizing this Board of Directors to adopt a resolution levying a special tax upon all taxable parcels of real property within the District in an amount not to exceed on an annual basis: (1) $40 per unimproved parcel, (2) $80 per parcel containing a single family residence or multiple dwelling units, and (3) $200 per parcel developed for commercial use; and

WHEREAS, on February 9, 2021, the San Bernardino Mountains Community Hospital District and the County of San Bernardino entered into the Agreement to Transfer a Portion of Appropriations Limit, whereby the County of San Bernardino transferred $2,000,000 of its appropriations limit to the San Bernardino Mountains Community Hospital District in recognition of the San Bernardino Mountains Community Hospital District's financial responsibility for providing service to areas within the County of San Bernardino's service area; and

WHEREAS, this Board of Directors finds that it is in the best interest of the District to impose the maximum special tax allowed by law for the Fiscal Year 2023/24;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the San Bernardino Mountains Community Hospital District as follows:

Section 1. The special tax for the Fiscal Year 2023/24 only shall be as follows:

Each unimproved parcel	$40
Each parcel containing a single family residence or multiple dwelling units	$80
Each parcel developed for commercial units	$200

Section 2. The records of the San Bernardino County Assessor as of March 1, 2023, shall determine for the purposes of the special tax whether or not any particular parcel of taxable real property is unimproved or is improved for residential of commercial use. "Parcel of real property" as used in this

Resolution shall mean any contiguous unit of improved or unimproved property held in separate ownership, including, but not limited to, any single family residence, any condominium unit, as defined in Civil Code 786, or any other unit of real property subject to the California Subdivided Lands Act (Business and Professions Code Section 11000 and following).

Section 3. The special tax shall be levied upon all unimproved and improved parcels of real property, except for parcels owned by any other local, federal, or state government agency, or any parcel of property that is exempt from the special tax pursuant to any provision of the state of federal constitutions for any paramount law.

Section 4. The special tax imposed shall be collected in the same manner, on the same dates, and subject to the same penalties and interest in accordance with the established dates, as, or with, other charges and taxes fixed and collected by the County of San Bernardino on behalf of the San Bernardino Mountains Community Hospital District, and the County may deduct its reasonable costs incurred for such service before remittal of the balance to the District.

Section 5. The special tax, together with all penalties and interest thereon, shall constitute a lien upon the parcels upon which it is levied until it has been paid, and the special tax, together with all penalties and interest thereon, shall, until paid, constitute a personal obligation to the District by the persons who own the parcel on the date the tax is due.

Section 6. The Secretary of this Board of Directors shall certify to the adoption of this Resolution and transmit a certified copy thereof to the Clerk of the Board of Supervisors and to the County Auditor of the County of San Bernardino. The Secretary and the District's legal counsel are authorized and instructed to take further action as may be necessary to carry out the purpose of this Resolution.

ADOPTED, SIGNED AND APPROVED this 30th day of June, 2023

_____

Kieth J Burkart
President of the Board of Directors
San Bernardino Mountains Community Hospital District

ATTEST:

_____

Cheryl J. Moxley
Secretary of the Board of Directors
San Bernardino Mountains Community Hospital District

CERTIFICATION

I, Cheryl J. Moxley, Secretary of the Board of Directors of the San Bernardino Mountains Community Hospital District, hereby certify that the foregoing is a full, true and correct copy of the Resolution 2023-11 adopted by the Board of Directors of the District at the Board Meeting held on June 30, 2023, by the following vote:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____

Cheryl J. Moxley
Secretary of the Board of Directors
San Bernardino Mountains Community Hospital District

AUDITOR-CONTROLLER/TREASURER/TAX COLLECTOR
AGREEMENT FOR COLLECTION OF SPECIAL
TAXES, FEES, AND ASSESSMENTS
FISCAL YEAR 2023-24

THIS AGREEMENT is made and entered into this 30th day of June, 2023, by and between the COUNTY OF SAN BERNARDINO, hereinafter referred to as "County" and the San Bernadino Mountains Community Hospital District, hereinafter referred to as "District".

WITNESSETH:

WHEREAS, Government Code Sections 29304 and 51800 authorize the County to recoup its collection costs when the County collects taxes, fees, or assessments for any city, school district, special district, zone or improvement district thereof; and

WHEREAS, the District and County have determined that it is in the public interest that the County, when requested by District, collect on the County tax rolls the special taxes, fees, and assessments for District.

NOW, THEREFORE, IT IS AGREED by and between the parties hereto as follows:

1. County agrees, when requested by District as hereinafter provided to collect on the County tax rolls the special taxes, fees, and assessments of District, and of each zone or improvement District thereof.

2. When County is to collect District's special taxes, fees, and assessments, District agrees to notify in writing the Auditor-Controller (268 W. Hospitality Lane, 4TH floor, San Bernardino, CA 92415) of the County on or before the 10th day of August of each fiscal year of the Assessor's parcel numbers and the amount of each special tax, fee, or assessment to be so collected. Any such notice, in order to be effective, must be received by the Auditor-Controller by said date.

3. County may charge District an amount per parcel for each special tax, fee, or assessment that is to be collected on the County tax rolls by the County for the District, not to exceed County's actual cost of collection.

4. District warrants that the taxes, fees, or assessments imposed by District and collected pursuant to this Agreement comply with all requirements of state law, including but not limited to, Articles XIIIC and XIIID of the California Constitution (Proposition 218).

5. District hereby releases and forever discharges County and its officers, agents, and employees from any and all claims, demands, liabilities, costs and expenses, damages, causes of action, and judgments, in any manner arising out of District's responsibility under

AGCY____

this agreement, or other action taken by District in establishing a special tax, fee, or assessment and implementing collection of special taxes, fees or assessments as contemplated in this agreement.

6. The County Auditor-Controller has not determined the validity of the taxes or assessments to be collected pursuant to this contract, and the undersigned District hereby assumes any and all responsibility for making such a determination. The undersigned District agrees to indemnify, defend, and hold harmless the County and its authorized officers, employees, agents, and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this contract or the imposition of the taxes or assessments collected pursuant to this contract, and for any costs or expenses incurred by the County on account of any claim therefore, except where such indemnification is prohibited by law. If any judgment is entered against County or any other indemnified party as a result of action taken to implement this Agreement, District agrees that County may offset the amount of any judgment paid by County or by any indemnified party from any monies collected by County on District's behalf, including property taxes, special taxes, fees, or assessments. County may, but is not required to, notify District of its intent to implement any offset authorized by this paragraph.

7. District agrees that its officers, agents and employees will cooperate with County by answering inquiries made to District by any person concerning District's special tax, fee, or assessment, and District agrees that its officers, agents, and employees will not refer such individuals making inquiries to County officers or employees for response.

8. District shall not assign or transfer this agreement or any interest herein and any such assignment or transfer or attempted assignment or transfer of this agreement or any interest herein by District shall be void and shall immediately and automatically terminate this agreement

9. This agreement shall be effective for the 2023-24 fiscal year.

10. Either party may terminate this agreement for any reason upon 30 days written notice to the other party. The County Auditor-Controller shall have the right to exercise County's right and authority under this contract including the right to terminate the contract.

11. County's waiver of breach of any one term, covenant, or other provision of this agreement, is not a waiver of breach of any other term, nor subsequent breach of the term or provision waived.

12. Each person signing this agreement represents and warrants that he or she has been fully authorized to do so.

IN WITNESS WHEREOF, the parties hereto have executed this agreement as of the day and year first above written.

District: San Bernadino Mountains Community Hospital District

By: _____

Printed Name: Mark Turner

Title: Chief Executive Officer

Date: June 30, 2023

ENSEN MASON CPA, CFA,
AUDITOR-CONTROLLER/TREASURER/TAX COLLECTOR
SAN BERNARDINO COUNTY

By Authorized Deputy: _____

Printed Name: Franciliza Zyss

Title: Interim Chief Deputy, Property Tax

Date: _____

AGCY____