Meetings convene at 6 p.m. on the last Wednesday of the month. Citizens wishing to schedule matters for Board consideration or to appear before the Board must contact the Clerk of the Board in writing stating the action requested. Appropriate requests will be scheduled before the Board at time allows. Deadline for submission of written materials is seven days in advance of the meeting.

Public Presentations: The law provides the opportunity for the public to be heard on any item within the subject matter jurisdiction of the Board, before or during the consideration of that item by the Board. For all items, including items not on the agenda, the public presentation time is appropriate. The President may set time limits as appropriate to manage the Agenda. State law does not allow action to be taken on any item not on the Agenda.

The agenda shall be made available upon request in alternative formats to persons with a disability, as required by the Americans with Disabilities Act of 1990 (U.S.C.§ 12132) the Ralph M. Brown Act (California Government Code § 54954.2). Persons requesting a disability related modification or accommodation in order to participate in the meeting should contact the Board Clerk at (530) 623-5541 Ext. 3255 during regular business hours, at least twenty four hours prior to the time of the meeting.

Pursuant to the Brown Act as codified in Government Code Section 54957.5, any documents pertaining to a non-closed agenda item distributed to a majority of the Board of Directors in less than 72 hours before a Board meeting shall be available for public inspection. Said documents shall be available for inspection at the Mountain Communities Healthcare District Administrative Office located at 60 Easter Avenue, Weaverville, California, Monday through Friday, except Holidays, between the hours of 9:00 a.m. and 12:00 p.m.

The Board may take action on any of the items listed on this agenda regardless of whether the matter is described as action item, a report, a communication, public input, or discussion item.

Call to order

Report from Closed Session on August 26, 2015

Public Input (3) Minute Time Limit)

Reports
a. Medical Staff Report – Daniel Harwood, MD/Donald Krouse, MD
b. Chief Executive Officer – Aaron Rogers, CEO
d. Chief Nursing Officer – Judy Nordlund, RN, Chief Nursing Officer
e. Quality Improvement – Sarah Cordtz, RN, Coordinator, Q/RM and Judy Nordlund, RN, Chief Nursing Officer
   • MCHD Quarterly OPPE Check List
   • Quarterly Report (September 5, 2015) – HealthTech Management Services
Consent Agenda
All matters listed under the Consent Agenda, are considered by the Board to be routine, and will be enacted by one motion in the form listed below. There will be no separate discussion of these items unless a request for discussion is made prior to the time the Board votes on the motion to approve.

All policies have been approved by the Manager/Director, Midlevel/Interdisciplinary Practice Committee, Medical Staff/Medical Director, and Chief Executive Officer per policy. The intent is that the MCHD Board of Director’s role is to assure the policy approval process for each policy.

a. Minutes from August 19, 2015
b. Minutes from August 26, 2015
c. Policies (See Attached)
d. Medical Staff Ongoing Professional Performance Evaluation (OPPE) Plan

Discussion Items
a. Parcel Tax
b. Clinic
c. Community Outreach – New Healthcare Model

Action Items
a. Items removed from the Consent Agenda
b. Accept VRad Medical Practice Bylaws/Credentialing Program
c. Accept Clinicians Medical Group Credentialing Manual

Board Reports
a. Board Member Reports

Announcement Designated Representatives for Closed Session item “Salaries and Benefits”

Close Public Session

Closed Session

- MEDICAL STAFF PRIVILEGES
  Government Code Section 54962; Health and Safety Code Section 1461

- SALARIES AND BENEFITS
  Government Code Section 54957.6
  Designated Representatives: Aaron Rogers

- PUBLIC EMPLOYEE PERFORMANCE EVALUATION
  Government Code Section 54957 – Public Employee
  Title: Chief Executive Officer

Adjourn Closed Session and Reconvene in Public Session
Report of any actions taken during Closed Session

Adjourn

Posted: September 25, 2015 1600 By: Jeanne Silvers
Medical Staff Report to the Board of Directors
September 30, 2015

I. Reappointments – Recommendation for Approval

Mark Hornsby, CRNA Consulting Staff  Specialty: Anesthesia
Lisa Taleraco, Psychologist Provisional Staff  Specialty: Psychology – Telemedicine

II. Peer Review/Utilization Review: No charts reviewed. Reviewed “MCHD Quarterly Check List” for 2015 (1st and 2nd quarter). There are still some charts that still need to be reviewed and staff is working on completing those reviews as quickly as possible. Medical Staff directed staff to complete outstanding reviews for the first and second quarter and report to the next Medical Executive Committee. This will be an ongoing report each quarter.

III. Laboratory Consultation Report:

- Laboratory Consultation reports from August 19, 2015 and September 2, 2015 was reviewed. There were 19 surgical charts reviewed (tissue) and 2 transfusion charts. Staffing still remains an issue in the laboratory.

IV. Items Discussed/approved:

- Approved policies and procedures- recommend approval by the MCHD Board of Directors

<table>
<thead>
<tr>
<th>ESR Auto (v.2)</th>
<th>Creatinine Clearance - Nomogram Body Surface Area, Children (v.2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alkaline Phosphatase (ALKP) (v.2)</td>
<td>Creatinine Clearance Test Procedures (v.2)</td>
</tr>
<tr>
<td>Ames Acetest (Ketones) (v.2)</td>
<td>Creatinine for GENs 80 and Above (CREA) (v.2)</td>
</tr>
<tr>
<td>Ammonia (AMON) (v.2)</td>
<td>D-Dimer Test Pack (v.2)</td>
</tr>
<tr>
<td>Amylase (AMY) (v.2)</td>
<td>Dealing with Testing Failure (v.2)</td>
</tr>
<tr>
<td>Bilirubin Unconjugated and Conjugated (BuBc) (v.2)</td>
<td>Digoxin (DGXN) (v.2)</td>
</tr>
<tr>
<td>Cardiac C-Reactive Protein -Acute Care (hsCRP) (v.2)</td>
<td>Direct Bilirubin (DBIL) (v.2)</td>
</tr>
<tr>
<td>Cerebrospinal Fluid Protein (PROT) (v.2)</td>
<td>Direct HDL Cholesterol (dHDL) (v.2)</td>
</tr>
<tr>
<td>Chloride (Cl) (v.2)</td>
<td>Direct I.DL (DIDL) (v.2)</td>
</tr>
<tr>
<td>Cholesterol (CHOL) (v.2)</td>
<td>Gentamicin (GENT) (v.2)</td>
</tr>
<tr>
<td>Reactive Protein (CRP) (v.2)</td>
<td>Glucose (GLU) (v.2)</td>
</tr>
<tr>
<td>Creatine Kinase (CK) (v.2)</td>
<td>HAV T (v.2)</td>
</tr>
<tr>
<td>Creatine Kinase MB (CK-MB) (v.2)</td>
<td>Rapid Influenza Screen (v.2)</td>
</tr>
<tr>
<td></td>
<td>Rapid Strep Screen (v.2)</td>
</tr>
<tr>
<td></td>
<td>Sputum Gram Stain Protocol (v.2)</td>
</tr>
</tbody>
</table>
- Accepted the VRAD and Clinicians Telemed Bylaws and credentialing policies and procedures
- Approved criteria for Anesthesia reviews.
- Approved Medical Staff Ongoing Professional Performance Evaluation (OPPE) Plan with minor changes to criteria for surgical reviews.

### V. Attendance:

**Present:**
- Henry Edelstein, MD
- Daniel Harwood, MD (Chief of Staff)
- Patrick Shipsey, MD (by Phone)
- Julia Mooney, MD (by Phone)
- Donald Krouse, MD

**Guests:**
- Jerry Cousins, MCHD Board Member
- Dero Forslund, MCHD Board Member

**Ad Hoc Members:**
- Aaron Rogers, CEO
- Judy Nordlund, RN, CNO
- Jeanne Silvers, Executive Assistant
- Vicky Williams, Director Ancillary Services
- Julie Roselli, CRNA
- Kevin Livengood, PharmD
- Hanna Smith, RN, UR
- Brett Williams, FNP

**Excused**
- Michael Novak, PA
- Maureen Breese, PA
- Christen Buirley, PA
- Clara Gordon, PA
From Aaron Rogers, CEO:
The following is an update on the ongoing matters of interest as of this date. I will provide a status update as appropriate, at the Board Meeting on September 30, 2015

Employee of the Month:
Renee Payne
CNA – Med/Surg
Renee always goes able and beyond her duties. She completes her work with a smile on her face, always putting her patient’s care and happiness before everything else. She is a team player and is a huge asset to Trinity Hospital.

Recruitment:
Clinical Lab Scientists, Nurses, Physicians, and PA/FNP’s are still recruitment needs. Two Physical Therapists have signed and will be starting around January 1, 2016. In the interim, we have a traveling physical therapist onsite that started Sept. 21. We are working through some final details with hiring a new physician for the clinic.

Utilization:
We are continuing to work on improving utilization of the Acute and Swing in the hospital. Recent census reports are continuing to show very positive improvements.

Updates:
SURVEY – State Hospital Survey has been accepted by Dr. Derby. State SNF Survey has been verbally accepted but we are waiting on the final.
HVAC/DRI – Construction continues. Emergency Room relocation has been discussed at length. State and OSHPD hopefully will be in agreement on whether we move or stay during construction.
LOAN – IGT money has been sent and we are just waiting to receive the money back.
TPUD wired the money to MCHD and was very understanding of the delay.
STRATEGY – We are focusing on our clinical strategies to create a better, more inclusive way to provide healthcare to the District. Staff is working hard on compiling data for the Board and communities.
REFINANCE – Optum Health loan paperwork has been signed. We have received confirmation that we are still eligible for our rebate.
FOLLOW-UP – Healthcare Collaborative discussion regarding the creation of a healthcare informational guide/brochure/education at the September meeting. Megan from Public Health has agreed to do preliminary work on it.
Financial Narrative for the month of August 2015

Summary

Mountain Communities Healthcare District earned an income from operations of $83,780 for the month, which is $232,766 higher than the budgeted operating loss of ($148,986). For the year-to-date, Operating Income is ($572k), which is a $670k improvement compared to a budget of ($1.24m).

Volume and Revenue

Total patient days were over budget by 30 in Acute (104 actual, 74 budget), 141 in Swing (165 actual, 24 budget), and below budget by 48 in SNF (553 actual, 599 budget). Outpatient volumes were over budget in all areas except Hayfork Clinic and Trinity Clinic due to provider availability, Home Health due to the increase in Swing, and Ultrasound and X-Ray. As a result of the high volumes and our recent increase in charge rates, the total patient revenue was over budget by $649k or 30%. Net Patient Revenues are over budget by 19% which includes an additional $150k reserve to increase the YTD estimate of the 2015 Medicare cost report. As a result, Net Patient Revenue is 45.0% of gross compared to a budget of 49.0%, but without the additional reserves it would have been 50.3% due to strong payor mix and service mix again this month. For the year-to-date, Total Operating Revenues are $8.93 million, which is $658k higher than budgeted $8.28 million.
**Expenses**

Salaries, benefits, and registry expenses are $721k for the month, which is $10k higher than the budget of $711k with higher patient volumes. All other expense categories combined are under budget by $40k, largely in the area of Utilities, due to lower than expected utilization, and Other Expenses, due to a vendor credit. As a result, total expenses are $1.19 million, which is $301k lower than the budget of $1.22 million. For year-to-date, total expenses are $9.61 million, which is just $3k lower than the budget.

**Non-Operating Revenue and Expense**

Non-operating activity for the month was budgeted to include routine items only, such as $70k for tax revenue. Total non-operating revenue for the month is $45k compared to a budget of $70k due to the recording of prior year cost report reserves and interest expense, offset by $23k in grant and non-operating revenue. For the year-to-date, non-operating revenue equals budget at $1.47 million. As a result, Net Income for the month is $278k compared to a budgeted loss of ($78k). For the year-to-date, the Net Income is $904k compared to a budget of $232k.

**Balance Sheet**

Days in Cash remain at 17, while Days in AR increased to 59 with the continuing strong revenue. Days in AP dropped again, now from 80 to 72 (earlier this year it was over 100), as we continue to generate positive cash flow and pay bills. The Gross AR increased to $4.5 million with another month of very strong revenue. Net AR is $1.71 million or 38.1% of gross, as our AR mix continues to remain new and collectable.
## Mountain Communities Healthcare District
### Balance Sheet

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>617,916</td>
<td>587,325</td>
<td>426,795</td>
</tr>
<tr>
<td>Gross accounts receivable</td>
<td>4,490,141</td>
<td>3,893,888</td>
<td>3,980,389</td>
</tr>
<tr>
<td>Net accounts receivable</td>
<td>1,709,739</td>
<td>1,469,219</td>
<td>1,387,429</td>
</tr>
<tr>
<td>Net % of gross</td>
<td>38.08%</td>
<td>37.73%</td>
<td>34.86%</td>
</tr>
<tr>
<td>Other Receivables</td>
<td>356,412</td>
<td>436,810</td>
<td>829,287</td>
</tr>
<tr>
<td>Estimated third party settlements, net</td>
<td>-</td>
<td>-</td>
<td>219,209</td>
</tr>
<tr>
<td>Inventories</td>
<td>154,173</td>
<td>158,236</td>
<td>151,434</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>258,687</td>
<td>246,509</td>
<td>186,522</td>
</tr>
<tr>
<td>Total current assets</td>
<td>3,096,927</td>
<td>2,898,100</td>
<td>3,200,676</td>
</tr>
<tr>
<td>Assets limited as to use</td>
<td>40,885</td>
<td>41,645</td>
<td>35,072</td>
</tr>
<tr>
<td>Total capital assets</td>
<td>10,701,310</td>
<td>10,595,180</td>
<td>10,599,676</td>
</tr>
<tr>
<td>Total accumulated depreciation</td>
<td>6,328,803</td>
<td>6,143,829</td>
<td>5,569,061</td>
</tr>
<tr>
<td>Capital assets, net of accumulated depreciation</td>
<td>4,372,507</td>
<td>4,451,352</td>
<td>5,030,615</td>
</tr>
<tr>
<td>Total assets</td>
<td>7,510,319</td>
<td>7,391,096</td>
<td>8,266,364</td>
</tr>
</tbody>
</table>

| Liabilities and Net Assets | | | |
| Current Liabilities: | | | |
| Line of credit | - | - | 301,150 |
| Current maturities of debt borrowing | 523,933 | 544,521 | 689,430 |
| Accounts payable and accrued expenses | 1,046,616 | 1,267,777 | 1,704,836 |
| Accrued payroll and related liabilities | 593,464 | 564,401 | 580,094 |
| Estimated third party settlements, net | 760,617 | 425,288 | - |
| Deferred Revenue | 210,273 | 351,693 | 829,408 |
| Total current liabilities | 3,134,903 | 3,153,680 | 4,104,918 |
| Debt borrowings, net of current maturities | 693,706 | 779,823 | 724,135 |
| Total liabilities | 3,828,609 | 3,933,502 | 4,829,053 |

| Net assets: | | | |
| Invested in capital assets, net of related debt | 3,154,868 | 3,127,008 | 3,617,051 |
| Unrestricted | 526,842 | 330,586 | (179,740) |
| Total net assets/deficit | 3,681,710 | 3,457,594 | 3,437,311 |
| Total liabilities and net assets | 7,510,319 | 7,391,096 | 8,266,364 |

| Days in cash | 17 | 16 | 12 |
| Days in accounts receivable (gross) | 59 | 55 | 63 |
| Days in accounts payable | 72 | 87 | 120 |
# Statement of Operations

## YTD Actual

<table>
<thead>
<tr>
<th>Item</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenues:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient revenue</td>
<td>7,881,923</td>
<td>6,777,380</td>
<td>1,104,543</td>
</tr>
<tr>
<td>Outpatient revenue</td>
<td>10,574,420</td>
<td>9,994,228</td>
<td>580,192</td>
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<tr>
<td>Total gross patient service revenue</td>
<td>18,456,343</td>
<td>16,771,608</td>
<td>1,684,734</td>
</tr>
<tr>
<td>Contractuals &amp; Bad Debt</td>
<td>9,520,372</td>
<td>8,493,512</td>
<td>1,026,860</td>
</tr>
<tr>
<td>Net patient service revenue</td>
<td>8,935,971</td>
<td>8,278,097</td>
<td>657,874</td>
</tr>
<tr>
<td>Net Revenue as a % of gross</td>
<td>48.4%</td>
<td>49.4%</td>
<td>-</td>
</tr>
<tr>
<td>EHR incentive revenue</td>
<td>53,458</td>
<td>53,458</td>
<td>-</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>49,282</td>
<td>40,124</td>
<td>9,158</td>
</tr>
<tr>
<td>Total operating revenues</td>
<td>9,038,710</td>
<td>8,371,679</td>
<td>667,032</td>
</tr>
<tr>
<td>Operating expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>4,211,912</td>
<td>4,183,044</td>
<td>28,868</td>
</tr>
<tr>
<td>Benefits</td>
<td>1,122,723</td>
<td>1,184,666</td>
<td>61,943</td>
</tr>
<tr>
<td>Registry</td>
<td>333,137</td>
<td>268,582</td>
<td>64,556</td>
</tr>
<tr>
<td>Professional fees</td>
<td>1,202,900</td>
<td>1,181,627</td>
<td>11,273</td>
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<tr>
<td>Supplies</td>
<td>948,822</td>
<td>879,988</td>
<td>68,834</td>
</tr>
<tr>
<td>Purchased services</td>
<td>602,605</td>
<td>502,452</td>
<td>153</td>
</tr>
<tr>
<td>Utilities</td>
<td>169,933</td>
<td>219,613</td>
<td>(49,680)</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>744,189</td>
<td>748,128</td>
<td>(3,939)</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>274,852</td>
<td>345,522</td>
<td>(71,070)</td>
</tr>
<tr>
<td>Total operating expenses</td>
<td>9,611,072</td>
<td>9,614,021</td>
<td>(3,949)</td>
</tr>
<tr>
<td>Operating gain/(loss)</td>
<td>(572,362)</td>
<td>(1,242,342)</td>
<td>669,980</td>
</tr>
<tr>
<td>Non-operating revenues/expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intergovernmental Transfer</td>
<td>1,200,094</td>
<td>808,015</td>
<td>392,079</td>
</tr>
<tr>
<td>Cost Report (prior year)</td>
<td>(271,450)</td>
<td>-</td>
<td>271,450</td>
</tr>
<tr>
<td>District tax revenue</td>
<td>565,677</td>
<td>565,680</td>
<td>(3)</td>
</tr>
<tr>
<td>Grants and contributions</td>
<td>35,745</td>
<td>137,089</td>
<td>(101,344)</td>
</tr>
<tr>
<td>Non Operating Revenue</td>
<td>7,334</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest expense</td>
<td>(61,248)</td>
<td>(36,756)</td>
<td>(24,492)</td>
</tr>
<tr>
<td>Total non-operating revenues/expenses</td>
<td>1,476,152</td>
<td>1,474,028</td>
<td>2,125</td>
</tr>
<tr>
<td>Net income/(loss)</td>
<td>903,791</td>
<td>281,688</td>
<td>621,105</td>
</tr>
<tr>
<td>Trinity EBITDA</td>
<td>1,709,228</td>
<td>1,016,569</td>
<td>692,658</td>
</tr>
<tr>
<td>Staffing costs as a % of net patient revenue</td>
<td>63.4%</td>
<td>68.1%</td>
<td></td>
</tr>
<tr>
<td>Total operating expenses as a % of net patient revenue</td>
<td>107.6%</td>
<td>116.1%</td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- YTD actual figures are compared against budget figures and variance is calculated.
- Operating revenues include inpatient and outpatient revenues, total gross patient service revenue, contractuals & bad debt.
- Operating expenses include salaries, benefits, registry, professional fees, supplies, purchased services, utilities, depreciation and amortization, other operating expenses.
- Non-operating revenues/expenses include intergovernmental transfer, cost report (prior year), district tax revenue, grants, non operating revenue, interest expense.
- Net income/(loss) is calculated after considering all operating and non-operating revenues/expenses.
## Mountain Communities Healthcare District
### Cash Projection - 2015

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Beginning Cash Balance</td>
<td>421,941</td>
<td>346,585</td>
<td>54,276</td>
<td>385,674</td>
<td>498,024</td>
<td>577,440</td>
<td>415,844</td>
<td>56,729</td>
<td>(175,519)</td>
<td>1,468,675</td>
<td>1,608,385</td>
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<tr>
<td>Patient Receipts</td>
<td>577,128</td>
<td>933,120</td>
<td>1,246,386</td>
<td>404,826</td>
<td>966,369</td>
<td>1,217,849</td>
<td>1,431,892</td>
<td>2,423,129</td>
<td>3,953,550</td>
<td>1,040,527</td>
<td>1,573,833</td>
<td>1,001,964</td>
</tr>
<tr>
<td>Intergovernmental Transfer Activity</td>
<td>-</td>
<td>-</td>
<td>244,758</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>AB-69</td>
<td>152,916</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>AB-935/PPS Recons/Cost Report</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
</tr>
<tr>
<td>MU Payments/CHAFF Refund</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tax Receipts</td>
<td>49,076</td>
<td>28,422</td>
<td>58,540</td>
<td>36,852</td>
<td>7,956</td>
<td>48,267</td>
<td>20,487</td>
<td>9,622</td>
<td>11,550</td>
<td>129,421</td>
<td>134,228</td>
<td></td>
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<tr>
<td>Miscellaneous Cash Receipts</td>
<td>1,015</td>
<td>9,124</td>
<td>3,812</td>
<td>25,218</td>
<td>34,171</td>
<td>48,798</td>
<td>3,835</td>
<td>55,590</td>
<td>385</td>
<td>28,888</td>
<td>66,848</td>
<td>28,848</td>
</tr>
<tr>
<td>Total Cash Collected</td>
<td>1,590,135</td>
<td>1,068,465</td>
<td>1,553,647</td>
<td>1,856,671</td>
<td>1,400,583</td>
<td>1,424,295</td>
<td>1,455,894</td>
<td>1,336,363</td>
<td>1,356,431</td>
<td>4,809,857</td>
<td>1,371,202</td>
<td>1,165,048</td>
</tr>
<tr>
<td>Total Cash Available</td>
<td>1,413,977</td>
<td>1,312,862</td>
<td>1,687,322</td>
<td>2,282,346</td>
<td>1,699,607</td>
<td>2,082,795</td>
<td>1,597,318</td>
<td>3,369,865</td>
<td>1,272,227</td>
<td>6,390,338</td>
<td>2,709,877</td>
<td>2,739,383</td>
</tr>
</tbody>
</table>

### Cash Disbursed

| Payroll | 508,906 | 628,180 | 635,874 | 677,396 | 675,758 | 655,280 | 688,747 | 658,529 | 688,448 | 669,057 | 664,288 | 976,497 |
| Accounts Payable | 446,026 | 140,813 | 498,451 | 671,942 | 575,150 | 728,404 | 759,641 | 657,359 | 584,273 | 489,716 | 450,000 | 438,551 |
| Bank Loan LOC | 25,000 | - | 75,300 | 200,500 | - | - | - | - | - | - | - | - |
| Intergovernmental Transfer Activity | 44,128 | - | 475,493 | - | - | - | - | - | - | - | - | - |
| United Healthcare/Help II Loan | 50,807 | - | - | 440,545 | 50,000 | 25,000 | 123,266 | 50,000 | 50,000 | 25,000 | 50,000 | 25,000 |
| Cost Report Reserves (1) | - | - | - | - | - | - | - | - | - | - | - | - |
| Total Disbursements | 1,247,000 | 1,260,677 | 1,322,948 | 1,813,523 | 1,292,388 | 1,840,591 | 1,540,900 | 1,887,479 | 1,434,432 | 1,244,987 | 1,303,545 | 1,302,328 |

### Cash Position

<table>
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<tr>
<th>Balance Before Financing</th>
<th>Actuals</th>
<th>Financing</th>
<th>Cash Balance</th>
<th>Actual</th>
<th>Outstanding</th>
<th>Outstanding</th>
<th>Outstanding</th>
<th>Outstanding</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Financing Activity</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Outstanding</td>
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<td>Outstanding</td>
</tr>
<tr>
<td>Trinity Public Utilities District LOC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
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<td></td>
</tr>
<tr>
<td>Trinity Public Utilities District 927 Loan</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>275,000</td>
<td>275,000</td>
<td>200,000</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
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<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
</tr>
</tbody>
</table>

**Notes:**

1. Funds placed in Money Market account to reserve for potential payback due to higher Inpatient utilization.
## Mountain Communities Healthcare District
### Line of Business Analysis with Overhead Allocated
#### August, 2015

<table>
<thead>
<tr>
<th></th>
<th>SNF</th>
<th>Trinity Community Health Clinic</th>
<th>Hayfork Community Health Clinic</th>
<th>Hospital with Emergency Department attached</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expected Net Revenue</strong></td>
<td>246,790</td>
<td>92,624</td>
<td>33,050</td>
<td>875,691</td>
<td>1,269,919</td>
</tr>
<tr>
<td><strong>Direct Expense</strong></td>
<td>84,998</td>
<td>85,799</td>
<td>32,931</td>
<td>591,513</td>
<td>819,517</td>
</tr>
<tr>
<td><strong>Direct Expense - Net Gain/(loss)</strong></td>
<td>161,792</td>
<td>6,825</td>
<td>119</td>
<td>284,178</td>
<td>450,401</td>
</tr>
<tr>
<td><strong>Overhead Expense</strong></td>
<td>82,661</td>
<td>25,917</td>
<td>14,883</td>
<td>238,627</td>
<td>368,882</td>
</tr>
<tr>
<td><strong>Overhead Expense - Net Gain/(loss)</strong></td>
<td>79,131</td>
<td>(19,091)</td>
<td>(14,764)</td>
<td>45,551</td>
<td>81,519</td>
</tr>
<tr>
<td><strong>Non Operating Revenue/Expense</strong></td>
<td>19,802</td>
<td>6,208</td>
<td>3,565</td>
<td>16,326</td>
<td>47,529</td>
</tr>
<tr>
<td><strong>Net Income/(loss)</strong></td>
<td>98,933</td>
<td>(12,883)</td>
<td>(11,199)</td>
<td>61,877</td>
<td>129,048</td>
</tr>
</tbody>
</table>

**Note:**
1. Overhead allocation of expenses and other revenue based on the Medicare as filed cost report.
### Mountain Communities Healthcare District

#### Monthly Activity Log

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<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td><strong>PATIENT DAYS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MED/SURG</td>
<td>55</td>
<td>50</td>
<td>97</td>
<td>78</td>
<td>104</td>
<td>4,048</td>
<td>86</td>
<td>76</td>
<td>86</td>
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<td>6</td>
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</tr>
<tr>
<td>SWING BED</td>
<td>20</td>
<td>3</td>
<td>18</td>
<td>42</td>
<td>28</td>
<td>322</td>
<td>36</td>
<td>38</td>
<td>28</td>
<td>84</td>
<td>87</td>
<td>88</td>
<td>107</td>
<td>105</td>
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<tr>
<td>OBSERVATION</td>
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<td>25</td>
<td>25</td>
<td>21</td>
<td>26</td>
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<td>18</td>
<td>12</td>
<td>14</td>
<td>11</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>INPATIENT SURGERIES</td>
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<td>11</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<td>1</td>
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<td>1</td>
<td>1</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>SWING BED</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>5</td>
<td>42</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>SNF</td>
<td>15</td>
<td>55</td>
<td>50</td>
<td>57</td>
<td>638</td>
<td>7,076</td>
<td>609</td>
<td>536</td>
<td>608</td>
<td>556</td>
<td>519</td>
<td>581</td>
<td>595</td>
<td>592</td>
</tr>
<tr>
<td><strong>TOTAL PATIENT DAYS:</strong></td>
<td>709</td>
<td>675</td>
<td>691</td>
<td>708</td>
<td>797</td>
<td>8,710</td>
<td>751</td>
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<td>781</td>
<td>743</td>
<td>758</td>
<td>766</td>
<td>842</td>
<td>884</td>
</tr>
</tbody>
</table>

| **INPATIENT ADMISSIONS:** |        |        |        |        |        |        |        |        |        |        |        |        |         |          |
| MED/SURG              | 21     | 31     | 57     | 26     | 29     | 333    | 30     | 28     | 31     | 19     | 28     | 29     | 20      | 20      | 206      |
| INPATIENT SURGERIES   | 2      | 2      | 1      | 0      | 0      | 17     | 1      | 1      | 1      | 1      | 1      | 0      | 0       | 0        | 3         |
| SWING BED             | 1      | 1      | 2      | 6      | 6      | 42     | 2      | 1      | 3      | 3      | 3      | 8      | 4       | 7        | 96        |
| SNF                   | 1      | 1      | 2      | 3      | 1      | 22     | 0      | 1      | 1      | 1      | 0      | 2      | 1       | 2        | 1         |
| **TOTAL INPATIENT ADMISSIONS:** | 27     | 36     | 41     | 35     | 35     | 354    | 32     | 32     | 38     | 24     | 37     | 35     | 28      | 253      |

| **TESTS/Visits:**     |        |        |        |        |        |        |        |        |        |        |        |        |         |          |
| CT SCAN TESTS         | 76     | 73     | 90     | 52     | 67     | 834    | 58     | 67     | 57     | 54     | 74     | 81     | 71      | 521      |
| ECHOCARDIOGRAM TESTS  | 9      | 13     | 21     | 24     | 12     | 250    | 21     | 12     | 10     | 15     | 27     | 57     | 53      | 181      |
| EMERGENCY ROOM VISITS | 414    | 472    | 410    | 375    | 430    | 4,688  | 319    | 429    | 412    | 447    | 466    | 475    | 515     | 478      | 3,628     |
| HAYFORK CLINIC VISITS | 431    | 450    | 470    | 337    | 374    | 4,507  | 401    | 337    | 386    | 355    | 378    | 372    | 350     | 2,909     |
| HOME HEALTH VISITS    | 114    | 86     | 59     | 43     | 48     | 1,334  | 60     | 99     | 84     | 86     | 89     | 84     | 81      | 82       | 615       |
| LABORATORY TESTS      | 34,830 | 16,661 | 17,943 | 16,072 | 17,947 | 184,236| 16,127 | 15,086 | 15,415 | 17,655 | 15,165 | 18,258 | 20,825  | 17,442    | 137,059   |
| PHYSICAL THERAPY      | 42     | 19     | 25     | 62     | 59     | 472    | 30     | 38     | 51     | 60     | 60     | 64     | 77      | 72       | 447       |
| RESPIRATORY THERAPY TESTS | 618    | 738    | 602    | 808    | 1,090  | 8,097  | 895    | 785    | 871    | 979    | 694    | 822    | 839     | 1,332    | 7,017     |
| TOP CARE VISITS       | 6      | 5      | 12     | 7      | 10     | 88     | 17     | 35     | 37     | 26     | 26     | 12     | 17      | 18       | 200       |
| TRINITY CLINIC VISITS | 907    | 952    | 853    | 828    | 908    | 10,880 | 957    | 786    | 728    | 945    | 694    | 929    | 955     | 726      | 8,718     |
| ULTRASOUND TESTS      | 65     | 56     | 72     | 53     | 75     | 703    | 59     | 52     | 56     | 57     | 36     | 54     | 81      | 42       | 437       |
| X-RAY TESTS           | 372    | 354    | 371    | 317    | 324    | 4,026  | 385    | 306    | 282    | 347    | 324    | 294    | 294     | 2,491     |
| **TOTAL TESTS/Visits:** | 17,640 | 19,877 | 20,377 | 18,030 | 20,834 | 230,336| 19,957 | 17,577 | 15,384 | 21,061 | 17,895 | 22,004 | 24,162   | 20,089    | 169,100   |

<table>
<thead>
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</tr>
</thead>
<tbody>
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<td>74</td>
<td>85</td>
<td>81</td>
<td>109</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>4</td>
<td>3</td>
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<td>24</td>
<td>35</td>
<td>28</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>24</td>
<td>18</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>599</td>
<td>623</td>
<td>596</td>
<td>599</td>
<td></td>
</tr>
</tbody>
</table>
From: Judy Nordlund, RN, CNO

1. Employee of the Month - September: Renee Payne CNA, ER Tech, MedSurg Ward Clerk; Renee goes above and beyond in performing any task that is assigned to her, is always kind and compassionate to our patients and picks up extra shifts whenever she is able. She is a valued member of the nursing department.

2. Pyxis implementation: Implementation after the ER/OR HVAC project

3. Pharmacy:
   a. 340B: Will start in October at CVS and Owens
   b. Pharmacist order verification within 24 hours compliance (August) at 98%.
      (Benchmark = 90%, goal 90%). Trinity Hospital’s Pharmacist is performing a weekly review all order verifications performed by TelnetRx to assure quality of the contracted service.
   c. Medication costs: $28K Medication charges: ~$170


   b. Swing: continuing to boost census numbers and revenue flow.

   c. Budget projection for 2016:
      i. Increase nursing staff to 3 licensed nurses on day and night shift: 2 RNs/1 LVN. (LVNs cannot make up more than 50% of the total shift coverage).
      ii. Increase day Nursing Aide coverage from 1 to 2.
      iii. Short 8 FTEs.
5. **SNF:**
   a. Census: Currently 17
   b. Annual State/Federal Survey Plans of Corrective Action accepted by CDPH

6. **ER:**
   a. HVAC project move
   b. OSHPD had stated move from ED necessary
   c. Plans for ED patient care in clinic building submitted to CDPH
   c. Within last week, alternative plans are being discussed / approved by OSHPD to allow ED functioning during HVAC project.

7. **OR:**
   a. No surgery capability during HVAC project.
   b. New estimate of closure time 7-10 days which includes supply transfer, supply and equipment re-processing, cleaning and re-supply of OR equipment and supplies.

8. **Home Health:**
   a. TOP-Care services and process are working well.
   b. Home Health is currently servicing 22 patients.

9. I will be stepping-down from the CNO responsibilities in the near future, due to personal reasons. I will be staying on at MCHD as a staff nurse in the OR and ER. Your support over the last two years has been very much appreciated. Thank you.
To: Board of Directors  
Re: MCHD Quality Improvement Program  

Greetings,

It is my pleasure to give you an update on the MCHD Quality Improvement Program.

On September 4, Aaron Rogers, CEO, Judy Nordlund RN, CNO, and I participated in a conference call with Carolyn St. Charles from Health Tech who has been a consultant for our hospital. She had several suggestions on fine tuning our Quarterly Report such as breaking out our numbers from some of our chart audits and reporting Swing patients separately from our In Patients and adding our restraint log information to the scorecard. She provided helpful tools in assisting us to try and meet some of our nursing goals such as care plan completion and nurse documentation in the ER. We are working at putting these suggestions into place and look forward to her next follow up call near the end of the calendar year. Carolyn had reviewed our Quarterly Report and in an email listed out questions and comments that she had regarding our measures by department. This was reviewed at our last CQI meeting.

Carolyn also requested follow up from administration regarding contracts, policy and procedures, peer review (internal and external), mid-level reviews, and Medical Staff review of CRNA peer review criteria, frequency and review of results.

Thank you for your participation and support of the Quality Improvement Program and Trinity Hospital.

Sarah Cordtz RN  
Coordinator Quality Assurance / Risk Management
# MCHD Quarterly OPPE Check List

## 1st Quarter 2015

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of patients</th>
<th>10% of charts</th>
<th>Charts completed</th>
<th>Actual % done</th>
</tr>
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<tbody>
<tr>
<td>SAMPLE</td>
<td>72</td>
<td>7.2</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>Medical/Swing</td>
<td>84</td>
<td>8.4</td>
<td>21</td>
<td>25%</td>
</tr>
<tr>
<td>Surgical (IP/OP)</td>
<td>52</td>
<td>5.2</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Procedures (IP/OP)</td>
<td>114</td>
<td>11.4</td>
<td>11</td>
<td>10%</td>
</tr>
<tr>
<td>Emergency (Random)</td>
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<td>123.3</td>
<td>140</td>
<td>11%</td>
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<tr>
<td>ER Indicators</td>
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</tr>
<tr>
<td>Med/Surg/Swing Indicators</td>
<td>84</td>
<td>-</td>
<td>9</td>
<td>11%</td>
</tr>
<tr>
<td>Other Requested Reviews</td>
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<td>-</td>
<td>4</td>
<td>-</td>
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<tr>
<td>Tissue Reviews</td>
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<td>51%</td>
</tr>
<tr>
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<td>7</td>
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<td>1</td>
<td>-</td>
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<tr>
<td><strong>Clinical Pertinence Reviews</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donald Krouse, MD</td>
<td>82</td>
<td>8.2</td>
<td>15</td>
<td>18%</td>
</tr>
<tr>
<td>Patrick Shipsey, MD</td>
<td>8</td>
<td>0.8</td>
<td>7</td>
<td>88%</td>
</tr>
<tr>
<td><strong>Trinity/Hayfork Clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael Novak, PA</td>
<td>863</td>
<td>86.3</td>
<td>68</td>
<td>8%</td>
</tr>
<tr>
<td>Donald Krouse, MD*</td>
<td>205</td>
<td>20.5</td>
<td>16</td>
<td>8%</td>
</tr>
<tr>
<td>Maureen Breese, FNP*</td>
<td>685</td>
<td>68.5</td>
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<td>2%</td>
</tr>
<tr>
<td>Randall Meredith, MD*</td>
<td>206</td>
<td>20.6</td>
<td>12</td>
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<tr>
<td>Christen Buirley, PA</td>
<td>875</td>
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<tr>
<td>Roxellen Auletto, FNP</td>
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<td>Jon Washburn, PA</td>
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<td>Michael Yorgensen, PA</td>
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<td><strong>Telehealth</strong></td>
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<tr>
<td>Nelson Madrilejo, MD*</td>
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<tr>
<td>Asela Jumao-As, MD</td>
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## 2nd Quarter 2015

<table>
<thead>
<tr>
<th>Department</th>
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<th>Charts completed</th>
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<tr>
<td>Medical/Swing</td>
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<td>Transfusion Reviews</td>
<td>10</td>
<td>-</td>
<td>8</td>
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<tr>
<td><strong>Clinical Pertinence Reviews</strong></td>
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<tr>
<td>Donald Krouse, MD</td>
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<td>Patrick Shipsey, MD</td>
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<td>Michael Novak, PA</td>
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<td>14%</td>
</tr>
<tr>
<td>Provider</td>
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<td>10% of charts</td>
<td>Charts completed</td>
<td>Actual % done</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------</td>
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<td>------------------</td>
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<tr>
<td>Anesthesia</td>
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<tr>
<td>Julie Roselli, CRNA</td>
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<tr>
<td>Barbara Wertz, CRNA</td>
<td>43</td>
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<td>Melissa Baxter, CRNA</td>
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<td>0</td>
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<tr>
<td>Sam Thibodeaux, CRNA</td>
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<tr>
<td>Emergency Room</td>
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<tr>
<td>Reviews with No Occurrence</td>
<td>100%</td>
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<tr>
<td>VRAD</td>
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<tr>
<td>Report Received within 30 minutes</td>
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<tr>
<td>Preliminary Report agrees with final report</td>
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<tr>
<td>MDI</td>
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<tr>
<td>Preliminary Report agrees with final report</td>
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<td>Stat Reports received within 1 hours</td>
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<td>Shasta Pathology</td>
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<td>Turnaround Time</td>
<td>Within 1 working day</td>
<td>94%</td>
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<td>Turnaround Time</td>
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<tr>
<td>Section</td>
<td>Percentage</td>
<td>Notes</td>
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<tr>
<td>---------------------------------</td>
<td>------------</td>
<td>---------------</td>
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<tr>
<td>Frozen Section Case Review</td>
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<tr>
<td>Trinity Community Health Clinic</td>
<td>95%</td>
<td></td>
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<tr>
<td>Hayfork Community Health Clinic</td>
<td>97%</td>
<td></td>
<td></td>
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<tr>
<td>Tissue</td>
<td>100%</td>
<td></td>
<td></td>
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<tr>
<td>Transfusion</td>
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<td>Credentialing up to date</td>
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<tr>
<td></td>
<td>x</td>
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</tr>
</tbody>
</table>
September 5, 2015

To: Aaron Rogers, CEO
     Judy Nordlund, CNO
     Sara Cordtz, Quality Director
     Jeanne Silvers, Executive Assistant

From: Carolyn St.Charles, RN, MBA

Re: Quarterly Call

Please find on the following pages my notes from this morning’s quarterly call. Please let me know if you have questions. We will plan on another call in September.

Follow-Up

- Care Plans: Develop improvement project to increase care plan completion compliance: Judy and Sarah
- ER Documentation: Develop improvement project to increase care plan completion compliance: Judy and Sarah
- Restraints: Please send restraint policy and restraint audit tool to Carolyn: Sarah or Judy
- Swing Bed Audit Tool: Carolyn will send.
- Contracts: Please send contract audit metrics to Carolyn: Jeanne
- Contracts: Please let me know when contract audits are complete: Jeanne
- P&P: Recommend adding percent completion within last 12 months to scorecard: Sarah
- P&P: Please send policy for P&P review including review by mid-level and physician: Sarah(?)
- Peer Review: Please verify that there is a process to ensure 100% of providers have internal peer review: Jeanne and Sarah
- Peer Review: A process for external peer review for ALL providers has not been finalized but is in process: Aaron
- Mid-Level: Please provide evidence of how you are tracking that mid-level reviews are done collaboratively with physician: Jeanne
- CRNA: Please validate that medical staff has approved review criteria and frequency of review for CRNA peer review and send to Carolyn: Jeanne
- CRNA: Please validate that medical staff receives peer review information for CRNAs and send to Carolyn: Jeanne

Let me know if questions.

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Notes from Call

1. Scorecard
   - Comments on most recent scorecard sent to Sarah who is following up with dept. managers. (I’m pretty sure I also cc Aaron and Judy but if not let me know and I will send.)
   - Some metrics on scorecard say, “no submission”. Apparently some of those marked no submission were metrics that were actually dropped. It is important to note this on the scorecard.

2. Care Plans
   - Care Plan completion within 24 hours is still poor – about 50%
     I would strongly recommend chartering an improvement project focused on improvement in care plan completion. I’m not sure what methodology you use for improvement but you may want to consider using a Lean Six Sigma tool called A3 shown on last page. I think using the 5 WHYs may be the most important tool so you can determine WHY care plans are not being completed. And of course, as you already know, it’s important to involve staff in the analysis and solution.
     Other suggestions include:
       o Review care completion DAILY
       o Post results in prominent place so that nurses can see – use a line or bar graph - something very visible
       o Morning and Evening huddles to review with staff WHY care plans weren’t done and what can be done today to make sure they are all completed.

3. Nutritional Risk
   - Nutritional assessment and reassessment MUCH improved. GOOD JOB! Will continue to monitor

4. Restraints
   - Restraint Log initiated.
   - I would recommend adding restraint documentation to scorecard.
   - Please send audit tool for restraint documentation.

5. Swing Bed
   - Swing Bed admission packet revised.
   - Not auditing swing bed documentation – Carolyn will provide audit form.

6. Emergency Department
   - Discharge Vital Signs and Medication Reconciliation still an issue, less than 50% compliance. You may want to consider the same process as described for med-surg care plans.

7. Medication Management
   - Full-time Pharmacist on-site.
   - Apparently the requirement for a pharmacist review before first dose is not in the new regulations – or at least I can’t find it.
   - NOTE: New CoPs have multiple changes to medication management – recommend pharmacist review to ensure all new requirements are in place.
8. Contract Services
- Evaluation of Contacts: Note from Jeanne stated, “Forms were sent to each manager for them to complete quality measures on the contracts that affected their departments on August 6th with a due date of August 21. I have received one back. I will send out again with a due date of September 15th and immediate response needed. These will be reported on the CQI quarterly report.”
- Please let me know when contract evals completed. Please send me metrics for each contract for review.

9. Policies and Procedures
- Process for P&P review in place
- P&P being reviewed by governing board. Plan is to still try to complete by Dec 31.
- Recommend adding percent of P&P current within last 12 months to scorecard.
- Please note new CoPs require an advisory committee made up of physician and mid-level – is this in place? Do you have a policy?

10. Quality Program
- Please send dashboard and quality metrics for next quarter when it is completed.

11. Internal and External Professional Practice Review
- Process to ensure 100% of providers have internal review has been put in place. Please verify that this is correct.
- External review has not been implemented for all physicians. Contract with another CAH is under consideration. In process.
- Mid-Level provider review must have evidence that the review was done collaboratively and/or results of physician review discussed with mid-level. Please review.

12. CRNA
- Information from Jeanne, “We are pulling every 10th chart for review. Julie and Barbara have separate contracts and review each other. There are two other anesthetists that are paid by Julie and Barbara reviews those charts.”
- The medical staff must approve review criteria and number of reviews.
- Results of review must be submitted to the medical staff – ideally quarterly but at a minimum annually.

12. Tele-Medicine Contracts
- In process

13. Certification
- No certification or other requirements for granting privileges for any provider including those working in ED.

15. Moderate Sedation
- Criteria developed and approved by medical staff (GOOD!)
- From Jeanne, “All ER physicians (the only ones that had privileges for conscious sedation) were sent the packet and a memo to complete and return. I have received three of the five. One is out of town and the other one we are contacting again today.”
Background
Why are you talking about it?
Why are you choosing to work on this issue?

Current Condition
Where things stand today
-What’s the problem with that, with where we stand?
-What is the actual symptom that requires action?
Show visually – parent charts, graphs, etc.

Target(s)/Goal(s)
The specific outcome required
-What is the specific change you want to accomplish?
-How will you measure success?

Analysis
-Why are we experiencing the problem?
-What constraints prevent us from reaching the goal?
Choose the simplest problem-solving tool:
-Five whys - Fishbone - Other tools

A3 WORKSHEET
Proposed Countermeasure(s)
Your proposal to reach goal – target.
-What alternatives should be considered?
-How will you choose among the options – Decision criteria?
How will your recommended countermeasures impact the root cause to change current situation and achieve target?

Implementation Plan
A chart or table that shows actions/outcomes, timeline and responsibilities.
May include implementation plan
-Who will do what, when and how?
Indicators of performance of progress
-How will we know if actions worked?
-What are the critical few, visual, most important measures?

Follow-Up
Remaining issues that can be anticipated.
-Any failure modes to watch out for? Unintended consequences.
-Ongoing PDCA
## Mountain Communities Healthcare District

### Policies Completing the Internal Approval Process

**September 24, 2015**

<table>
<thead>
<tr>
<th>Policy</th>
<th>Name</th>
<th>Approval Date</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Drill Procedure v 2</td>
<td>Nordlund</td>
<td>9/23/2015</td>
<td>Rodgers</td>
</tr>
<tr>
<td>Auditor v 1</td>
<td>Williams</td>
<td>9/22/2015</td>
<td>Rodgers</td>
</tr>
<tr>
<td>Code of Conduct 2 (v1)</td>
<td>Williams</td>
<td>9/22/2015</td>
<td>Rodgers</td>
</tr>
<tr>
<td>Compliance Officer 2 (D) [v1]</td>
<td>Williams</td>
<td>9/22/2015</td>
<td>Rodgers</td>
</tr>
<tr>
<td>Ethics Representative (v5)</td>
<td>Williams</td>
<td>9/22/2015</td>
<td>Rodgers</td>
</tr>
<tr>
<td>Fraud and Abuse (v2)</td>
<td>Williams</td>
<td>9/22/2015</td>
<td>Rodgers</td>
</tr>
<tr>
<td>Whistleblower Protection (v1)</td>
<td>Williams</td>
<td>9/22/2015</td>
<td>Rodgers</td>
</tr>
</tbody>
</table>

All policies are maintained within the Navex PolicyTech system which is a secure, centralized and auditable repository. Each approver listed above has electronically approved each document inside Navex which ensures audit tracking and accountability for all documents. The above is a listing of policies that have completed the District’s policy and procedure review and approval process.

---

Aaron Rogers, Chief Executive Officer  
On Behalf of the Board of Directors

---

Jerry Cousins, Board President  
On Behalf of the Board of Directors
MOUNTAIN COMMUNITIES HEALTHCARE DISTRICT
MEETING MINUTES
“SPECIAL” BOARD MEETING
August 19, 2015
Trinity County Library
Weaverville CA

DISTRICT BOARD MEMBERS

GERALD BRASUELL  DERO FORSLUND  JERRY H. COUSINS  LYNN JUNGWIRTH  FRANCIS MOORE
Vice-President  Clerk  President  Treasurer  Member

Note: These minutes contain a description for each item to be considered. Supporting documentation is available in the public packet at the Board meeting or at the Administrative Office at Trinity Hospital.

District Board Members Present:
Gerald Brasuell, Vice-President
Jerry H. Cousins, President
Dero Forslund, Clerk
Francis Moore

District Board Members Absent:
Lynn Jungwirth, Treasurer

Staff Present:
Aaron Rogers, CEO
Jeanne Silvers, Executive Assistant
Hollie Malloy, Manager – Trinity Community Health Clinic

10:00 AM CALLS MEETING TO ORDER IN OPEN SESSION

Public Input - None

Announcement of Agency Negotiator Designees – President Cousins announced that the agency negotiator if Aaron Rogers and/or Jerry Cousins.

Close Public Session

Closed Session
The Board entered into closed session at 10:03 AM on the following:

- CONFERENCE WITH REAL PROPERTY NEGOTIATORS
  Government Code Section 54956.8
  Property: APN – 001-040-02; 001-040-57; 001-040-56; 001-040-58; 024-150-31; 024-150-29
  Agency negotiator: Aaron Rogers and/or Jerry Cousins
  Negotiating parties: Nancy Morris Adrian
  Under negotiation: Terms and Price
The Board came out of Closed Session at 10:34 AM and immediately reconvened in Open Session.

President Cousins reported that the Board reviewed options and through a motion, second and unanimously approved authorizing the CEO to enter into negotiations for the purchase above mentioned property.

Adjourn:
There being no further business, the meeting was adjourned at 10:35 AM.

Dero Forslund, Clerk of the Board
Mountain Communities Healthcare District
6:03 PM CALLS MEETING TO ORDER IN OPEN SESSION

Report from Closed Session on July 29, 2015

Closed Session
The Board entered into closed session at 7:42 pm on the following:

- MEDICAL STAFF PRIVILEGES
  Government Code Section 54962; Health and Safety Code Section 1461

- PUBLIC EMPLOYEE PERFORMANCE EVALUATION
  Government Code Section 54957 – Public Employee
  Title: Chief Executive Officer
Mountain Communities Healthcare District
Board of Directors Board Meeting
August 26, 2015

- LABOR NEGOTIATIONS
  Government Code Section 54957.6
  Designated Representative: Mark Vegh/Aaron Rogers
  Employee Organization: Professional Group

- CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION (Subdivision (a) of Section 54956.9) California Department of Fair Employment and Housing. Name of Case: Menovske/Trinity Hospital et al: Case No. 430236-137546

- CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION (Subdivision (a) of Section 54956.9) Name of Case: Pamela Balsly vs. Mountain Communities Healthcare District: Case No. 2:13-cv-02334-GEB-CMK

The Board came out of Closed Session at 7:42 pm and immediately reconvened in Open Session.

President Cousins reported that the Board reviewed the recommended actions on Medical Staff Privileges. For each applicant the following information has been reviewed and/or verified: Privilege List, NPDB Report, and AMA Profile, peer references and verifications of staff privileges at other facility. Items verified were Liability Insurance Coverage, Licenses, Certifications, and the Medicare exclusion list was checked.

On motion of Director Jungwirth seconded by Director Brasuell approves the following appointments/reappointments/resignations from the Medical Staff pending completion of signatures by Daniel Harwood, MD, Chief of Staff.

Appointments/Reappointments:

<table>
<thead>
<tr>
<th>Name</th>
<th>Reappointment/Consulting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norman Bell, MD</td>
<td>Reappointment/Professional</td>
</tr>
<tr>
<td>Barbara Wertz, CRNA</td>
<td>Reappointment/Consulting</td>
</tr>
<tr>
<td>Shahin Korangy, MD</td>
<td>Reappointment/Consulting</td>
</tr>
<tr>
<td>Richard Hodge, MD</td>
<td>Reappointment/Consulting</td>
</tr>
<tr>
<td>Amy Sherman, MD</td>
<td>Reappointment/Consulting</td>
</tr>
<tr>
<td>Christopher Govea, MD</td>
<td>Reappointment/Consulting</td>
</tr>
<tr>
<td>Ray Miller, MD</td>
<td>Appointment/Provisional</td>
</tr>
</tbody>
</table>

Resignations

- James Dunn, MD (MDI)
- Elizabeth Mulkerrin, CRNA

The motion passed with the following voice vote:

Ayes: Dero Forslund; Gerald Brasuell; Jerry Cousins; Lynn Jungwirth; Francis Moore
Noes: None
Absent: None
Abstain: None
President Cousins reported that there were no discussions in regards to “Public Employee Performance Evaluation”.

President Cousins reported that the Board met with the Districts representative and there was no action taken.

President Cousins reported that the Board discussed two cases of existing litigation and there was no action taken on the “Menovske/Trinity Hospital et al: Case No. 430236-137546.

On a motion of Director Forslund and seconded by Director Brasuell the Chief Executive Officer was given direction and parameters for negotiations in the case of Pamela Balsly vs Mountain Communities Healthcare District: Case No. 2:13-cv-02334-GEB-CMK.

The motion passed with the following voice vote:

Ayes: Dero Forslund; Gerald Brasuell; Jerry Cousins; Lynn Jungwirth; Francis Moore
Noes: None
Absent: None
Abstain: None

Public Input - None

Reports

Medical Staff Report
Received written report from Daniel Harwood, MD, Chief of Staff/Donald Krouse, MD, Vice Chief of Staff regarding activities of the Trinity Hospital Medical Staff.

Chief Executive Officer
Received written /verbal report from Aaron Rogers, CEO on the current operations of the hospital. Other items discussed in addition to the written report were:
- Status of the HVAC construction project was reviewed. There has not been a decision as to whether the emergency room will have to be moved in order to complete the project.

Chief Financial Officer
Received written /verbal report from Jon Marshall, CFO and Jennifer Van Matre, Director of Finance, on the current financial status and current status of revenue cycle management and accounts receivable. Other items discussed in addition to the written report were:
- Gerald Brasuell reported that the Finance Committee is pleased with the direction that the District is headed.

Chief Nursing Officer
Received written/verbal report from Judy Nordlund, RN, Chief Nursing Officer on the current status of the nursing departments.

Quality Improvement
Received written/verbal report from Sarah Cordtz, RN, Coordinator, Q/RM on the current status of the Quality Program.
Mountain Communities Healthcare District  
Board of Directors Board Meeting  
August 26, 2015

- MCHD Quarterly Checklist of ongoing professional practice evaluations was reviewed and staff reported that some of the reviews have not been completed. Staff is requesting that delinquent reviews are completed and future reviews are done in a timely manner. Staff will report to the medical staff and MCHD Board on a quarterly basis statistics regarding completed ongoing professional practice evaluations.

**Consent Agenda**
All matters listed under the Consent Agenda, are considered by the Board to be routine, and will be enacted by one motion in the form listed below. There will be no separate discussion of these items unless a request for discussion is made prior to the time the Board votes on the motion to approve.

On Motion of Director Forslund seconded by Director Jungwirth approves the following consent items:

a. Minutes from July 29, 2015  
b. Minutes from July 29, 2015  
c. Minutes from August 19, 2015  
d. Policies (see attached)

The motion passed with the following voice vote:

Ayes: Dero Forshmd; Gerald Brasuell; Lynn Ji.mgwirth  
Noes: None  
Absent: Jerry Cousins; Francis Moore  
Abstain: None

**Discussion Items**

a. Parcel Tax

The Board reviewed financial status of the District and requested a pro forma of financial status. There is no information that has proven that the parcel tax is not needed for the future. The District is heading in the right direction and if the growth continues then at some point the District would have the ability to lower the parcel tax.

d. Clinic – Community Outreach

Hollie Malloy has submitted updated information and application to increase the HPSA score for the Weaverville are. Unofficially the score will be upgraded to a 19 which would allow for loan repayment for practitioners who would come to work for the District.

Michael Novak reported that the Weaverville clinic is expanding telemedicine services. They say 55 patients last month. Partnership is offering incentives for the clinic to offer additional specialties through the telemedicine program. The Weaverville clinic will be receiving $10,000 for adding two new specialties (endocrinology and neurology) to the telemedicine program.
Michael Novak as assumed the duties of the Director of Clinical Services for the clinics. He reported that he will be working together with the managers of each clinic on time management, increasing telemedicine services, referral processes, upgrading telemedicine equipment, and the use of new providers at both clinics.

**Action Items**

a. Items removed from the Consent Agenda

Minutes from August 19, 2015 will be presented for approval at the September meeting.

b. Consider approval of Resolution #2015-7 “Approve Authorized Signatures for Securing a Loan from Optum Bank”

On Motion of Director Jungwirth seconded by Director Forslund approves Resolution #2015-7 “Approve Authorized Signatures for Securing a Loan from Optum Bank”

The motion passed with the following a roll call vote:

Ayes: Dero Forslund; Gerald Brasuell; Lynn Jungwirth
Noes: None
Absent: Jerry Cousins; Francis Moore
Abstain: None

**Board Reports**

Director Forslund reported that there were 299 funds available for fiber optic connections. There was a proposal by Del Norte and Trinity County and the Indian reservation submitted several years ago.

Announcement of Designated Representatives for Closed Session item “Salaries and Benefits”. Representative is Aaron Rogers, CEO

**Close Public Session**

**Closed Session**

The Board entered into closed session at 7:25 pm on the following:

- MEDICAL STAFF PRIVILEGES
  Government Code Section 54962; Health and Safety Code Section 1461
- QUALITY IMPROVEMENT/RISK MANAGEMENT
  Government Code Section 54962; Health and Safety Code Section 32155
- SALARIES AND BENEFITS
  Government Code Section 54957.6
  Designated Representatives: Aaron Rogers
Mountain Communities Healthcare District
Board of Directors Board Meeting
August 26, 2015

The Board came out of Closed Session at 7:50 pm and immediately reconvened in Open Session.

Vice President Brasuell reported that the Board reviewed the recommended actions on Medical Staff Privileges. For each applicant the following information has been reviewed and/or verified: Privilege List, NPDB Report, and AMA Profile, peer references and verifications of staff privileges at other facility. Items verified were Liability Insurance Coverage, Licenses, Certifications, and the Medicare exclusion list was checked.

On motion of Director Jungwirth seconded by Director Forslund approves the following reappointments upon the recommendation from the Medical Staff.

Appointments/Reappointments:

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam Attoun, DO</td>
<td>Consulting</td>
<td>Radiology</td>
</tr>
<tr>
<td>Ewa Bauer, MD</td>
<td>Consulting</td>
<td>Radiology</td>
</tr>
<tr>
<td>Thomas Bey, MD</td>
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<td>Radiology</td>
</tr>
<tr>
<td>Danford Bickmore, MD</td>
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<td>Radiology</td>
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<tr>
<td>Don Chin, MD</td>
<td>Consulting</td>
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<tr>
<td>Reed Grabow, MD</td>
<td>Consulting</td>
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<tr>
<td>Patricia Hadley, MD</td>
<td>Consulting</td>
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<tr>
<td>Stephen Hofkin, MD</td>
<td>Consulting</td>
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<td>Jon Hohmeister, MD</td>
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<tr>
<td>Irwin Maier, MD</td>
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<tr>
<td>Sander Saidman, MD</td>
<td>Consulting</td>
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<tr>
<td>David Swanson, MD</td>
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<tr>
<td>Rhonda Wyatt, MD</td>
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<td>Radiology</td>
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<tr>
<td>Henry Edelstein, MD</td>
<td>Active</td>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Randall Meredith, MD</td>
<td>Courtesy</td>
<td>Family Medicine</td>
</tr>
<tr>
<td>Julia Mooney, MD</td>
<td>Consulting</td>
<td>Pathology</td>
</tr>
<tr>
<td>Steve Maron, MD</td>
<td>Consulting</td>
<td>Emergency Medicine</td>
</tr>
</tbody>
</table>

The motion passed with the following voice vote:

Ayes: Dero Forslund; Gerald Brasuell; Lynn Jungwirth
Noes: None
Absent: Jerry Cousins; Francis Moore
Abstain: None

Vice President Brasuell reported that the Board thoroughly reviewed the quality data presented and there no action was taken.

Vice President Brasuell reported that the Board reviewed options for salary increases and possible employee bonuses and through a motion, second and unanimously approved the option for an employee bonus pending approval by the attorney for the District.
Adjourn:
There being no further business, the meeting was adjourned at 7:52 p.m.

Dero Forslund, Clerk of the Board
Mountain Communities Healthcare District
Mountain Communities Healthcare District

MEDICAL STAFF ONGOING PROFESSIONAL PERFORMANCE EVALUATION (OPPE) PLAN

POLICY:

Mountain Communities Healthcare District Medical Staff and the Board of Directors are responsible for the quality of care provided to the patients seen throughout the District including the hospital and the clinics. Therefore it is the policy of the District to support the medical staff OPPE process. The OPPE process is a nonbiased activity performed by the appropriate practitioners to measure, assess and, where necessary, improve performance on an organization-wide basis.

DEFINITIONS:

“OPPE” is the evaluation of the quality of care provided by individual practitioners both medical staff and professional staff members, including identification of opportunities to improve care by individuals with the appropriate subject matter expertise to make this evaluation.

A “peer” is defined as an individual practicing in the same profession. The level of subject matter expertise required to provide meaningful evaluation of care will determine what “practicing in the same profession” means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer would be considered an individual well trained in that surgical specialty. For all OPPE performed by the medical staff, the Medical Executive Committee shall determine the degree of subject matter expertise required for a provider to be considered a peer.

PROCEDURE:

OPPE Program Components

Definitions of circumstances requiring OPPE are listed below. This list can be revised at any time, as deemed appropriate by the Medical Staff Executive Committee. Circumstances requiring review may include:

Emergency Department
- Patient returned to ED within 48 hours of admission
- Death in ED
- Trauma patient who is hospitalized
- Patient hospitalized within 72 hours of ED visit
- Death within 48 hours of admission
- Code Blue
- AMA
- Response time (more than 10 minutes for cardiac/trauma and 30 minutes for all other cases)
- Transfer
- Random Review (10%)
Medical

- All Deaths
- Hemorrhages unrelated to admitting diagnosis
- Neurological deficit present on discharge that was not present on admission
- Transfers to acute care facility (within 24 hours of admission)
- Unexpected complications in patient condition and/or care or treatment, including those that result in major permanent loss of function, not related to the natural course of the patient's illness or underlying condition
- Pediatric Admission
- AMA
- Readmissions within 48 hours
- Random 10%

Anesthesia

- Random 10% review

Surgical/Anesthesia

- Dehiscence: any return of the patient to surgery for wound closure. This does not include those patients scheduled for delayed closure
- Death during or within 24 hours of surgery.
- Unplanned return to surgery within the same admission
- Unplanned removal of injury requiring repair of an organ or part of an organ during an operative procedure
- Myocardial infarction within 48 hours of operative procedure
- Anesthesia related problems: aspiration, unplanned ventilator, re-intubation within 24 hours of extubation, difficult intubation
- Anesthesia occurrence: prolonged recovery room stay,
- Any abnormal reaction during or after a procedure, such as: asystole, fibrillation, arrests, hemiplegia, stroke, hematoma, seroma, hemorrhage, pneumothorax
- Wrong site/wrong patient
- Post-operative complications
- Surgical/Tissue Correlation
- Surgical Reviews - 10% random reviews and traumas (to be reviewed by outside reviewer)

Other Reviews

- Moderate to severe adverse drug reactions
- Transfusion reactions.
- Patient complaints and/or grievances regarding a medical staff member or members and those patient complaints or grievances related to medical staff management of care rendered
- Staff complaints, grievances or concerns regarding a medical staff member or members related to the management of patient care and/or the disruption of unit function.
- Utilization issues in regard to hospital admission and appropriateness of resource use.
• Iatrogenic events, i.e.; a condition or state of ill health caused by medical treatment.
• Appropriateness of blood and blood components.
• Appropriateness, timeliness, completion and legibility of medical record content.
• Disease specific defined indicators, as established and approved by the Medical Staff Executive Committee.
• Sentinel events or "near misses" identified during concurrent or retrospective review.
• All "Codes"

Medical Clinics
• Clinic reviews – 10% random reviews, complaints, possible litigations as well as variance from the pain management protocols are reviewed for all physicians/practitioners

Any staff member may forward issues for case review to the medical staff by completing a "Request for Chart/Case Review" and submitting the completed form to the Medical Staff Office.

Shasta Pathology
• Quality improvement statistics are completed by Shasta Pathology including:
  ▪ All cases where a frozen section diagnosis is rendered are compared with the final diagnosis for agreement/discrepancy.

VRAD
• Statistics on re-reads are completed by Virtual Radiology and submitted to MCHD on a quarterly basis.
• MCHD will review the preliminary CT reports for completion within 60 minutes and whether the preliminary report submitted agrees with final report submitted by MDI. This information will be completed on a quarterly basis.

MDI
• Statistics on re-reads are completed by MDI and submitted to MCHD on a quarterly basis.
• STAT reports are reviewed for timeliness

Clinicians Telemed
• 10% of charts will be submitted for outside review quarterly.

Teleconnect Therapies
• 10% of charts will be submitted for outside review quarterly.

OPPE process participants:

For the purposes of the OPPE program, a practitioner shall not be involved in his/her case being reviewed. Opinions from other attendees may be offered and considered, regarding specific issues related to the management of the case under review if these individuals are members of the Medical Staff.
Selection of OPPE panels for specific circumstances:

OPPE panels may be selected in certain circumstances when additional consideration is necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.

OPPE activity time frames:

Cases forwarded to the medical staff are to be reviewed within one month of identification of the cases. Cases determined by the medical staff reviewer not to require immediate review will undergo the medical record completion process prior to referral to committee, but at no time shall the referral be greater than a two month time period from issue identification to medical staff OPPE.

Cases are identified on a concurrent basis during routine quality and utilization review case management activities. Those cases requiring immediate action will be referred to the medical staff leadership for determination. Cases determined to require immediate committee review by the medical staff committees reviewer would be referred to the Medical Executive Committee within the month.

Circumstances which may require external OPPE:

The external OPPE will be completed by a qualified entity.

Circumstances that may require external OPPE, but may not be limited to:

- Need for specialty review when there are no medical staff members of the institution with the identified specialty within the organization.
- The individual whose case is under review requests an external OPPE.
- The Medical Executive Committee may request an external review.
- When dealing with the potential for litigation.
- When a medical staff member requests permission to utilize new technology or perform a procedure new to this organization and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- When the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring.

Participation in the OPPE process by the practitioner whose performance is under review:

The individual whose case is under review has the right to present his/her information regarding care management to the Medical Executive Committee.
The Medical Staff Coordinator shall notify the individual practitioner of case(s) being reviewed, including the medical record number, date of occurrence, and the reason for the review. After all necessary information is available for review, the practitioner may, at their discretion, attend a committee meeting to address the case. Upon completion of the review, the Medical Staff Executive Committee will send a final determination letter to the practitioner advising of the outcome of their review. In a case of immediate referral to the committee, the Medical Staff Coordinator will notify the individual whose case is under review and the reason for review.

**OPPE PROGRAM METHODOLOGY**

To provide for an effectively functioning OPPE process, the following program methodology will be conducted:

The OPPE program is consistent. All cases referred for OPPE shall follow the OPPE program components listed above.

- Time frames are adhered to in a reasonable fashion. All cases referred for OPPE shall be reviewed within the time frames as listed above. In those instances where OPPE falls out of the required time frames (medical record incomplete, practitioner under review is unavailable, reviewing committee rescheduling, etc.) the reasons for delay will be documented in the OPPE minutes. All efforts will be made to complete the OPPE process as soon as practicable within the confines of the delay.

- All cases undergoing OPPE will have documented rationale for the conclusion made by the reviewer(s). Rationale must be based on the reason the case was reviewed and supported by current clinical practice, practice guidelines and/or literature.

- OPPE is balanced. All opinions regarding medical management, including minority opinions, of the case under review will be considered in the ultimate determination of the case. This includes information and opinions from the individual whose case is under review.

Results of OPPE are utilized at time of medical staff reappointment and kept in a locked file in the strictest confidentiality:

- Results of OPPE activities are available at time of medical staff reappointment to provide for practitioner specific appraisal of competency and renewal of clinical privileges. A practitioner specific performance profile is completed and forwarded in the Credentials file to the Medical Executive Committee at the time of reappointment consideration.

- The OPPE program is an ongoing component of the Medical Executive Committee.
The policies and procedures set forth in this manual are applicable to Virtual Radiologic Professionals, LLC ("VRP") and Virtual Radiologic Corporation ("VRC"), to the extent that VRC performs managerial and administrative functions for VRP. VRP and VRC expressly acknowledge and agree that VRC does not exercise clinical or professional judgment or oversight with respect to VRP physicians, and nothing in these medical practice bylaws (the "Bylaws" or the "VRP Bylaws") shall be construed to the contrary.

The information contained in this document is the proprietary and sole property of VRP, VRC, and their affiliates. Use, duplication, or dissemination is subject to prior written permission of VRC. This information may not be used by or disclosed to others for any purpose except as specifically authorized in writing by VRC. By accepting this document, the recipient agrees that neither this document nor the information disclosed herein nor any part thereof shall be reproduced or transferred to other documents or used or disclosed to others for any purpose except as specifically authorized in writing by VRC.

VRP Bylaws revised and updated since VRP Inception in June 2004.

Current Version: May 2014
VRad Medical Practice Bylaws
It is Virtual Radiologic’s (vRad) policy to process all applications for staff appointment and clinical privileges consistent with our Medical Staff Bylaws and Credentialing Policy.

1. **Pre-Application.** Each physician interested in seeking clinical privileges shall complete a Physician Information Request form (PIR), submit a current CV and request that two letters of recommendation be sent to vRad by physicians who are in the same discipline as the applicant. vRad’s Physician Services Department will review the completed form and other documents, including but not limited to AMA, NPDB, FSMB and a background check, to make a preliminary determination of the applicant’s suitability for appointment. The preliminary determination will be made based upon company needs.

2. **Application.** All applications for appointment and privileges shall be signed by the applicant using forms designated by Physician Services policies and procedures. The application requires the provision and disclosure of detailed information regarding the applicant’s training, experience, professional behavior, character, competence and general qualification for clinical privileges, including the Delineation of Privileges. Three current, professional references from the same discipline are also a required component of all applications.

3. **Interviews.** The applicant shall be interviewed by current members of the Medical Staff and administration:
   a. Vice President of Operations
   b. vRad Medical Director
   c. Others as requested

4. **Primary Source Verification.** The Credentialing Staff shall seek to primary source verify all of the information in the application and obtain any other information and / or documentation relating to the applicant’s medical competency, including but not limited to:
   a. Educational background, including Premedical education, Medical School, Internship, Residency, and Fellowship
   b. Specialty board certification(s)
   c. Malpractice coverage and claims history
   d. Three Professional references, from physicians within the same professional discipline.
   e. Professional work history, including all employment, locum tenens, moonlighting, and hospital affiliations.
f. State license verifications

In addition to these documents, vRad also requires that a Health and Physical and PPD test be completed annually.

5. Burden of Proof. The applicant shall have the positive burden of proof to demonstrate that he/she is qualified for privileges. The applicant's refusal or failure to fully complete an application in the manner and form required, or to provide information or supporting documentation upon request, or to be interviewed shall disqualify the applicant from obtaining privileges. It shall not be required or expected that the Physician Services and/or vRad shall have a burden or responsibility to prove or produce evidence that the applicant is qualified.

6. Review of Credentials. The completed credentials file shall be transmitted to the vRad Credentialing Committee within 30 days of the receipt of the completed application for review and evaluation. The applicant may be required to produce further information or documentation which the Credentialing Committee determines is necessary for an adequate evaluation of the applicant's eligibility for privileges. The same shall be considered a component of the application. If the Credentialing Committee is unable, due to lack of information, to make its recommendation to the board within 5 days of the Committee's receipt of the file, the Credentialing Committee shall notify the applicant in writing of the delay, explaining the reasons and asking the applicant to assist the Committee by providing any additional items that Committee needs in order to reach a decision regarding the applicant's file, and make a recommendation to vRad Board. If the applicant fails to respond or provide the requested information within 15 days of the applicant's receipt of the Committee's request, the application shall be deemed withdrawn.

7. Consent of Applicant. By filing out an application for privileges, and notwithstanding the absence of an express consent, the applicant shall be deemed to have consented to the following:

a. vRad representatives may consult with members of other Medical Staff offices at which the applicant may have had membership of privileges, and they may give candid evaluations and opinions regarding the applicant.

b. vRad representatives may consult with anyone who may have information regarding the applicant's qualifications for privileges, and they may give candid evaluations and opinions regarding him or her.

c. vRad representatives may obtain and inspect any records and documents material to the evaluation of the applicant's qualification for privileges. Any and all interviews conducted pursuant to this
subsection may be reported in writing and such reports may be included with the application. A summary of copies of any and all documents inspected pursuant to this subsection shall be included with and a component of the application.

8. **Appointment.** Within five days of completion of all components of the application, the complete credentials file shall be reviewed by the Credentialing Committee and a written report of the review and evaluation shall be sent to the vRad Credentialing Board, with recommendations from the Credentialing Committee. The Board will make recommendations to grant or deny privileges to vRad's Medical Director.

9. **Review of Clinical Privileges.** The Medical Director will review the applicant’s request for clinical privileges, which shall include reasonable documented evidence of the applicant’s current ability to perform the requested privileges and shall determine whether privileges should be granted or denied. The Medical Director shall review the applicant’s number of reads on the Delineation of Privileges form to ensure that the applicant meets vRad's minimums in all modalities.

10. **Appointment.** The Medical Director will sign the Delineation of Privileges.

11. **Reappointment.** All reappointment applications shall be reviewed and signed by the physician every two years. The following information will be obtained / verified:

   a. Any non-static information since the last appointment for privileges was made will be primary source verified again.
   b. NPDB proactive disclosure service enrollment is confirmed.
   c. 3 Professional references are required from physicians in the same professional discipline.
   d. VRP application and Delineation of Privileges, signed
   e. Health and Physical form, including PPD test results, within the past year.
   f. All state license verifications are primary source verified again
   g. All malpractice coverage and claims history is primary source verified again.
   h. The following reports are run: AMA, FSMB, and a Background check.

12. **Announcement.** The Director of Physician Services will sign the privilege letter, and a member of the Physician Services team will send a letter to the applicant and various vRad Departments, announcing the privileges.
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6300 Policy – Privilege Categories

POLICY

Any physician providing medical services to VRP must have appropriate clinical privileges. VRP may grant to a physician Associate Staff, Consulting, or Provisional clinical privileges only if the physician has met the requirements for the privilege type described in Policies 6301–6307 of this Manual.

PROCEDURE

   VRP hereby establishes the following classes of clinical privileges:
   I. Associate Staff, as more fully described in Policy 6301.
   II. Consulting Privileges, as more fully described in Policy 6306.
   III. Provisional Privileges, as more fully described in Policy 6307.

   No physician shall provide medical services to VRP, its customers, or its customers' clients before VRP has granted the physician clinical privileges suitable for the medical services that the physician will provide, unless such physician is an independent contractor providing on-site services to the client or customer via a subcontract between VRP or one of its affiliated companies and a locum tenens physician or placement agency (or similar company) and the customer or client assumes complete responsibility for credential verification and privileging of the physician for on-site services. In either case, the subcontract shall include performance indicators consistent with Joint Commission Standard for Ambulatory Care Facilities LD.04.03.09 or any subsequent revision to or replacement of such standard.

2. Scope of Privileges.
   The Privileging Board shall: (a) determine the types of medical services allowed under each class of privilege; (b) communicate the extent and limitations of each class of privileges to the class members, as required; and (c) develop and monitor safeguards to ensure that physicians operate within the bounds of their granted privileges. The Privileging Board may also grant a particular physician limited or extended privileges on a case-by-case basis, provided such special privileges are granted in compliance with minimum Joint Commission requirements for credentialing at Ambulatory Care facilities found at HR.02.03.01, as may be amended from time to time.
3. **Limitation or Removal of Privileges.**

The Privileging Board may limit, restrict, or suspend clinical privileges of any physician if the Privileging Board determines that limitation, suspension, or removal of privileges would be in the best interests of patient care, or if the Privileging Board discovers non-compliance with these Policies or other VRP rules or procedures that have been communicated to the physician.
6301 Policy – Associate Staff Privileges

POLICY
VRP will consider a physician for Associate Staff privileges at VRP following a determination of need, an examination of the physician’s competency, personal interviews with the physician, and the physician’s compliance with the requirements of this Policy 6301.

PROCEDURE
1. Pre-application.
   Each of the following items shall be completed before a physician ("Candidate") will be considered for Associate Staff privileges under this Policy 6301.

   a. The Privileging Board shall determine if the addition of the Candidate to VRP’s roster of physicians is necessary to meet its current or anticipated customer obligations.

   b. VRP shall provide, and the Candidate shall complete and return, a fully completed physician information request form (PIR). VRC’s Director of Physician Services, or the person he/she designates, shall review the PIR to identify any event in the Candidates’ history that may lead to license or credential denials at one or more customer sites, and to determine if the Candidate may otherwise be unsuitable for VRP’s environment. In particular, any candidate with one of the following conditions in their file shall be reviewed by the Privileging Board before the Candidate will be allowed beyond the pre-application stage:

      (1) Three or more malpractice cases in which payment was made on behalf of physician, in an aggregate amount of at least $500,000;

      (2) Any single malpractice case in which payment was made on behalf of physician in the amount of at least $750,000; or

      (3) Three or more currently open malpractice cases.

   The Privileging Board may from time to time specify other conditions that require its special review, and such other conditions shall be communicated to VRC’s Director of Physician Services and the Credentialing Board (as defined in Policy 6303). The Credentialing Board shall record the new requirement in the meeting minutes of its next meeting.

   c. The Candidate shall complete a performance test (an “Imaging Interpretation Review”) as directed by the Privileging Board. The Privileging Board shall direct the creation and periodic review and revision, as appropriate, of the testing materials, shall review all test results, and shall periodically re-evaluate the minimum score required.
d. The Candidate shall present himself or herself for in-person interviews or via an acceptable alternative, including, but not limited to, video conference, with at least three members of VRP’s physician candidate review team, unless waived by the Privileging Board. VRP’s physician candidate review team means the individuals holding the following positions: VRP’s President, any Medical Director, the Chief Medical Officer, or their respective designees, and the Director of Medical Services for VRC. All individuals required to conduct an interview should complete a written report regarding the interviewer’s impressions of the Candidate and make the report available to other interviewers.


f. The Privileging Board shall make a final decision if the Candidate will proceed to the application stage; provided, however, that such review shall take into consideration the interview reports, the completed PIR, performance test results, and any other information provided by, or known about, the Candidate.

2. Application.
Each Candidate who successfully completes the pre-application stage may apply for Associate Staff privileges (each, an “Applicant”) under this policy. To initiate the application process, the Applicant must complete VRP’s application for such privileges and provide any additional information requested by VRP or VRC within a reasonable amount of time, as determined by VRP or VRC and communicated to Applicant. At a minimum, the completed application must disclose:

a. Each jurisdiction in which the Applicant holds, or has held, a license to provide medical services.

b. Complete details regarding the Applicant’s medical education and training. The Applicant must provide information regarding all medical education and training, even if it is unrelated to the duties associated with the requested privileges.

c. Health conditions that would hinder the Applicant’s performance of the duties associated with the requested privileges.

d. An explanation of any gap in work or medical schooling greater than 30 days.

e. All special medical certifications, registrations, or licenses held by the Applicant. If an Applicant is requesting privileges to perform radiology, the Applicant shall provide proof of certification by the American Board of Radiology (“ABR”), or the American
Osteopathic Board of Radiology ("AOBR"), or present other satisfactory evidence of education and expertise consistent with the anticipated services the physician will perform if granted Associate Staff Privileges.

f. Identification of, and a satisfactory explanation for, any events in the Applicant's history that fall into one of the following categories:
   i. Any adverse event associated with medical licensure in any jurisdiction.
   ii. Any adverse event associated with medical staff membership or clinical privileges.
   iii. Each medical malpractice case that names the Applicant as a defendant, and each medical malpractice matter that was not filed but that resulted in a reported claim on the Applicant's medical malpractice policy.

For purposes of this Policy, an adverse event means loss, restriction, suspension, limitation, relinquishment, probation, challenge, or similar event related to the Applicant's medical license or privileges.

g. Three practicing physicians who can speak to the Applicant's current capability and competence to perform the duties associated with the requested privileges. Each identified physician must be in the same professional discipline as the Applicant.

h. The Applicant's DEA certificate, if available.

i. The details of a general physical examination performed in the last twelve (12) months. The physical examination must confirm the Applicant's physical and mental ability to perform the duties associated with the requested privileges.

j. An authorization form allowing VRP and its agents to verify any information in the Applicant's work, education, medical license, clinical, and personal history.

k. If applicable, a report showing the number and types of procedures performed by the Applicant that fall within the scope of the requested privileges. For radiology privileges, the Applicant must provide a report listing the number of interpretations the Applicant has performed (by modality) in the last two years. If the Applicant's duties will include mammography, the Applicant must provide proof of current compliance with MQSA and ACR requirements for mammography practice.
3. **Completion of Applicant’s File.**

VRC, on behalf of VRP, shall assign one or more Credentialing Specialists to review each submitted application and complete the Applicant’s file. The Credentialing Specialist shall perform the following tasks to complete the Applicant’s file:

a. Obtain at least three letters of reference from physicians who have worked with the Applicant. The letter of reference must include the following information:
   i. The dates when the physician-reference worked with the Applicant;
   ii. Any health condition that the person writing the reference believes may have a bearing on the Applicant’s ability to perform the duties associated with the requested privileges;
   iii. The personal opinion of the person writing the reference regarding the Applicant’s relevant training, experience, and current competence; and
   iv. An assertion that the person generating the reference works in the same professional discipline as the Applicant.

Each request for a letter of reference should be in writing and should specifically ask for information in each of the above areas, and must come directly from the person writing the reference (not through the applicant). If the produced letter of reference only generally recommends the Applicant and does not include each of the above items, VRP shall not consider it to be an acceptable reference without approval by the Privileging Board.

b. Obtain a National Practitioner Data Bank ("NPDB") report for the Applicant directly from the NPDB website. VRC shall request the NPDB report under its own NPDB registration number.

c. Review the Application and work with the Applicant to obtain any missing information, and investigate any conflicting or additional information. Any errors or omissions shall be noted in the Applicant’s file.

d. Verify each of the following items in writing from the source that originally generated the information (primary source verification):
   i. Each state medical license required for the medical work that the Applicant will perform.
   ii. Each item evidencing the medical education and training required for the work that the Applicant will perform. If a particular item of training is duplicative or unrelated to the duties associated with the privileges requested, primary source verification may not be required. Where less than all the education and training materials are verified from the primary source, the Privileging Board (as defined in Section 6 of
iii. Each special certification, registration, or license required for the requested privileges.

iv. All medical facilities where the Applicant holds, or has held, clinical privileges, except that if the Applicant holds, or has held, clinical privileges at more than 25 facilities, only the most recent five facilities and a random sample of at least 20 of the remaining facilities need be verified.

All verifications in this Section 3.d shall be performed by a VRC employee trained on how to conduct such verifications.

e. Verify, or have a contracted agent verify, the Applicant’s identity by live, visual comparison between the Applicant and a government-issued photo identification card (e.g., driver's license or official government passport). If a contracted agent will perform the verification, the agent performing the verification must confirm in writing that the verification has occurred, and the confirmation shall be kept in a VRP file for the Applicant. Unless the agent is an official government-designated notary, the Privileging Board shall approve the agent.

f. Obtain confirmation that the Applicant’s Drug Enforcement Agency (“DEA”) certificate is in good standing.

g. Conduct a background check, including driving record, criminal background check, FACIS search for OIG/GSA sanctions, civil court record search, and credit check (new physicians only).


i. Obtain claim histories for all malpractice insurance covering the Applicant during the past ten years.

j. Obtain a copy of the physician’s American Medical Association (“AMA”) Profile at initial appointment.

k. Review whether Applicant is on pace for completing all continuing medical education requirements for each state where the Applicant holds a license.

l. Completion and verification of each item on Schedule 1 hereto.

m. For radiologists, confirm that the Applicant has read the following minimum number of studies in each specified modality within the past two years:
4. **Credentials Committee Review and Approval.**

VRC's Credentials Committee (as more fully described in Policy 6302) shall promptly review completed Applicant files (each, an "Application"), and approve appropriate Applications for consideration by VRC's Credentialing Board (as more fully described in Policy 6303). If the Credentials Committee determines that further information or documentation is necessary for an adequate evaluation of the Applicant's qualification for privileges, the same shall be considered a required component of the Application, and shall be requested from the Applicant by a Credentialing and/or Licensing Specialist. If the Applicant fails to respond or provide the requested information within 15 calendar days of the Applicant's receipt of a request for the information, VRP may consider the Application withdrawn.

5. **Credentialing Board Review and Recommendation.**

The Credentialing Board shall review each Application approved by the Credentials Committee within 30 days of the Committee's approval. The Credentialing Board shall take one of the following actions after review of the Application:

(a) recommend the Applicant to the Privileging Board for privileges;

(b) recommend to the Privileging Board that the Applicant not be granted privileges;

(c) table the Application for collection of additional information and reconsideration at a later date; or

(d) recommend the Applicant to the Privileging Board for privileges, pending collection of additional minor items. "Minor additional items" shall mean items that in all likelihood will not change the outcome of the Credentialing Board's recommendation.

If the Credentialing Board lacks complete Information and is therefore unable to make a recommendation to the Privileging Board, the Credentialing Board shall direct the Credentials Committee to notify the Applicant in writing of the delay, explaining the reasons
therefore, and requesting any required additional information needed to move the Application forward.

6. **Privilege Determination.**
   VRP's President, any Medical Director, the VRC Chief Medical Officer, or their respective designees (the individual(s) acting in this capacity may be referred to as the “Privileging Board”) shall promptly review each Applicant that the Credentialing Board recommends for consideration, and shall make one of the following determinations:
   
   (a) the Applicant will be granted privileges;
   
   (b) the Applicant will be denied privileges;
   
   (c) more information is required before the Privileging Board can make a privileging decision.

   In making its determination, the Privileging Board shall take into consideration any noteworthy facts or circumstance identified by the Credentialing Board, Credentials Committee, or the Applicant's assigned Credentialing and/or Licensing Specialist.

   If the Privileging Board elects to grant the requested privileges, the Privileging Board shall also delineate in writing the types of procedures the Applicant may perform, and any restrictions thereto. If the Privileging Board elects not to grant privileges, the Privileging Board shall indicate the reasons therefore, and shall provide a copy of its decision to the Credentialing Board for collection of the needed information.

7. **Announcement.**
   VRC's Director of Physician Services or the person he/she designates shall promptly notify the Applicant regarding any privileging decision, or need for additional information.

8. **Reappointment.**
   Privileges granted under this Policy 6301 shall lapse if not renewed before the end of two years from the date of initial grant. Physicians seeking renewal of privileges at the end of two years must apply for reappointment. Each reappointment shall include re-review and re-verification of all items that VRC originally reviewed and verified at the time of initial application; provided, however, that static items need not be re-reviewed. A “static item” is an historical item that by its nature would not have changed since the time of initial appointment (e.g., an already-issued medical degree, post-graduate training).

9. **Post-Grant Requirements for Associate Staff Privileges.**
   A physician granted Associate Staff privileges shall report any of the following events to VRP within two days of the occurrence:
   
   1. Patient death or serious bodily injury related to care provided by the physician.
ii. The initiation of an investigation or other action against the physician related to the physician's medical license in any state or the clinical privileges at any medical institution.

iii. The initiation of an investigation into the physician's possible abuse of drugs or alcohol.

iv. A new medical malpractice action, filed in any jurisdiction, which names the physician as a defendant.

v. The Physician is under investigation by Medicare, Medicaid or any third-party payer.

vi. The Physician is charged with any misdemeanor or felony criminal offense (other than a minor traffic-related violation that is not considered a misdemeanor). Traffic violations involving alcohol or drugs must be reported within the timeframe listed in Section 9 above.

10. Right of Hearing and Review.
A physician granted Associate Staff Privileges shall have a right of hearing and review as allowed under the laws of the State of Minnesota and as further outlined in VRP Policy 6301.01.
6302 Policy – Credentials Committee

POLICY

The Credentials Committee shall oversee and review the work product of Virtual Radiologic Corporation ("VRC") employees and agents who assist in the review of applications for clinical privileges (each, an "Application"). The Committee shall also assist the Credentialing Board (as defined in Policy 6303) and the Privileging Board (as defined in Policy 6301) in identifying information in an Application that may be relevant to a grant or denial of clinical privileges.

PROCEDURE

1. Members.

VRP has established and shall maintain a Credentials Committee (the "Committee") composed of members who meet the following criteria:

(a) The member shall be an employee of the Physician Services group for at least six months; and

(b) The member's addition to the Committee shall have been approved by one or more members of the Physician Services management team.

The Committee shall hold meetings as specified in Section 2 of this policy (each, a "Committee Meeting").

2. Meetings.

Minimum Attendees: A minimum of three (3) members of the Committee must attend each Committee Meeting. VRC's Physician Services Manager for Applications and Privileging or his or her designee should chair each Committee Meeting. If VRC's Physician Services Manager for Applications and Privileging is unable to attend a Committee Meeting, the chairperson shall be the highest ranking, most senior Privileging team member in attendance. A Credentialing and/or Licensing Specialist familiar with the Application shall also attend to present the Application and answer any of the Committee's questions.

VRC's Physician Services Manager for Credentialing and Licensing or the person he/she designates shall promptly schedule a Committee Meeting to review each Application that:

(a) a Credentialing Specialist identifies as complete and ready for approval by the Committee;

(b) a Credentialing Specialist identifies as requiring the Committee's input and assistance due to new or critical information regarding the Application; or

(c) has been pending and un-reviewed by the Committee for three months or more. The Director of Physician Services may also request a Committee Meeting at his/her discretion, or at the request of other VRC departments or at the request of the Privileging Board.
At the end of each Application review, the chairperson for the Committee Meeting shall call for a vote to “pass,” “pass pending additional information,” or “table the Application pending resolution of the incomplete or missing item(s).” The Committee must vote unanimously to approve the Application; otherwise the Application will be tabled, pending resolution of the incomplete or missing item(s). The Committee may also vote to recommend the Board review an Application for denial of privileges, or for reasons the Committee thinks the Board should have knowledge about (e.g., an uncooperative or untruthful Applicant). The Committee may also vote to recommend that privileges not be issued and forward the Application with such recommendation to the Board. A Credentialing Specialist who presents an Application may not also act as a voting member of the Committee.

3. **Reports.**

VRC’s Physician Services Manager for Credentialing and Licensing or the person he/she designates shall generate a report for each Application presented at a Committee Meeting. The report shall contain at least one of the following:

(i) a list of open actions items;

(ii) an approval to send the Application to the Credentialing Board; or

(iii) identification of any missing or noteworthy item in the Application that may affect how the Credentialing Board or the Privileging Board may choose to act.

At a minimum, noteworthy items shall include each item specified in Policy 6301, Section 2.f (concerning adverse actions) that is known. VRC’s Physician Services Manager for Credentialing and Licensing or his or her designee must sign any report that approves an Application for review by the Credentialing Board. All other reports shall be signed by the most senior member present at the Committee Meeting.

4. **Material for Review.**

A VRC Credentialing Specialist familiar with the Application file shall make copies of the Application file available for review by the Committee. The Application file available to the Committee shall contain each document or piece of information obtained to date from or about the individual who is the subject of the Application. The Credentialing Specialist shall highlight or identify missing or open items in the Application, as well as items the Credentialing Specialist thinks merit special attention.
5. **Reappointment.**

For the purposes of reappointment of physicians seeking renewal of their privileges through VRP, the process for the Credentialing Committee meeting outlined in Section 2 of this policy (Policy 6302) shall be waived, and the following procedures shall be used:

a. Two members of the Credentialing Committee shall electronically review the completed Reappointment file for the physician and document any needed changes, updates or additional documentation required prior to presentation of the physician’s file to the Credentialing Board.

b. Following approval of the file by the Credentialing Committee, the standard Board process for reviewing the file shall be conducted as outlined under Policy 6303 of these Bylaws.
6303 Policy – Credentialing Board

POLICY

The Virtual Radiologic Corporation ("VRC") Credentialing Board (the "Credentialing Board") shall develop recommendations for use by the Privileging Board in considering applications for clinical privileges (each an "Application") with VRP. For purposes hereof, each physician with an application before the Credentialing Board is an “Applicant.”

PROCEDURE

1. Members and Attendees.
   VRP has established and shall maintain a Credentialing Board composed of four standing members. A majority of the Credentialing Board members must be present for there to be a quorum. There must be a quorum of three members for the Credentialing Board to make a decision; provided, however, that those Credentialing Board members may identify alternates, subject to approval of the remaining Credentialing Board members, which alternates need not be from the same department as the original member. Further, lack of attendance of an original Credentialing Board member will not affect the actions of the Credentialing Board, provided that a quorum of three or more individuals is present. Credentialing Board members (or alternates) may participate by telephone or similar means and still be considered present; however, such participants must have access to all materials otherwise available at the meeting.

   In addition to the Credentialing Board members, one of the following people must also be present at each Credentialing Board meeting:
   (a) Credentialing Specialist for each Applicant that is familiar with the Applicant’s file; or
   (b) lead Credentialing Specialist for the group primarily responsible for each Applicant.

2. Physicians to be Reviewed.
   The Credentialing Board shall review each Application approved by the Credentials Committee within twenty-one (21) days but in no case more than sixty (60) days of the Committee’s approval of that Application. The Credentialing Board may also review an Application at the Credentials Committee’s request, if the Credentials Committee reasonably determines that an Application requires special action (e.g., uncooperative or untruthful Applicant).
3. Materials to be Presented.
The Credentialing Specialist shall make available to the Credentialing Board all documentation in the Application, as well as the final recommendation from the Credentials Committee. If the Credentialing Board is reviewing a Physician to determine if it should recommend the Applicant for privileges the Credentialing Board shall:

a. Review the Credentials Committee’s approval and comments.

b. Confirm collection of each item requested on the Application for the type of privileges requested. The Credentialing Board shall also review the Applicant’s work timeline to identify any anomalies, errors, negative, or missing items.

c. For Radiologists, review the Physician’s number of reads to confirm compliance with the minimum requirements. If the Applicant does not meet the requirements, a waiver of this requirement to be signed by the Privileging Board will be noted and included in the Applicant’s Credentialing Board packet documents.

d. Review and consider each item specified in Policy 6301, Section 2.f concerning adverse actions that is currently known.

Upon the Credentialing Committee’s recommendation to deny privileges or take special notice of any matters, the Credentialing Board shall consider the above factors (a)–(d) as applies in the circumstances.

3. Record Keeping.
The Director of Physician Services or the person he/she designates shall attend and maintain records for all Credentialing Board meetings. The records shall include all directives and actions taken by the Credentialing Board. All Credentialing Board records shall be made available to the Credentialing Board or the Privileging Board upon request and shall be maintained for the period specified in VRC’s records retention policy for such documents, as then in existence.

All votes by the Credentialing Board require a majority of the present quorum to pass, except that a vote to table consideration of an Application for a later Credentialing Board meeting only requires a single vote.

[Continued on following page]
5. Decision of the Credentialing Board.
Each decision to recommend or not recommend an Applicant for clinical privileges shall be
recorded in the recommendation to the Privileging Board, including the reasons supporting
such recommendation, and shall highlight any noteworthy items in the Applicant’s file.
“Noteworthy” items include, but are not limited to, the following:
• Applicant’s FSMB or NPDB records include negative items.
• The Applicant has omitted or provided inaccurate information to VRP.
• Applicant’s FSMB report shows one or more disciplinary actions.
• The Applicant is unable or unwilling to provide sufficient, cooperative medical
references.
• Any of the items specified in Policy 6301, Section 2.f are currently known.
• The Applicant’s record includes evidence of drug abuse, alcohol abuse or clinical mental
instability in the past five years.

If the Credentialing Board is presented with an Application containing any of the following
items, the Credentialing Board must recommend to the Privileging Board that it deny the
Applicant clinical privileges:
• The Applicant’s failure to pass their medical board exams more than twice.
• The Applicant name appears in an “excluded persons” list maintained by the OIG or
GSA.
• The Applicant’s NPDB report includes two or more negative reports filed by a hospital
for adverse privileging decisions.
• The Applicant has been convicted of a felony.
• The Applicant shows a revocation, denial or probation of any state medical license.

7. Right of Hearing and Review.
A physician granted Associate Staff, Consulting or Provisional Privileges by VRP shall have a
right of hearing and review as allowed under the laws of the State of Minnesota and as
further outlined in VRP Policy 6301.01.

8. Post-Meeting.
The Credentialing Specialist shall send the Credentialing Board’s report and
recommendation for each physician Applicant to the Privileging Board for signature within
21 business days of creation of the report.
6306 Policy – Consulting Privileges

POLICY
VRP will consider granting Consulting privileges to physicians who have met basic competency, licensing and training requirements, and are otherwise in good standing in the medical community.

PROCEDURE

1. Prerequisites.
   Before considering a physician for privileges under this policy, the physician must first present evidence that the physician:
   
   (a) holds a valid state medical license;
   (b) has graduated from an AAMC- or LCME-accredited medical school or holds certification from the Education Commission for Foreign Medical Graduates ("ECFMG"); and
   (c) holds appropriate certifications for the privileges requested or presents other satisfactory evidence of education and expertise consistent with the anticipated services the physician will perform if granted Consulting Privileges, as established by this policy or by the Privileging Board.

VRP shall independently confirm that the physician is in good standing in the medical community by reviewing the Physician’s FSMB and NPDB records, and shall also confirm that the Applicant’s name does not appear on either the Federal Office of Inspector General ("OIG") (currently, www.oig.hhs.gov) or the General Service Administration ("GSA") (currently, www.epis.gov) exclusion lists. If VRP is unable to verify the physician’s current good standing, or the physician is unable to produce requested proof of licensure, training or certification, VRP shall not consider the physician for Consulting Privileges. For purposes of this paragraph, “good standing” means that the physician is not currently:

   (a) subject to a challenge of his/her license or privileges;
   (b) subject to involuntary termination of professional or medical staff membership; or
   (c) subject to involuntary limitation, reduction, denial, or loss of privileges.

In reviewing “good standing,” the Privileging Board will consider previous challenges to the items listed in (a), (b), and (c) above on a case-by-case basis.
Additionally, any candidate with one of the following conditions in their file shall be reviewed by the Privileging Board before the Candidate will be allowed beyond the pre-application stage:

1. Three or more malpractice cases in which payment was made on behalf of physician, in an aggregate amount of at least $500,000;
2. Any single malpractice case in which payment was made on behalf of physician in the amount of at least $750,000; or
3. Three or more currently open malpractice cases.

The Privileging Board may, from time to time, specify other conditions that require its special review, and such other conditions shall be communicated to VRC's Credentialing Board (as defined in Policy 6303). The Credentialing Board shall record the new requirement in the meeting minutes of its next meeting.

2. Application.
Each physician who successfully satisfies the prerequisites may apply for Consulting privileges (each, an "Applicant") under this policy. To initiate the application process, the Applicant must complete VRP's application for such privileges and provide any additional information requested by VRP. At a minimum, the completed application must disclose:

a. Each jurisdiction where the Applicant holds, or has held, a license to provide medical services.

b. Complete details regarding the Applicant’s medical education and training. The Applicant must provide information regarding all medical education and training.

c. Health conditions that would hinder the Applicant’s performance of the duties associated with the requested privileges.

d. All special medical certifications, registrations, or licenses held by the Applicant.

e. Identification of, and an explanation for, any events in the Applicant’s history that fall into one of the following categories:
   i. Any adverse event associated with medical licensure in any jurisdiction.
   ii. Any adverse event associated with medical staff membership or clinical privileges.
   iii. Each medical malpractice case that names the Applicant as a defendant, and each medical malpractice matter that was not filed, but which resulted in a reported claim on the Applicant’s medical malpractice policy.

For purposes of this Policy, an adverse event means loss, restriction, suspension, limitation, relinquishment, probation, challenge, or similar event related to the Applicant’s medical license or privileges.
f. Three practicing physicians who can speak to the Applicant’s current capability and competence to perform the duties associated with the requested privileges. The identified physician must be in the same professional discipline as the Applicant.

g. For radiologists, confirm that the Applicant has read the following minimum number of studies in each specified modality within the past two years:

<table>
<thead>
<tr>
<th>Procedure Type</th>
<th>Minimum Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiography</td>
<td>50</td>
</tr>
<tr>
<td>Computed Tomography (CT)</td>
<td>100</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>50</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>200</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging</td>
<td>20</td>
</tr>
</tbody>
</table>

* If Candidate was granted certification by the ABR or AOBR in the past two years.

The Privileging Board may, at their discretion, waive the required minimum number of studies based on verification and review of the applicant’s combined education and work experience.

If the Applicant’s duties will involve interventional radiology, the report must include the number of each type of interventional procedure that the Applicant has performed in the past two years. If the Applicant’s duties will include mammography, the Applicant must provide proof of current compliance with the MSQA and ACR guidelines for interpreting physicians for mammography practice.

3. **Completion of Applicant’s File.**  
   VRP shall assign one or more Credentialing Specialists to review each submitted application and complete the Applicant’s file. The Credentialing Specialists shall perform the following tasks to complete the Applicant’s file:

a. Obtain at least three letters of reference from physicians who have worked with the Applicant during the last 24 months. The letter of reference must include the following information:

   i. The dates when the physician-reference worked with the Applicant;

   ii. Any health condition that the person writing the reference believes may have a bearing on the Applicant’s ability to perform the duties associated with the requested privileges;

   iii. The personal opinion of the person writing the reference regarding the Applicant’s relevant training, experience, and current competence; and

   iv. An assertion that the person generating the reference works in the same professional discipline as the Applicant.
Each request for a letter of reference should be in writing and should specifically ask for information in each of the above areas, and must come directly from the person writing the reference (not through the applicant). If the produced letter of reference only generally recommends the Applicant and does not include each of the above items, VRP shall consider it to be an acceptable reference without approval by the Privileging Board.

b. Obtain an NPDB report for the Applicant from the NPDB website. VRC shall request the NPDB report under its own NPDB registration number.

c. Review the application and work with the Applicant to obtain any missing information, and Investigate any conflicting or additional information. Any errors or omissions shall be noted in the Applicant's file.

d. Verify each of the following items in writing from the source that originally generated the information (i.e., primary source verification):

   i. Each state medical license required for the medical work that the Applicant will perform.

   ii. Each item evidencing the medical education and training required for the work that the Applicant will perform.

      If a particular item of training is duplicative or unrelated to the duties associated with the privileges requested, primary source verification may not be required. Where less than all the education and training materials are verified from the primary source, the Privileging Board shall determine the sufficiency of the information verified and approve the scope of information collected.

   iii. Each special certification, registration or license required for the requested privileges.

      (**All verifications in this Section 3.d shall be performed by a VRC employee.)

   e. Verify, or have a contracted agent verify, the Applicant's identity by live, visual comparison between the Applicant and a government-issued photo identification card. If a contracted agent will perform the verification, the agent performing the verification must confirm in writing that the verification has occurred, and the confirmation shall be kept in (the VRP) file for the Applicant. Unless the agent is an official government-designated notary, the Privileging Board shall approve use of the agent.

   [Continued on following page]
4. Review and Consideration.

   a. After the Applicant’s file is completed, VRP shall process the application using the procedures specified in Sections 4–8 of VRP Policy 6301.

   b. Locum Tenens Radiology. VRP shall consider granting mammography and/or Interventional radiology privileges to an Applicant requesting such privileges if they also met the following additional criteria:

      i. For general diagnostic radiology, Physician shall meet minimum studies read requirement specified in Policy 6301, Section 3.m.

      ii. For mammography, the Applicant has fulfilled the current requirements established by MSQA and American College of Radiology (“ACR”) for the practice of mammography.

      iii. For adult interventional radiology, the Applicant:

          (1) has completed training for the procedure established by the ACR or the Society of Interventional Radiology (“SIR”);

          (2) has received either Basic Life Support (“BLS”) or Advanced Cardiovascular Life Support (“ACLS”) training that meets American Heart Association Standards; and

          (3) has received training in conscious sedation, as evidenced by post graduate medical training, or certification documents.

5. Post-Grant Requirements for Consulting Privileges.

   A physician who has been granted Consulting Privileges under this policy shall be subject to the following post-grant requirements:

   a. Event-Triggered Review: If the physician provides less than 100% of their work for VRP clients or customers, the physician shall report any of the following events to VRP within 24 hours of the occurrence:

      i. Patient death or serious bodily injury related to care provided by the physician.

      ii. The initiation of an investigation or other action against the physician related to the physician’s medical license in any state or the clinical privileges at any medical institution.

      iii. The initiation of an investigation into the physician’s abuse of drugs or alcohol.

      iv. A new medical malpractice action, filed in any jurisdiction that names the physician as a defendant.

      v. Physician is under investigation by Medicare, Medicaid, or any third-party payer.

      vi. Physician is charged with any misdemeanor or felony criminal offense (other than a non-misdemeanor traffic-related violation). Traffic violations involving alcohol or drugs must also be reported within the timeframe listed in this Section 5.a.
c. **Periodic Review; Privilege Change Review.** VRP shall re-review each physician according to this policy at least every two years, and whenever the physician’s privileges change.

d. **Training.** Each Physician granted Consulting Privileges shall complete VRP’s training for Consulting physicians, and shall sign an acknowledgement confirming completion of such training.

e. **Right of Hearing and Review.** A physician granted Consulting Privileges shall have a right of hearing and review as allowed under the laws of the State of Minnesota and as further outlined in PRC Policy 6301.01.
6307 Policy – Provisional Privileges

POLICY

VRP will consider granting Provisional privileges to a new applicant if the physician meets basic competency, licensing and training requirements, and provided the physician has maintained good standing in the medical community for the duration of his or her medical career.

PROCEDURE

1. Prerequisites.
   Before considering a physician for Provisional Privileges under this policy, the physician must first present evidence that the physician:
   (a) holds a valid state medical license;
   (b) has graduated from an AAMC or LCME accredited medical school or holds certification from the Education Commission for Foreign Medical Graduates (ECFMG); and
   (c) holds appropriate certifications for the privileges requested or presents other satisfactory evidence of education and expertise consistent with the anticipated services the physician will perform if granted Consulting Privileges, as established by this policy or by the Privileging Board.

VRP shall independently confirm that the physician is, and has always been, in good standing in the medical community by reviewing the physician’s FSMB and NPDB records. In addition, any physician whose record contains one or more disciplinary actions or medical malpractice payments larger than $500,000 may not proceed to the application stage without the prior approval of the Privileging Board. If VRP is unable to verify the physician’s continual good standing, or the physician is unable to produce requested proof of license, training or certification, VRP shall not consider the physician for Provisional privileges. For purposes of this paragraph, “good standing” means that the physician is not currently:
   (a) subject to challenge to his/her license or privileges;
   (b) subject to involuntary termination of professional or medical staff membership; or
   (c) subject to involuntary limitation, reduction, denial, or loss of privileges.

In reviewing “good standing”, the Privileging Board will consider previous challenges to the items listed in (a), (b), and (c) above on a case-by-case basis.