Draft Agenda

Estes Park Health Board of Directors' Regular Meeting by GoToWebinar and In-Person

Monday, June 19, 2023

5:30 - 7:30 pm Board Meeting

Estes Park Town Hall - Town Board Meeting Room, 170 MacGregor Ave, Estes Park CO 80517

	Regular Session			Mins.	Procedure	Presenter(s)
1	Call to Order and Welcome			1	**Action**	Dr David Batey
2	Approval of the Agenda			1	**Action**	EPH Board of Directors
3	Public Comments on Items Not on the Agenda			3	Information	Public
4	General Board Member Comments			3	Information	EPH Board of Directors
5	Consent Agenda Items Acceptance:			2	**Action**	EPH Board of Directors
	5.1	Board Minutes				
		5.1.1	EPH Board Regular Meeting Minutes May 15, 2023			
		5.1.2	EPH Board Executive Session Minutes May 16, 2023			
		5.1.3	EPH Board Executive Session Minutes May 23, 2023			
		5.1.4	EPH Board Executive Session Minutes May 24, 2023			
		5.1.5	EPH Board Executive Session Minutes May 30, 2023			
		5.1.6	EPH Board Executive Session Minutes June 08, 2023			
		5.1.7	EPH Board Executive Session Minutes June 13, 2023			
	5.2	**Other Documents**				
		5.2.1	Home Health, Hospice, Home Care Update Report			
6	Medical Staff Credentialing Report			2	**Action**	EPH Board
7	Revised Rules and Regulations of the Medical Staff of Estes Park Health			2	**Action**	EPH Board
8	Presentations:					
	8.1	CEO Strategic Actions Update		15	Discussion	Mr Vern Carda
	8.2	EPH Quality Strategic Update		15	Discussion	Ms Kendra Simms & Dr Ken Epstein
	8.3	EPH Chief Nursing Officer Strategic Update		15	Discussion	Ms Pat Samples
	8.4	Community Health Initiative Strategic Update		15	Discussion	Ms Wendy Ash
	8.5	Possible Healthcare System Affiliation - Activity Update		5	Discussion	Board of Directors
9	Executive Summary - Significant Items Not Otherwise Covered			1	Discussion	Senior Leadership Team
10	All Attendee Conversation on Emerging Topics			30	Conversation	Community Attendees, EPH Board of Directors, EPH Senior Leadership Team
11	Potential Agenda Items for Monday July 17, 2023 Regular Board Meeting			1	Discussion	EPH Board of Directors
12	Adjournment			1	**Action**	Board
			Estimated Total Regular Session Mins.	112		

Next Regular EPH Board Meeting: Monday July 17, 2023 5:30 - 7:30 pm

July 2023 Possible Agenda Items:

ESTES PARK HEALTH

ESTES PARK HEALTH
BOARD OF DIRECTORS'
Regular Meeting Minutes – May 15, 2023

Board Members in Attendance correspondence
Dr. David Batey, Chair
Dr. Steve Alper, Finance Committee Chair
Mr. Drew Webb, Vice Chair
Ms. Diane Muno, Member at Large
Mr. Bill Pinkham, Member at Large
Dr. Cory Workman, Member at Large
Ms. Brigitte Foust, Member at Large

Other Attendees
Mr. Vern Carda, CEO
Ms. Pat Samples, CNO
Ms. Shelli Lind, CHRO
Mr. Gary Hall, CIO
Ms. Lesta Johnson
Ms. Rachel Ryan (via webinar)
Ms. Kaci Early
Ms. Nancy Dietz
Ms. Wendy Rigby
Ms. Heather Bird
Ms. Aysha Reeves
Dr. John Knudtson

Community Attendees (present and via webinar):
Randy Brigham
Jim Cozette
Gail Cozette
Jeff Hanrahan
Mark Richards
Larry Leaming
Meg Masterson

1. **Call to Order**
   The board meeting was called to order at 5:31 PM by David Batey; there was a quorum present. Notice of the board meeting was posted in accordance with the Sunshine Law Regulation.

5.1.1

2. **Approval of the Agenda**
Steve Alper motioned to approve the agenda as submitted. Bill Pinkham seconded the motion, which carried unanimously.

3. **Resolution 2023-03 Bond Covenant Waiver for Debt Coverage Ratio**
Two debt covenant waivers were received from bank for 2022; the Board has to acknowledge these waivers. Several health systems had negative net assets at the end of 2022, so it is not unusual for EPH. The bank has encouraged the Board to adopt this resolution. No new debt has been incurred since 2016; the debt in question is "old debt." David Batey motioned to accept resolution. Bill Pinkham seconded the motion, which carried unanimously.

Jeff Hanrahan asked for clarification on the Covenant Waiver in laymen's terms: is it just a notice from the bank in which EPH agrees that due to taking a loss in 2022, there will be no penalty for the debt taken? Aysha Reeves responded in the affirmative. David Batey motioned to approve resolution, which carried unanimously.

4. **Medical Staff Credentialing Report**
Steve Alper recommended the approval of the Medical Staff Credentialing Report. Drew Webb seconded the motion, which carried unanimously.

5. **Appreciation of Six Years of Estes Park Health Board Service for Diane Muno and Bill Pinkham**
   - Numerous accolades surrounding Diane Muno and Bill Pinkham's years of service. They are vastly appreciated, and both of them wished the new board members the very best.

6. **Swearing In Newly Elected EPH Board Members: Steve Alper, Brigitte Foust, and Cory Workman**
Steve Alper, Brigitte Foust, and Cory Workman were sworn in by Deputy Designated Election Official, Rachel Ryan.

7. **Public Comments Not on Agenda**
No comments.

8. **General Board Member Comments**
No comments.

9. **Consent Agenda Items Acceptance**
David Batey motioned to approve consent agenda items as listed, which carried unanimously. Second by Steve Alper and Drew Webb.

10. Presentations

10.1 CEO Strategic Actions Update – Mr. Vern Carda

- The COVID-19 PHE ended May 11, 2023 and with it, so did many pandemic era provisions for COVID-19 vaccines and treatments. Some experts are concerned that these changes will decrease patients access to care and increase costs; please contact individual insurance providers to confirm what will stay covered or not.
- EPH is in the process of replacing its Fluoroscopy machine. A fluoroscopy is a medical procedure that makes a real-time video of the movements inside a part of the body by passing x-rays through the body over a period of time. A fluoroscopy is an diagnostic exam that can be used for diagnosing a health problem such as heart or intestinal disease. It also can be used to guide treatments such as injections. It helps a physician to look inside organs or bones, etc. Installation for the Flouro will be completed by the end of May.
- General Surgeon Chris Bogardus will begin practice June 1, 2023. Dr. Woodard will remain in Wound Care and helping with call.

10.2 EPH Chief Financial Officer – First Quarter 2023 Financials – Ms. Aysha Reeves

- See presentation. Topics included breakdown of the first quarter financials for 2023.
- $2.5 million was transferred out of investments and into cash for debt payments and capital acquisitions.
- Accounts Payable balances decreasing due to decrease in expenses and timing of bills received.
- Inpatient revenue down 9%; largely due to fluxes in inpatient admissions, but expenses are being controlled (through cutting of contract labor, supplies, etc.).

10.3 EPH Chief of Staff Strategic Update – Dr. Bridget Dunn

- See presentation. Updates from March, and April and May were as follows:
- March: Clinic completed 2023 Vaccines for Children recertification; Dr. Wiesner's last day was 3/31/23; favorable antibiotic infusions within 1 hour of incision (96% rate).
- April: Pediatric coverage transition occurred; Dr. Christine Bogardus signed contract for General Surgery and will start in June; Dr. Woodard transitioned to wound care/prn call; Kaycee Simon was promoted to new CRNA Lead.
- May: Ballot Measure 8A passed with Steve Alper retaining his membership; Cory Workman and Brigitte Foust elected as new BOD members. DNV Survey was completed 5/10/23. Covid PHE ended 5/11/23 and COVID related vaccines, testing, etc. reverted to traditional insurance coverage rules.

10.4 DNV Update – Ms. Pat Samples

- DNV arrived on 5/9/23 for a two-day survey; they are the company EPH uses to seek certification, and represent CMS. This is the first survey that has been in person for the duration of the entire survey since Covid-19 began in 2020.
- DNV can assign five levels of violation of a process or policy, ranging from NC-2 (NC being "Non-Conformity") to Immediate Jeopardy (life safety issues that put employees and patients at risk). EPH did not receive any Conformities or Immediate Jeopardy.
- Considerable progress was made from last year; over 80% of the nonconformities were corrected.
- DNV has ten business days to email their document with the findings, then EPH has ten calendar days to return a plan. All NC-1s must be addressed and fixed within 60 days. NC-2s are checked at the following year's survey.
- Drew Webb asked Ms. Samples how she would rate the most recent DNV Survey. She believes we did very well as we continue to solidify the care delivery model, which is the goal.
- Steve Alper questioned: can you talk about how the things that have been done to change the culture and leadership structure contributed to the results of the Quality Survey? – From a culture perspective, Senior Leadership identified the strength in leadership, while also creating a succession plan to develop leaders as they move up in the organization. The Quality structure also has had a huge impact; finding experts that know quality and risk management. There has also been an increase in ownership and accountability amongst leaders, which works its way down the ladder.

10.5 Possible Healthcare System Affiliation – Activity Update – EPH Board of Directors

- See presentation.

11 Executive Summary

No comments.

12 All Attendee Conversation on Emerging Topics

- Floor opened at 7:02 PM. No questions were asked.

13 Potential Agenda Items for Monday June 19, 2023 Regular Board Meeting

Officer roles for new Board Members.

14 Adjournment

David Batey motioned to adjourn the meeting at 7:05 PM. Drew Webb and Steve Alper seconded the motion, which carried unanimously.

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David M. Batey, Chair
Estes Park Health Board of Directors

Draft Public Agenda

Estes Park Health Board of Directors' Executive Session - In Person and by TEAMS

Tuesday, May 16, 2023

7:00 am - 8:30 am

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome (Time 08:04 am)	1	Action	Dr David Batey
2	Approval of the Agenda (Motion Workman 2nd Alper - Unanimous)	1	Action	Board
3	Public Comments on Items Not on the Agenda - None	1	Information	Public
4	General Board Member Comments on Items Not on the Agenda - None	1	Information	Board
5	Entertain a motion to enter Executive Session pursuant to Section 24-6-402(4)(e) C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations; and instructing negotiators, and pursuant to Section 24-6-402(4)(f) C.R.S. for the purpose of discussing a personnel matter. (Motion Alper 2nd Webb - Unanimous)	85	Action	Board
6	Adjournment (Motion Alper 2nd Workman - Unanimous Time 09:14 am)	1	Action	Board
	Total Regular Session Mins.	90		

Board Members Present: Alper, Batey, Foust, Webb, Workman

5.1.2

Draft Public Agenda

Estes Park Health Board of Directors' Executive Session - In Person and by TEAMS

Tuesday, May 23, 2023

8:00 am - 9:00 am

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome (Time 08:12 am)	1	Action	Dr David Batey
2	Approval of the Agenda (Motion Alper 2nd Workman - Unanimous)	1	Action	Board
3	Public Comments on Items Not on the Agenda - None	1	Information	Public
4	General Board Member Comments on Items Not on the Agenda - None	1	Information	Board
5	Entertain a motion to enter Executive Session pursuant to Section 24-6-402(4)(e) C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations; and instructing negotiators, and pursuant to Section 24-6-402(4)(f) C.R.S. for the purpose of discussing a personnel matter. (Motion Alper 2nd Webb - Unanimous)	85	Action	Board
6	Adjournment (Motion Alper 2nd Webb - Unanimous Time 09:19 am)	1	Action	Board
	Total Regular Session Mins.	90		

Board Members Present: Alper, Batey, Foust, Webb, Workman

Draft Public Agenda

Estes Park Health Board of Directors' Executive Session - In Person and by TEAMS

Wednesday, May 24, 2023

4:00 pm - 5:00 pm

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome (Time 04:02 pm)	1	Action	Dr David Batey
2	Approval of the Agenda (Motion Alper 2nd Webb - Unanimous)	1	Action	EPH Board
3	Public Comments on Items Not on the Agenda - None	1	Information	Public
4	General Board Member Comments on Items Not on the Agenda - None	1	Information	EPH Board
5	Entertain a motion to enter Executive Session pursuant to Section 24-6-402(4)(e) C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations; and instructing negotiators. (Motion Alper 2nd Workman - Unanimous)	55	Action	EPH Board
6	Adjournment (Motion Alper 2nd Foust - Unanimous Time 04:53 pm)	1	Action	EPH Board
	Total Regular Session Mins.	60		

Board Members Present: Alper, Batey, Foust, Webb, Workman

Draft Public Agenda

Estes Park Health Board of Directors' Executive Session - In Person and by TEAMS

Tuesday, May 30, 2023

7:00 am - 10:00 am

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome (Time 07:06 am)	1	Action	Dr David Batey
2	Approval of the Agenda (Motion Alper 2nd Webb - Unanimous)	1	Action	EPH Board
3	Public Comments on Items Not on the Agenda - None	1	Information	Public
4	General Board Member Comments on Items Not on the Agenda - None	1	Information	EPH Board
5	Entertain a motion to enter Executive Session pursuant to Section 24-6-402(4)(e) C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations; and instructing negotiators, and pursuant to Section 24-6-402(4)(f) C.R.S. for the purpose of discussing a personnel matter. (Motion Alper 2nd Webb - Unanimous)	175	Action	EPH Board
6	Adjournment (Motion Alper 2nd Webb - Unanimous Time 10:00 am)	1	Action	EPH Board
	Total Regular Session Mins.	180		

Board Members Present: Alper, Batey, Foust, Webb, Workman

5.1.5

Draft Public Agenda

Estes Park Health Board of Directors' Executive Session - In Person and by TEAMS

Thursday, June 08, 2023

4:45 pm - 7:45 pm

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome (Time 04:47 pm)	1	Action	Dr David Batey
2	Approval of the Agenda (Motion Alper 2nd Webb - Unanimous)	1	Action	EPH Board
3	Public Comments on Items Not on the Agenda - None	1	Information	Public
4	General Board Member Comments on Items Not on the Agenda - None	1	Information	EPH Board
5	Entertain a motion to enter Executive Session pursuant to Section 24-6-402(4)(e) C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations; and instructing negotiators. (Motion Alper 2nd Webb - Unanimous)	175	Action	EPH Board
6	Adjournment (Motion Alper 2nd Foust - Unanimous Time 7:38 pm)	1	Action	EPH Board
	Total Regular Session Mins.	180		

Board Members Present: Alper, Batey, Foust, Webb, Workman

5.1.6

Draft Public Agenda

Estes Park Health Board of Directors' Executive Session - In Person and by TEAMS

Tuesday, June 13, 2023

8:00 am - 9:30 am

Estes Park Health, 555 Prospect Avenue, Estes Park CO 80517

	Regular Session	Mins.	Procedure	Presenter(s)
1	Call to Order/Welcome (Time 08:03 am)	1	**Action**	Dr David Batey
2	Approval of the Agenda (Motion Alper 2nd Workman - Unanimous)	1	**Action**	EPH Board
3	Public Comments on Items Not on the Agenda - None	1	Information	Public
4	General Board Member Comments on Items Not on the Agenda - None	1	Information	EPH Board
5	Entertain a motion to enter Executive Session pursuant to Section 24-6-402(4)(e) C.R.S. for the purpose of determining positions relative to matters that may be subject to negotiations; developing strategy for negotiations; and instructing negotiators. (Motion Alper 2nd Foust - Unanimous)	175	**Action**	EPH Board
6	Adjournment (Motion Alper 2nd Workman - Unanimous Time 09:47 am)	1	**Action**	EPH Board
	Total Regular Session Mins.	180		

Board Members Present: Alper, Batey, Foust, Workman Webb not present

5.1.7

Expenses ($73,638) are 58% below budget

2022 YTD Roll-up for all three agencies through April:

Total for all: Revenue ($412,160) is 34% below budget

Expenses ($441,492) are 32% below budget

V. Community

As the pandemic season appears to have ended, we at Home Health and Hospice are again beginning to imagine how we might build on what we've done in the past to enhance our current work in the community. Building and enhancing are tangible ways we demonstrate our commitment to the Estes Valley community.

Hospice volunteers are grateful to be seeing patients under the supervision of Alyssa Bergman, MSW. Our hospice families express gratitude and report significant benefits from having volunteers provide respite and support for the family caregivers. Two of our volunteers are currently working together to create a structure for presentations highlighting the work of hospice and telling of their personal experience with hospice. Two other volunteers support our grief work by regularly calling the bereavement families and by mailing the monthly addition of Journey's Newsletter, filled with support for those on a grief journey.

The Hospice Bereavement program, created for the families of our hospice patients, regularly reaches out to care for persons from the community who have not been connected to Hospice. It is part of our community service. All our staff refer people who could benefit from this service. Currently the Bereavement program is comprised of 25% non-hospice community families.

Herm Weaver, Chaplain, offers a Grief Support Group that is aimed at directly supporting the 13-month Bereavement program. It serves people in the first year of grief and at times beyond. This group meets every other week and is currently meeting in a room at Shepherd of the Mountain Lutheran Church. 25% of the current participants in the Grief Support Group are community folks who are not connected to hospice. They have most often been referred by local pastors. Herm also provides consultation for an ongoing community group that has grown out of previous bereavement clients who continue to gather for grief support.

Nancy Bell continues to provide caregiver support to the community through online communication, phone calls, and forwarding of educational opportunities. She also runs a caregiver's support group that is meeting face to face again at Good Samaritan twice a month. In addition, Nancy has once again begun offering some children's and community-based music therapy groups and has started a community-based support group for women who have early to moderate stages of dementia. Nancy imagines training a person from the community to facilitate the new women's group in time.

Serving the Estes Valley community continues to be at the very center of Home Health and Hospice. The best energy of our staff is directed toward health and safety of our community. If you, the reader, imagines new ways for us to serve the community we welcome your suggestions.

Report to Board of Directors—June 2023
From Estes Park Health Home Health Care, Estes Park Health Home Care, and Estes Park Health Hospice

I. People

We have a strong team of 27 employees. Our Clinical Secretary/Unit Coordinator, Carol Blanchard retired at the end of August 2022, but has stayed with us PRN until a permanent replacement can be found. Jaime Bell has joined the team as a contract physical therapist until a permanent solution is found. Additionally, Paul Asher, occupational therapist, has been assisting us with our occupational therapy needs from the outpatient rehab department while we continue to search for a permanent occupational therapist solution. We currently have open positions for a fulltime physical therapist, fulltime clinical secretary, fulltime occupational therapist, part time registered nurse, a part time and PRN personal care provider.

II. Quality

We monitor, track/trend, and strive to improve our 2023 quality measures for all three of our agencies. Much of our clinical educational in-services this year will focus on how to improve our OASIS outcome scores which were lower and are a part of our quality improvement management.

In March the home care staff attended the workplace violence in-service that was hosted by EPH human resources. Additionally, there was the first OASIS-E workshop/education for the skilled clinical staff put on by Emily Weber, RN. This first OASIS education covered the newly added aspects of the assessment as well as touching on the existing areas that need improvement.

In May the director and the clinical coordinators attended the annual Home Health and Hospice conference in Beaver Creek, Co. This conference allows for the administrative staff learn about the new happenings within the home health and hospice world as well as providing continuing education credits.

Now that the COVID precautions are gone the home care staff can see patients without a mask on. This brings back an element of personal connection that staff felt was really missing from their work.

III. Service

We continue to provide quality patient care in the community through our three different types of services (skilled home health care, non-medical home care, and hospice). We serve Estes Park and its surrounding mountain communities—Glen Haven, Drake, Allenspark, and Pinewood Springs.

We are currently providing non-medical personal care provider/homemaker services to some clients through the Larimer County Office on Aging grant program and Foothills Gateway. We have 13 people on our waiting list for non-medical home care services. We hope that we will be able to hire another personal care provider soon to further serve the community with our non-medical service line.

Our volumes YTD over this year through February are down 28% for Home Health Care, down 17.07% for home care, and up 12.8% for Hospice. We recognize that our volumes are lower than usual, and we plan to pick up on marketing for Home Health and Hospice. Fliers have been created advertising the availability of the Home Health and Hospice service to the community as well as placed in exam rooms at the EPH clinic and in the Timberline exam rooms.

IV. Financial (Three separate P&Ls for three agencies)

2023 YTD Financials through April (only available) (Three separate P&Ls for three agencies)
Home Health Care: Revenue ($188142) is 48% below budget
Expenses ($309017) are 19% below budget
Home Care (non-skilled): Revenue ($20,987) is 34.21% below budget
Expenses ($12,478) are 49% below budget
Hospice: Revenue ($123,528) is 6.5% below budget

ESTES PARK HEALTH

Park Hospital District Board
June 19, 2023

CREDENTIALING RECOMMENDATIONS

Credentials Committee approval:
May 31, 2023
Present: Drs. McLellan (Chair), Dunn, Zehr, Gary Hall, Vern Carda, Brigitte Foust, Cory Workman, Bobbi Chambers, Kate Cramer

Medical Executive Committee approval:
June 7, 2023

Initial Appointment:

McFall, Michael, DO	Courtesy, Pathology

Reappointments:

Mize, Nicholaus, DO	Active, Internal Medicine
Treat, Stephen, MD	Courtesy, Cardiology

Additional Privileges:

Knudtson, John, MD	Active, Diagnostic Radiology

Resignations:

Meyer, Karen, L., MD	Effective 4/30/2023
Payden, Richard, W., MD	Effective 4/30/2023
Mohr, Victoria, H., MD	Effective 4/30/2023

Documents:

Credentials Verification Policy
Credentials Folder Content & Retention Policy – Archive
Medical Staff life Support Certification Policy

RULES AND REGULATIONS

OF THE

MEDICAL STAFF

OF

ESTES PARK HEALTH

Approved and Adopted by the Park Hospital District Board

MEDICAL STAFF RULES AND REGULATIONS
ESTES PARK HEALTH

DEFINITIONS

For purposes of these Rules and Regulations and unless stated otherwise, the following definitions will apply.

1. **ADMITTING PHYSICIAN** means the physician on the Medical Staff who has the necessary clinical privileges and who is formally and legally responsible for admitting the patient to the hospital.

2. **ATTENDING PHYSICIAN** means the physician on the Medical Staff who is formally and legally responsible for primary care and treatment during the patient's admission to the hospital.

3. **CLINICALLY PRIVILEGED PRACTITIONER** means a physician on the Medical Staff, Advanced Practice Practitioner, or other practitioner holding clinical privileges at EPH.

4. **HOSPITALIST PHYSICIAN ("Hospitalist")** means the Attending Physician on service who is formally and legally responsible for the inpatients admitted to the Hospitalist service.

5. **PRIMARY CARE PHYSICIAN ("PCP")** means the physician primarily chosen by an individual to provide continuous medical care, trained to treat a wide variety of health-related problems, and is responsible for referral to specialists as needed.

6. **TELEMEDICINE/TELEHEALTH** refers to a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the person is located at an originating site and the provider is located at a distant site.

PART I
ADMISSION OF PATIENTS

1.1 GENERAL ADMISSION RULES

A patient may be admitted to the hospital only by a physician member of the Medical Staff who has appropriate clinical privileges to admit patients, or by a physician holding temporary admitting privileges. All adult medical, non-surgical patients are admitted to the Hospitalist service. Surgical patients may be admitted directly to the surgeon's service or to the Hospitalist service. Pediatric patients (< 15 years of age) and pregnant patients with an obstetric problem will be assessed for stability and appropriateness for transfer to another facility providing those services. Pregnant patients at < 20 0/7 week gestation, with

a non-obstetric problem will be admitted to the appropriate service with obstetric or perinatology consultation as indicated. The Admitting Physician is responsible for the medical care and treatment of the patient, for the completeness and accuracy of the medical record, for necessary instructions and for transmitting reports of the condition of the patient to a referring practitioner and to relatives of the patients. The Admitting Physician will be the Attending Physician unless the patient is transferred to the care of another physician and that physician accepts care, or the Attending Physician of record is otherwise specified. All patients admitted to the hospital must have orders entered in the Electronic Medical Record ("EMR").

1.1.1 OBSERVATION STATUS POLICY

When a patient is admitted for Observation services, an Observation note shall be recorded reflecting that the patient is being seen and evaluated in the hospital. This note shall include the clinical rationale for the decision for Observation with a pertinent history and relevant physical findings to support the Observation services. If the patient is changed to Inpatient status, a complete History and Physical must be recorded within twenty-four (24) hours of the status change if the History and Physical was not completed at the time of admission to Observation status.

1.1.2 PATIENT TRANSFER

Patients who present to EPH and require specialty care unavailable at EPH or who cannot be admitted due to the hospital being on divert status will be transferred to the appropriate facility pursuant to the transfer agreement with that facility. The reason for transfer, name of receiving facility and accepting physician will be documented in the medical record. The transferring physician will complete all required documentation and forms prior to the patient transfer.

1.2 LIMITATIONS FOR PODIATRISTS AND DENTISTS

The admission of a patient for podiatric or dental services is a dual responsibility involving the podiatric physician (DPM), dentist (DDS, DMD), and the MD/DO member of the Medical Staff.

The podiatrist's and dentist's responsibilities are:

a. To provide a detailed podiatric or dental history justifying hospital admission and/or surgery;
b. To provide a detailed description of the podiatric or dental examination, including when indicated, the initial and final diagnosis surgery and prognosis;
c. To complete operative report describing the findings, technique, and specimen(s) removed for postoperative diagnosis;
d. To write orders for services and medications as they relate to the podiatric/dental care rendered;
e. To provide accurate Progress Notes and final summary as they relate to the podiatric or dental care rendered; and

f. To provide pertinent instructions relative to the podiatric or dental condition of the patient.

The MD or DO responsibilities are:

a. To perform a medical History and Physical examination and provide a Discharge Summary of hospitalization;
b. To provide for overall care of the patient's general health during the hospital stay; and
c. To write orders for services and medications for the general care of the patient.

1.3 TYPES OF PATIENTS

EPH accepts and admits patients for care and treatment except for the following categories:

a. Conditions where the patient is a danger to him/herself or others; or
b. Patients requiring tertiary care services not available at EPH.

Within these guidelines, patients are admitted without regard to race, national origin, religion, color, creed, sex, gender identity, sexual orientation, age, financial status, or other legally protected status. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the Chief Executive Office or administrative designee. For clarity, this Rule 1.3 applies to patients being considered for admission to the hospital and does not apply to patients who present to the EPH Emergency Department ("ED"), who are required to be screened and then either stabilized or appropriately transferred, as provided by these rules.

1.4 ADMISSION INFORMATION

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been provided by the physician requesting admission or admission orders have been entered into the EMR by the Admitting Physician (or bridge orders entered by an ED physician).

The Admitting Physician is also responsible for providing the following information regarding the patient being admitted:

a. Any risk of significant infection control issues; and
b. Behavioral characteristics that would disturb or endanger others.

1.5 TIMELY VISITATION AFTER PATIENT ADMISSION

Each member of the Medical Staff must assure timely, adequate professional care for patients who present to the Emergency Department or who have been admitted to EPH. The Medical Staff member must be available or have eligible alternative physician coverage (i.e. another member of the Medical Staff in good standing with requisite clinical

privileges to care for the patient) with whom prior arrangements have been made or must arrange to admit the patient to the Hospitalist service.

The Attending Physician or alternate must see the patient within the time frames listed below and within a shorter time frame as the condition of the patient requires:

a. Patients directly admitted by the Attending Physician to EPH must be personally evaluated on the day of admission;
b. Patients admitted to the Hospital through the Emergency Department must be seen by the Attending Physician within eight (8) hours, unless the Emergency Department physician indicates otherwise.

In the event the Attending Physician or alternate cannot respond because of situations beyond the physician's control, the Emergency Department will attempt to locate another appropriate physician to care for the admitted patient. After exhausting facility resources and stabilizing the patient within the hospital's capability, the Emergency Department will arrange for transfer of the patient to another institution.

A refusal or failure to respond in a timely manner and according to these Rules and Regulations shall be immediately reported to the Chief of Staff and the CEO who may initiate appropriate corrective action pursuant to the Medical Staff Bylaws.

1.6 TELEMEDICINE/TELEHEALTH

Physicians and independent practitioners (collectively, "Practitioners") are permitted to exercise clinical privileges by and through Telemedicine/Telehealth technology as long as: (a) EPH has approved the use of Telemedicine/Telehealth to provide such clinical services; and (b) the provision of the clinical services through Telemedicine/Telehealth is otherwise permitted by applicable state and federal law and regulation, as well as applicable Hospital and Medical Staff Bylaws, Rules and Regulations, and Policies. Under these circumstances, and unless otherwise expressly required by EPH, separate clinical privileges are not required at EPH for the provision of services through Telemedicine/Telehealth. Additionally, Practitioners may only render professional services through Telemedicine/Telehealth within their licensed scope of practice and hospital clinical privileges, and only to the extent that the professional services can be provided within the standard of care applicable to in-person services. Practitioners must further ensure compliance with all licensure, professional practice, and insurance requirements applicable to the state where the patient is physically located at the time of the professional service. In complying with the applicable legal requirements in all relevant jurisdictions, Practitioners should be particularly mindful of and must ensure compliance with: (i) relevant licensing board requirements and prohibitions; (ii) technology requirements and restrictions; (iii) HIPAA obligations and other privacy requirements; (iv) patient consent requirements; and (v) medical record keeping requirements. Any questions regarding the use of telemedicine at EPH or to registered patients of EPH should be directed to the Chief Operating Officer.

PART II

GENERAL ATTENDANCE OF PATIENTS

2.1 ATTENDANCE OF PATIENTS

All medical/nonsurgical patients will be admitted to the appropriate service.

2.2 PHYSICIAN CLINIC "COMMUNITY DOCTOR ON-CALL ROSTER"

The Estes Park Health Physician Clinic ("Clinic") maintains a Community Doctor On Call Roster ("DOC") in relation to patient-related telephone calls directed to the Clinic. This service is in addition to Hospital Emergency Department On-Call responsibilities, which are addressed in Section 9, below. The following provisions pertain to DOC obligations:

a. The DOC includes physicians and APPs who are employed or contracted to provide clinical services in the Clinic.
b. The DOC on-call providers are required to submit their on-call schedule requests to the Provider Relations Specialist who makes their on-call schedules.
c. Any changes to the DOC on-call schedule must be reported to the Provider Relations Specialist, and will be published on the EPH Intranet. The Provider Relations Specialist will notify the Chief of Staff (or designee) of any call coverage concerns, including but not limited to any unexpected unavailability or other potential gaps in coverage. The Chief of Staff will consult with the CEO in order to arrange for appropriate back-up coverage.
d. The call day begins at 0700 of the day assigned and continues until 0700 the following morning
e. Any provider who is designated as on-call for the Clinic must respond to calls concerning patients within twenty (20) minutes. The on-call provider is not required to be available in-person to examine patients on behalf of the Clinic.
f. If the DOC on-call provider determines that the patient may require emergent medical treatment, or in the event the patient believes the patient may be experiencing an emergency medical condition, the DOC on-call provider will instruct the patient to present to the nearest Emergency Department and/or to call 911.
g. Except as provided immediately above regarding potential emergencies, the DOC on-call provider may refer the patient to Urgent Care and/or for other appropriate follow-up.
h. When reasonably possible, if a telephone call relates to a Post-Operative patient, the telephone call will be directed to the physician or surgeon who performed the procedure, or otherwise, to the physician or surgeon covering that service
i. All phone encounters should be documented in the EMR.
j. Failure to comply with the rules governing on-call obligations may result in disciplinary action.

PART III

GENERAL RESPONSIBILITY AND CONDUCT OF CARE

3.1 RESPONSIBILITY FOR TREATMENT OF PATIENT

A member of the Active, Courtesy, or Locums Medical Staff shall be responsible for the medical care and treatment of each patient at EPH, for the prompt completeness and accuracy of those portions of the medical record for which he/she is responsible and for providing the patient and family with necessary information and instructions. Primary responsibility for these matters belongs to the Attending Physician.

Commented [RZ1]: Clinically Privileged Practitioner.....I thought was going to globally replace "Active, Courtesy, or Locums Medical Staff Members" although the former includes APP while the latter does not?

3.2 TRANSFER RESPONSIBILITY

When responsibility for a patient's care is transferred from the Admitting or current Attending Physician to another staff physician, a formal physician-to-physician handoff must occur. It is the responsibility of the accepting physician to arrange for next handoff or subsequent transfer of care.

3.3 ALTERNATE COVERAGE

Each physician must assure timely, adequate, and professional care for his/her patients at EPH by being available or designating a qualified alternate physician with whom prior arrangements have been made and who has requisite clinical privileges at EPH to care for the patient. Unless otherwise specified by the Attending Physician in the medical record, after-hours, weekend, and holiday care for the patient will be assumed by the hospitalist or surgeon.

3.4 ADVANCED PRACTICE PRACTITIONER (APP)

An Advanced Practice Practitioner ("APP") may treat patients under the conditions provided for in the Medical Staff Bylaws. APPs are not members of the Medical Staff. As such, APPs cannot serve as the Admitting or Attending Physician of record. Each APP is responsible for documenting in the medical record, in a timely fashion, a complete and accurate description of the services provided to the patient. CRNAs and other APPs have separate rules and regulations document (Allied Health Practitioner Rules and Regulations).

3.5 IMMEDIATE QUESTIONS OF CARE

If a nurse has a concern or question regarding the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall contact the Attending Physician to discuss his/her concern. If the nurse continues to have significant concern, the nurse shall call this to the attention of the nursing supervisor who in turn may refer the matter to the Clinical Service Chief or Chief of Staff. Where circumstances are such as to justify such action, the Clinical Service Chief or Chief Of Staff may request a consultation with the Attending Physician and/or another physician.

3.6 CONSULTATIONS

3.6.1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The Attending Physician or Attending Physician's qualified designee

is primarily responsible for calling for a consultation with a qualified Clinically Privileged Practitioner when indicated or required pursuant to the guidelines in these rules. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the Attending Physician.

3.6.2 GUIDELINES FOR CONSULTATION

Except in an emergency, consultations with another qualified physician, podiatrist, or other practitioner should be obtained according to the judgment of the Attending Physician.

The Attending Physician or Attending Physician's qualified designee is responsible for requesting the consultation in writing specifying the individual physician, physician group practice, or consultation specialty.

A satisfactory consultation includes examination of the patient as well as review of the medical record. When nonemergency operative procedures are involved, the consultation will be recorded prior to the operation.

3.6.3 QUALIFICATIONS OF CONSULTANT

Any qualified practitioner with appropriate clinical privileges at EPH may be called as a consultant regardless of his/her staff category assignment. The consultant may be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluate and treat the condition or problems presented and have been granted the appropriate level of clinical privileges.

3.6.4 DOCUMENTATION

a. Consultation request: When requesting consultation, the Attending Physician must indicate this in the medical record as an order, and the physician or designee shall notify the consulting physician of this request;
b. Consultant report: The consultant must make and sign a report for his/her findings, opinions, and recommendations within the medical record. Such report shall become part of the patient's medical record; and
c. Attending Physician response to consultant opinion: In cases of elective consultation when the Attending Physician elects not to follow the advice of the consultant, he/she shall either seek the opinion of a second consultant or record in the Progress Notes his/her reasons for electing not to follow the consultant's advice.
d. In the event a phone consultation is obtained, documentation of the conversation should be noted by the requesting physician.

PART IV
TRANSFER OF PATIENTS

4.1 TRANSFER TO ANOTHER FACILITY

4.1.1 GENERAL REQUIREMENTS

A patient shall be transferred to another medical care facility only upon the order of the Attending Physician, only after arrangements have been made for admission with the receiving facility, including consent to receive the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to ensure continuity of care must accompany the patient, including, but not limited to, an accepting physician at the receiving facility, the required EMTALA forms and notes, and the name of the accepting physician in the medical record by the accepting physician indicating the acceptance of the patient.

4.1.2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT

A transfer demanded by an emergency or critically ill patient is not permitted until the physician has explained to the patient, family, or significant other the seriousness of the condition and generally not until a physician has determined that the condition is appropriate for transport. Moreover, transfers of patients who are unstable may only be made: (a) when the hospital does not have the capacity or capability to stabilize the patient and the benefits to be received by transfer to another hospital outweigh the risk of transfer; or (b) when the patient (or his or her representative) insists on transfer even after being informed of the risks of transfer and the hospital's obligations under EMTALA. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

PART V
DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER

The Attending Physician must determine when a patient is appropriate for discharge or transfer. Patients shall be discharged only on the order of the Attending Physician or qualified designee.

5.2 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave EPH against medical advice, the Attending Physician will be notified, and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves EPH against medical advice or without proper discharge, a notation of the incident must be made in the patient's medical record.

5.3 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parent, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he/she shall so state in writing and the statement must be made a part of the patient's medical record.

PART VI
ORDERS

6.1 GENERAL REQUIREMENTS

All orders for treatment or diagnostic tests must be entered into the EMR and signed electronically in a reasonable timeframe. Verbal, facsimile, or other written orders are not acceptable until entered into the EMR.

6.2 COLLABORATIVE ORDERS

Collaborative orders for any clinical area may be formulated by the Active and Courtesy Medical Staff members in consultation with the nursing service and the appropriate representative of the Active and Courtesy administration. Collaborative orders must be consistent with nationally recognized evidence-based guidelines and are subject to the initial approval of the Medical Executive Committee, as well as subject of annual review and updates (as may be required) in the final discretion of the Medical Executive Committee. These orders shall be followed insofar as proper treatment of the patient will allow. Clinical instruction to the staff shall be provided, as needed, regarding such orders. Where a practitioner has written a set of orders or is using a preprinted order set contained on one page, or on several pages, the physician shall sign, date, and time the last page of the orders, with the last page also identifying the total number of pages in the order set. When specific orders are not written by the Attending Physician, the collaborative orders will constitute the orders for treatment and be co-signed and authenticated by an Active or Courtesy Medical Staff member or qualified consulting MD, DO, DPM or APP pursuant to the qualifications described in Section 3.6.2. All collaborative orders shall be authenticated by the responsible physician within forty-eight (48) hours. The Attending Physician may, from time to time, supplement the collaborative orders with routine orders necessary for the patient's care.

6.3 VERBAL/TELEPHONE ORDER

Telephone or other verbal orders are not allowed except in emergency situations, including during downtime procedures. All emergency verbal orders shall be taken and signed by the qualified recipient to whom the order is dictated. The qualified recipient's name, the name of the ordering Active, Courtesy, or Locums Medical Staff member, the consulting physician pursuant to Section 6.2, or other practitioner privileged to write orders, and the date and time of the order shall be noted in writing. The qualified recipient must indicate that he/she has recorded the order in writing and shall read the verbal order back to the ordering practitioner (who is required to immediately verify that the read-back order is correct) and indicate that the order has been confirmed.

The following are qualified recipients in accordance with EPH policy who may take verbal orders for medication, treatment, and/or procedures within their respective areas of practice and which they will prepare, deliver, or perform: Registered Nurse, Registered Pharmacist, Respiratory Therapist/Technician, Certified Registered Nurse Anesthetist, Physical Therapist, Medical Technologist, APP, and Radiology Technologist.

6.3.1 DOCUMENTATION

All emergency verbal orders must be entered into the EMR. The ordering physician or privileged practitioner who is also responsible for the care of the patient shall electronically authenticate, time, and date any order, including but not limited to medication orders, as soon as possible, but no longer than forty-eight (48) hours from dictating the verbal order.

6.3.2 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically discontinued, unless a specific order is written otherwise, when the patient goes to surgery, is postpartum, or is transferred to another level of service. The medical record shall be flagged to indicate that this has occurred, and a listing of the discontinued orders shall be attached thereto. The Attending Physician must indicate on the order sheet that the listing was noted by either so stating, re-instituting all or some of the orders, or referring to another practitioner for a decision on whether or not to re-institute all or particular orders.

6.4 SPECIAL ORDERS

6.4.1 PATIENTS WITH OWN DRUGS AND SELF-ADMINISTRATION

Medications brought to EPH by a patient may not be administered to that patient during the hospital stay unless:

a. The drug is not stocked in the EPH pharmacy;
b. The drug is identified by the hospital pharmacist or a physician and the identification is noted in the orders and signed by the person making the identification; or
c. There is a written order from the Attending Physician to administer the patient's own medications after verified by pharmacy.

6.5 FORMULARY

EPH's formulary lists drugs available for ordering from stock. Each member of the Medical Staff assents to the use of the approved formulary as appropriate by the Clinical Quality Committee on behalf of the Medical Staff.

PART VII
MEDICAL RECORDS

7.1 SCOPE OF MEDICAL RECORD DOCUMENTATION

The Attending Physician, Active and Courtesy Medical Staff members, consulting physicians and other practitioners so privileged, are responsible for a complete EMR on each patient. The content of the EMR must be clear, complete, accurate, in English, and contain the essential positive and negative findings relevant to the patient's clinical condition. All entries in the EMR must be electronically signed. The members of the Medical Staff and the Advance Practice Practitioner staff must complete electronic medical record training prior to entering orders into the electronic medical record. All access to electronic records will be tracked, and unauthorized access to a patient's record is not permitted. Unauthorized access to a patient's record will result in disciplinary measures up to and including termination of privileges.

7.2 AUTHORIZED ENTRIES

The medical record will contain sufficient meaningful observation and information to identify the patient, support the diagnosis/condition, justify the care, treatment and services, document the course and results of care, and promote continuity of care among health care providers. Clinically Privileged Practitioners may document in the medical record only after completing the credentialing process or satisfying applicable policy requirements and only after being granted appropriate clinical privileges.

7.3 REQUIRED CONTENT

The medical record content shall be pertinent and current. The record shall include identification, date, complaint, personal history, history of present illness (including, when appropriate, family history, assessment of the patient's emotional, behavioral and social status), properly executed consent forms, physical examination, past history and system review, special reports such as consultations, diagnostic and therapeutic procedures, radiology, laboratory work, tests and results; admitting diagnosis, medical or surgical treatment, Operative Report, pathological findings, diagnostic and therapeutic orders, Progress Notes made by authorized individuals, reassessments and plan of care revisions, relevant observations, response to care, treatment, and services provided, relevant diagnosis/es/conditions established during the course of care, treatment and services, condition on discharge, summary or Discharge Note (clinical resume), and autopsy report when performed.

An appropriate medical record shall be kept for every patient receiving emergency services. Emergency Department records on all patients will be completed within forty-eight (48) hours of registration.

7.4 HISTORY AND PHYSICAL

A history and physical must be completed no more than thirty (30) days before or twenty-four (24) hours after admission to the Hospital and always prior to a surgical or outpatient procedure requiring anesthesia services, except in emergency circumstances.

A medical history and physical examination shall be performed and completed by a practitioner in accordance with Federal and State law, facility policy and approved privileges. History and physicals performed by an appropriately licensed and credentialed

Advanced Practice Practitioner shall be subsequently countersigned, dated, and timed in the medical record by the patient's Admitting Physician during the next daily visit or prior to operative invasive procedures.

In situations where the patient is going to surgery within the first twenty-four (24) hours of admission, the update to the patient's condition and the pre-anesthesia assessment could be accomplished in a combined activity. In situations where the patient goes to surgery greater than twenty-four (24) hours of admission, any changes in the patient's condition prior to surgery should be documented in the progress notes.

A history and physical report shall include at a minimum the following:

(a) Medical history, including the chief complaint; details of the present illness including, when appropriate, assessment of the patient's emotional, behavioral and social status.
(b) Relevant past, social, and family histories (appropriate to the patient's age); and an inventory of body systems.
(c) A summary of the patient's psychosocial needs, as appropriate to the patient's age.
(d) A report of relevant physical examinations and current assessment of all body systems.
(e) A statement on the conclusions or impressions drawn from the admission history and physical examination.
(f) A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate.
(g) For children and adolescents as deemed appropriate:
    - an evaluation of the patient's development age;
    - consideration of educational needs and daily activities as deemed appropriate;
    - the parent's report or other documentation of the patient's immunization status; and
    - the family and/or guardian's expectations for and involvement in the assessment, treatment, and continuous care of the patient as deemed appropriate.
(h) Allergies.

7.4.1 USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION

If a medical history and physical examination were performed within thirty (30) days prior to admission to the hospital, surgical or outpatient procedure, a durable, legible copy of the prior report may be used in the patient's Hospital medical record provided an update or addendum is written within twenty-four (24) hours of admission. In addition, the report must include all the required elements of a history and physical as described in Section 7.4. An updated examination of the patient including any changes in the patient's condition must be completed and documented, signed, dated, and timed within twenty-four (24) hours after admission. A statement of "no change in the patient's history and physical

condition" must be documented, signed, dated, and timed if no changed to the patient's history and physical is determined. This report shall reflect a comprehensive current physical assessment.

7.5 PREOPERATIVE DOCUMENTATION

7.5.1 HISTORY AND PHYSICAL EXAMINATIONS FOR SURGERY OR PROCEDURES REQUIRING ANESTHESIA

Any patient undergoing a procedure or surgery requiring anesthesia must have a medical history and physical completed and documented in the electronic medical record. The history and physical must be performed within thirty (30) days of the procedure by the licensed independent practitioner (Qualified Licensed Practitioner) and placed in the medical record prior to the procedure. The history and physical must contain all required elements per CMS guidelines. The surgical nursing team will confirm completion of the history and physical before the patient is brought to the operating room.

7.5.2 HISTORY AND PHYSICAL EXAMINATIONS FOR EMERGENCY SURGERY OR PROCEDURE

In cases of emergency, the Clinically Privileged Practitioner must make at least a pertinent note indicating that the history and physical has been dictated but not yet present in the patient's medical record and pertinent information regarding the patient's condition prior to the induction of anesthesia and start of surgery/procedure and the History and Physical examination shall be recorded immediately after the emergency surgery/procedure has been completed.

7.5.3 PREOPERATIVE ANESTHESIA EVALUATION

The anesthesiologist or CRNA must conduct and document in the record a pre-anesthesia evaluation of the patient, in accordance with current standards of anesthesia care, including, at a minimum, review of the medical history, including anesthesia, drug, and allergy histories; an interview and examination of the patient; identification of potential anesthesia-related problems; notation of American Society of Anesthesiologists (ASA) patient status classification; additional pre-anesthesia evaluation, if applicable; development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance, and post-operative care; and discussion with the patient (or his or her representative) of the risks and benefits of the delivery of anesthesia, and orders for pre-op medication. The pre-anesthesia evaluation should be performed within forty-eight (48) hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. Except in cases of emergency, this evaluation should be recorded immediately prior to the patient's transfer to the operating area and before preoperative medication has been administered.

7.5.4 INTRAOPERATIVE ANESTHESIA RECORD

The intraoperative anesthesia record must include:

a. Name and EPH identification number of the patient;
b. Name of practitioner who administered anesthesia and, as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;
c. Medication name, dosage, route, and time of administration;
d. Technique(s) used to and patient position(s), including the insertion/use of any intravascular or airway devices;
e. Name and amounts of IV fluids, blood, and blood products, if applicable;
f. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, including Oxygen flow rate; and
g. Complications, adverse reactions, or problems occurring during anesthesia and patient's response to treatment.

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7.5.5 POST ANESTHESIA EVALUATIONS

The post anesthesia evaluation must include:

a. Completion by the practitioner who administered the anesthesia within forty-eight (48) hours after surgery and before the patient is discharged;
b. Is required for general, regional, and monitored sedation including deep sedation; and
c. The elements of an adequate post-anesthesia evaluation should be clearly documented in accordance with current standards of anesthesia care, including:
    - Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
    - Cardiovascular function, including pulse rate and blood pressure;
    - Mental status;
    - Temperature;
    - Nausea and vomiting;
    - Postoperative hydration; and
    - Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

7.6 PROGRESS NOTES

7.6.1 GENERAL

Pertinent Progress Notes must be recorded by a physician at least daily and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the Attending Physician. Each of the patient's pertinent clinical problems must be clearly identified in the Progress Notes and correlated with specific orders as well as results of tests and treatment. Progress Notes by the

Attending Physician must be written at least daily for Inpatients and Observation patients, at least weekly for Swing Bed patients, and as needed for Hospice patients. In addition to any Progress Notes recorded by a rounding physician, Progress Notes written by a physician-directed Advanced Practice Practitioner must be countersigned by the sponsoring physician within seven (7) days.

7.7 OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative and special procedure reports must contain, as applicable, the name and EPH identification number of the patient, the date and time of the surgery, the name of the procedure, the preoperative and postoperative diagnoses, the name of the primary performing practitioner and any assistant and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner the type of anesthesia administered, a detailed account of the findings, the technical description of the procedure, the specimens removed, estimated blood loss, any complication, any prosthetics devices, grafts, tissues, transplants, or devices implanted, and the status and disposition of the patient at the completion of the procedure.

7.7.1 OPERATIVE OR-PROCEDURE REPORT

An operative procedure requires a report, dictated or written, immediately upon completion of the operative or procedure, before the patient is transferred to the next level of care. In the event that an operative report cannot be dictated or documented and authenticated in its entirety before the patient is transferred to the next level of care, an immediate post-operative/post procedure note is required to be documented. The note shall include identification or description of the surgeon and assistants, pre-operative and post-operative diagnosis, procedures performed, specimens removed, estimated blood loss (specify N/A if no blood loss), complications (if any encountered), type of anesthesia administered, and grafts or implants (may indicate where in chart for detail, if any).

The Operative Report is completed and authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

7.7.2 TISSUE EXAMINATION AND REPORTS

All tissues, foreign bodies, artifacts, and prostheses removed during a procedure, except lens (cataract surgery), orthopedic appliances, nasal cartilage (not including soft tissue), foreskin (prepubertal), scars, placentas (from normal deliveries), IUD's, contraceptive implants, surgical mesh, bones from hammertoes, skin, fat, cartilage removed for cosmetic purposes, teeth, nail tissue, bunions, corns, kidney stones or gallstones shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

7.8 ENTRIES AT CONCLUSION OF HOSPITALIZATION

7.8.1 FINAL PROGRESS NOTE

If a Discharge Summary is not entered in the EMR at the time of discharge then the final Progress Note needs to be documented for every patient to include the following: principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure, discharge condition, and instructions. The note must be electronically signed and authenticated by the Attending Physician (or covering physician) prior to the patient's discharge. The final Progress Note must indicate any specific instructions given to the patient and/or caregiver relating to physical activity, medication, diet, and follow-up care. If no instructions were required, a record entry must be made to that fact.

7.8.2 DISCHARGE SUMMARY

The Discharge Summary is the responsibility of the Attending physician unless otherwise arranged. A concise clinical résumé provides information to other caregivers and facilities continuing of care. The Discharge Summary shall contain the principal diagnosis, secondary diagnoses, co-morbidities, complications, reason for hospitalization, significant findings, procedures performed, and treatment rendered the patient's condition on discharge, and pertinent instructions to the patient and family. Consideration is given to instructions relating to physical activity, medications, diet, and follow up care. The Discharge Summary must be written or dictated in full and must be dated and authenticated by the Attending Physician (or covering physician) within fourteen (14) days of patient discharge.

7.8.3 DEATH

In the event of a death, a summary statement is added to the record as a final Progress Note/Discharge Summary indicating the reason for admission, the medical course in EPH and the events contributing to the death. This is to be completed by the Attending Physician (or covering physician) within forty-eight (48) hours. If the death took place in the Emergency Department, the ED note shall suffice as the summary statement.

7.9 AUTHENTICATION

Medical record entries include the date, time, and author according to law, regulation or EPH policy, and are authenticated by electronic signature, identifiable initials, or computer key. Electronic physician signature, initials, or computer key indicates the physician has reviewed the pertinent aspect of the chart for accuracy, completeness, and authentication.

7.9.1 USE OF UNAPPROVED SYMBOLS AND ABBREVIATIONS

A list of unapproved abbreviations will be reviewed by the Medical Executive Committee. A list is available at the nursing stations, physician dictation areas, and Health Information Management Department.

7.9.2 FILING

The records of discharged patients are to be completed within thirty (30) days following discharge. A medical record shall not be filed until it is complete, reviewed, and properly authenticated. In the event a chart remains incomplete by reasons of the death, resignation, or other inability or unavailability of the responsible physician to complete the record, the Chief of Staff, Vice Chief of Staff, or the Past Chief of Staff shall consider the circumstances and may enter such reasons in the record and order it to be completed and filed.

7.9.3 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including radiology images and pathological specimens and slides, are property of EPH and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the Chief Executive Officer. Copies of records, films, slides, etc., may be released for follow-up patient care only upon presentation of appropriate authorization for duplication.

Unauthorized removal of a medical record or any portion thereof from EPH is grounds for disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the Medical Staff and Board.

7.9.4 ACCESS TO RECORDS

Medical records shall be accessed and/or released only in accordance with EPH policies and the requirements for federal and state law.

PART VIII
CONSENTS

8.1 GENERAL

Each patient's medical record must contain evidence of the patient's or his/her legal representative's general consent for treatment.

8.1.2 ADULT PATIENT CONSENT

a. Adults with legal capacity to consent may consent for themselves.
b. If an adult patient lacks the decisional capacity to provide informed consent to or refusal of medical treatment, (i) guardian with medical decision-making authority, (ii) agent appointed in a medical durable power of attorney, (iii) person with the right to act as a proxy decision-maker in a designated beneficiary agreement, or (iv) other known person has the legal authority to provide such consent or refusal on the patient's behalf (each a "Health Care Representative") may provide such consent or refusal on the patient's behalf.
c. If an adult patient's Attending Physician determines that the patient lacks the decisional capacity to provide informed consent to or refusal of medical treatment and no known Health Care Representative has the legal authority to provide such consent or refusal on the patient's behalf, a health-care provider or health-care

facility may rely, in good faith, upon the medical treatment decision of a proxy decision-maker selected in accordance with the following:

i. Each of a patient's spouse, either parent of the patient, any adult child, sibling, or grandchild of the patient, or any close friend of the patient (each an "Interested Person") who is informed of the patient's lack of decisional capacity shall make reasonable efforts to reach a consensus as to who among them shall make medical treatment decisions on behalf of the patient. The person selected to act as the patient's proxy decision-maker should be the person who has a close relationship with the patient and who is most likely to be currently informed of the patient's wishes regarding medical treatment decisions. If any of the interested persons disagrees with the selection or decision of the proxy decision-maker or if, after reasonable efforts, the Interested Persons are unable to reach a consensus as to who should act as the proxy decision-maker, then any of the Interested Persons may seek guardianship of the patient by initiating guardianship proceedings pursuant to State law.

ii. An Attending Physician may designate another willing physician to make health-care treatment decisions as a patient's proxy decision-maker if:

- After making reasonable efforts, the Attending Physician or his or her designee cannot locate any interested persons, or no interested person is willing and able to serve as proxy decision-maker;
- The Attending Physician has obtained an independent determination of the patient's lack of decisional capacity from another physician, by an advanced practice registered nurse who has collaborated about the patient with a licensed physician either in person, by telephone, or electronically, or by a court;
- The Attending Physician or his or her designee has consulted with and obtained a consensus on the proxy designation with the medical ethics committee of the health-care facility where the patient is receiving care; and
- The identity of the physician designated as proxy decision-maker is documented in the medical record.

d. The authority of the proxy decision-maker terminates in the event that:

i. An interested person is willing to serve as proxy decision-maker;
ii. A guardian is appointed;
iii. The patient regains decisional capacity;
iv. The proxy decision-maker decides to no longer serve as the patient's proxy decision-maker; or
v. The patient is transferred or discharged from the facility, if any, where the patient is receiving care, unless the proxy decisionmaker expresses his or her intention to continue to serve as proxy decision-maker.

If the authority of a proxy decision-maker terminates for one of the reasons described above, the Attending Physician shall document the reason in the patient's medical record.

e. The Attending Physician and the proxy decision-maker shall adhere to the following guidelines for proxy decision-making:

i. For routine treatments and procedures that are low-risk and within broadly accepted standards of medical practice, the Attending Physician may make health-care treatment decisions;
ii. For treatments that otherwise require a written, informed consent, such as treatments involving anesthesia, treatments involving a significant risk of complication, or invasive procedures, the Attending Physician shall obtain the written consent of the proxy decision-maker and a consensus with the medical ethics committee (if any);
iii. For end-of-life treatment that is nonbeneficial and involves withholding or withdrawing specific medical treatments, the Attending Physician shall obtain an independent concurring opinion from a physician other than the proxy decision-maker, and obtain a consensus with the medical ethics committee.

f. When the Attending Physician determines that an adult patient lacks decisional capacity, the Attending Physician or another health-care provider shall make reasonable efforts to advise the patient of such determination, of the identity of the proxy decision-maker, and of the patient's right to object.
g. Artificial nourishment and hydration may be withheld or withdrawn from a patient upon a decision of a proxy only when the Attending Physician and a second independent physician trained in neurology or neurosurgery certify in the patient's medical record that the provision or continuation of artificial nourishment or hydration is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning.
h. The assistance of a health-care facility's medical ethics committee shall be provided upon the request of a proxy decisionmaker or any other interested person whenever the proxy decision-maker is considering or has made a decision to withhold or withdraw medical treatment. If there is no medical ethics committee for a health-care facility, such facility may provide an outside referral for such assistance or consultation.
i. If any interested person or the guardian or the Attending Physician believes the patient has regained decisional capacity, then the Attending Physician shall reexamine the patient and determine whether the patient has regained such decisional capacity and shall enter the decision and the basis therefore into the patient's medical record and shall notify the patient, the proxy decisionmaker, and the person who initiated the redetermination of decisional capacity.

8.1.3 MINOR PATIENT CONSENT

a. A minor may consent to:
    i. Organ or tissue donation, or the furnishing of hospital, medical, dental, emergency health, and surgical care to himself or herself, if the minor:
        - is eighteen years of age or older;
        - is fifteen years of age or older who is living separate and apart from his or her parent, parents, or legal guardian, with or without the consent of his or her parent, parents, or legal guardian, and is

managing his or her own financial affairs, regardless of the source of his or her income;
- has contracted a lawful marriage; or
- is an offender under the age of eighteen years who has been sentenced to the youthful offender system pursuant to C.R.S. § 18-1.3-407.

ii. the donation of his or her blood and to the penetration of tissue that is necessary to accomplish the donation, if the minor is at least sixteen years of age but is less than eighteen years of age, so long as the minor's parent or legal guardian consents to authorize the donation of the minor's blood and the penetration of tissue. C.R.S. § 13-22-104

iii. Treatment, examination, or prescription for use of drugs or a substance use disorder.

iv. Mental health services, if the minor is fifteen years of age or older, with or without the consent of a parent or legal guardian. C.R.S. § 27-65-104

v. If the minor is pregnant, prenatal, delivery, and post-delivery medical care for herself related to the intended live birth of a child. Additionally, any parent, including a parent who is a minor, may request and consent to organ or tissue donation of his or her child or the furnishing of hospital, medical, dental, emergency health, and surgical care to his or her child or ward. The consent of a minor parent shall not be subject to disaffirmance because of minority, and, when such consent is given, said minor parent has the same rights, powers, and obligations as if he or she were of legal age. C.R.S. § 13-22-103.

vi. The receipt of birth control procedures, supplies, and information furnished by licensed physicians if the minor:
- is pregnant, or a parent, or married;
- has the consent of the minor's parent or legal guardian;
- has been referred for such services by another physician, a member of the clergy, a family planning clinic, a school or institution of higher education, or any agency or instrumentality of this state or any subdivision thereof; or
- requests and is in need of birth control procedures, supplies, or information. C.R.S. § 13-22-105

vii. Abortion services. However, no abortion shall be performed upon an unemancipated minor until at least forty-eight (48) hours after written notice of the pending abortion has been delivered as required in C.R.S. § 13-22-704, unless notice is not required pursuant to C.R.S. § 13-22-705.

viii. Customary and necessary examinations to obtain evidence of a sexual offense and treatment of the patient for any immediate condition caused by a sexual offense, if the minor, as a patient, indicates that he or she was the victim of a sexual offense. However, prior to examining or treating a minor, a physician shall make a reasonable effort to notify the parent, parents, legal guardian, or any other person having custody or decision-making responsibility with respect to the medical care of such minor of the sexual offense.

8.2 INFORMED CONSENT

8.2.1 WHEN REQUIRED

The performing practitioner is responsible for obtaining the patient's or his/her legal representative's informed consent for the procedures and treatments listed below:

a. Anesthesia;
b. Surgical and other invasive and special procedures;
c. Use of experimental drugs;
d. Organ donation;
e. Chemotherapy;
f. Autopsy;
g. Photography;
h. Observing of a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form;
g. Blood and blood products;
h. STI testing (as required under Section 8.2.4 Special Circumstances below); and
i. Use of non-FDA approved experimental drugs or off-label use of medications.

8.2.2 DOCUMENTATION REQUIRED

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

a. Patient identity;
b. Date and time when patient was given information, and date and time when patient signed the form, if different;
c. Nature of the procedure or treatment proposed to be rendered;
d. Name(s) of the individuals(s) who is (are) to perform the procedure or administer the treatment;
e. Authorization for any required anesthesia;
f. Indication that the risks and potential complications of the procedure or treatment, the alternatives available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, with sufficiency and in terms that a patient would reasonably consider material to the decision as to whether or not to undergo the procedure or treatment;
g. Authorization for disposition of any tissue or body parts as indicated;
h. Name of the practitioner who informs the patient and obtains the consent; and
i. For STI testing, informed consent documentation must also address the Special Circumstances requirements outlined in Section 8.2.4

8.2.3 SIGNATURES

An informed consent must be signed by the patient (or on the patient's behalf by the patient's authorized representative), and witnessed by a legally competent third party, as set forth above.

8.2.4 SPECIAL CIRCUMSTANCES

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 8.2.1 without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record. Where possible, two physicians shall document the medical advisability of proceeding without informed consent.

STI Testing, Generally: Before testing any specimen of a patient for any STI the practitioner must:

a. Ensure the patient signs a general consent form for treatment;
b. Provide verbal consultation about STIs, testing, and reporting requirements; ***and***
c. Provide the patient with the opportunity to opt-out of testing following the verbal consultation.

HIV / Syphilis Testing for Pregnant People Presenting for Prenatal Care: A pregnant person receiving prenatal care for which the provider is required to take a blood sample for HIV / Syphilis testing must be informed that:

a. HIV / Syphilis serological testing is part of standard prenatal testing;
b. HIV / Syphilis test results inform the decision as to whether to provide prophylaxis to prevent transmission of STI to the infant; and
c. The pregnant person has the opportunity to decline to receive the test.

8.2.5 EMERGENCIES

Nothing in 9.2.4 shall be construed to prevent a physician from performing an emergency procedure without consent, in a case where the patient's life or limb is in danger.

PART IX
SPECIAL SERVICES UNITS

9.1 EMERGENCY SERVICES

9.1.1 MEDICAL STAFF COVERAGE

Medical coverage of the emergency services is provided in the following manner:

a. Basic Emergency Department coverage: EPH shall contract with appropriately qualified members of the Medical Staff to provide primary emergency service coverage.

b. Back-up coverage: Back up physician specialty coverage is provided as set forth below.

9.1.2 BASIC EMERGENCY DEPARTMENT COVERAGE EXPECTATIONS

On-call Emergency Physician must be Members of the Medical Staff with appropriate clinical privileges at EPH. The on-call emergency medicine physician must be available for phone triage and to examine patients in the Emergency Department. The on-call emergency medicine physician must respond to phone calls immediately and be available to examine a patient and perform the Medical Screening Examination in the Emergency Department within twenty (20) minutes after the phone notification and thirty (30) minutes of the patient's arrival.

9.1.3 EMERGENCY DEPARTMENT ON-CALL ROSTER

Given the composition of the Medical Staff, the on-call roster for the Emergency Department will generally consist of on-call surgeons and on-call hospitalists. Other specialists may be added to the roster, from time to time, depending upon the reasonable capabilities of the Hospital and Medical Staff.

a. Surgical On-Call Roster: On call Surgeons must be Active, Courtesy, or Locums Medical Staff members. The on-call Surgeon must be available by phone and for in-person consultation in the Emergency Department at the request of the emergency department physician.

b. Hospitalists On Call Roster: On call Hospitalists must be Active, Courtesy, or Locums Medical Staff members. The on-call Hospitalist must be available by phone and for in-person consultation in the Emergency Department at the request of the emergency department physician.

c. Call coverage may also be provided from time to time by Locums Tenens physicians with appropriate clinical privileges.

9.1.4 SCHEDULING ON-CALL ROSTERS

a. Initial backup for ED providers will be other on-staff ED providers. Hospitalists will serve as backup for ED.

b. Providers who have on-call responsibilities for the Emergency Department will submit their on-call schedule requests to the Provider Relations Specialist who will generate the on-call schedule. The service chiefs are ultimately responsible for ensuring the on-call shifts are covered.

c. Changes from the published schedule are the responsibility of the physician who would normally be on call requesting the change. All changes must be reported to the Provider Relations Specialist, and will be published on the EPH Intranet. The Provider Relations Specialist will notify the Chief of Staff of any call coverage concerns. Any potential gaps in call coverage, should be discussed with the Chief of Staff or designee. Except for

unpredictable emergencies, if the on-call physician or surgeon is unable for any reason to meet the call obligation, the CEO in consultation with Chief of Staff will collaborate to identify coverage by a physician with the appropriate clinical privileges to fulfill this obligation.

d. The call day begins at 0700 of the day assigned and continues until 0700 the following morning.

e. Failure by a provider to comply with the rules governing on call obligations may result in corrective action pursuant to the Medical Staff Bylaws.

9.1.5 PHYSICIANS' GENERAL ON-CALL RESPONSIBILITIES

a. Physicians who are on-call for the Emergency Department have the following general responsibilities:

   i. Responsibility for coverage on the days to which they are assigned except in cases of an unexpected emergency. If a physician cannot take the assigned call, it is his/her responsibility to arrange for coverage during the absence; and
   ii. Responsibility for responding to telephone calls or messages concerning patients within twenty (20) minutes and being able to evaluate a patient who has presented to the ED as soon as reasonably possible, but in all cases within thirty (30) minutes of a request from staff. All phone encounters should be documented in the EMR.

b. The Emergency Department physician is responsible for the patient until the transfer of care is accepted by on-call Surgeon or the Hospitalist.

c. Should any physician or surgeon on-call fail to fulfill any of the stated responsibilities or obligations, such failure shall be reported to the Chief of Staff or designee. The Chief of Staff, or authorized designee, will review the case (on behalf of the Medical Staff). If two such actions occur within a twelve (12)-month period, the action will be reported to the Chief of Staff or designee and Medical Staff Leadership should convene and determine if further action is warranted pursuant to the Medical Staff Bylaws. Nothing herein, however, shall serve to prevent further, additional, or more immediate action pursuant to the Medical Staff Bylaws.

9.1.6 MEDICAL SCREENING EXAMINATION

A patient presenting to the Emergency Department for evaluation/treatment will have been offered a medical screen examination by the Emergency Department physician or qualified medical personnel on duty. If a patient or designated representative refuses a medical screening examination, the physician, if requested, will inform the patient of the risks and benefits of refusal. The Medical Staff will comply with the federal Medical Screening Examination and Stabilization Treatment Act (EMTALA).

When the medical screening examination indicates the patient has an emergency medical condition, the patient will be stabilized, admitted to the hospital, and/or appropriately transferred pursuant to these Rules and Regulations and the requirements of EMTALA.

9.1.4 TRANSFER OF PATIENTS

Transfer of an emergency service patient to another health care agency shall be carried out in accordance with the policies stated in Part IV of this document.

9.1.5 INSTRUCTIONS TO PATIENTS DISCHARGED

Patients seen for emergency services who are not admitted to EPH shall be given written instructions regarding their follow-up care. The patient or responsible party shall acknowledge delivery and understanding of the instructions. A copy of the instructions shall become part of the patient's emergency service record. Clinically Privileged Practitioners shall be obligated to see unattached patients, when reasonably required, who are referred for follow-up care following discharge from the Hospital or Emergency Department.

9.1.6 MEDICAL RECORD

Consistent with the general Medical Record requirements outlined above, an accurate and complete medical record shall be maintained for each patient seen by the emergency service and will be part of the patient's permanent EPH record. EPH medical records for each emergency service patient shall be available–to the Attending Physician and other authorized personnel. The EMR record for each emergency service visit must include at least:

a. Adequate identification, or if not obtainable, the reason for such;
b. Date, time, and method of transport;
c. Pertinent history of the injury or illness and physical findings, including vital signs;
d. Allergy history and current medications;
e. Details of care given the patient prior to arrival at EPH;
f. Evidence of appropriate informed consent, or if not obtainable, the reason for rush;
g. Diagnostic and therapeutic orders;
h. Treatment given;
i. Clinical observations, including results of treatment;
j. Diagnosis or diagnostic impression; and
k. Conclusion at the termination of evaluation/treatment, including final disposition, patient's condition on discharge or transfer, and instructions given to the patient or responsible party for follow-up care.

PART X
HOSPITAL DEATHS

10.1 PRONOUNCEMENT

In the event of a patient death at EPH, the deceased shall be pronounced dead by the Attending Physician or his/her physician designee.

10.2 REPORTABLE DEATHS

Reporting of deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local law.

10.3 DEATH CERTIFICATE

In all cases where the coroner has held an investigation or inquest (i.e., a death occurring without medical attendance as described in C.R.S. § 30-10-606), the certificate of death shall be issued by the coroner. For all other patient deaths at EPH, the death certificate must be signed by the Attending Physician. In the absence of the Attending Physician, or with his or her approval, the death certificate may be signed by another designated physician, the EPH Chief Medical Officer, or by the physician who performed an autopsy, provided that such individual has access to the medical history of the case, views the decedent at or after the time of death, and the death is due to natural causes. The death certificate must be signed and returned to the funeral director (or person acting as such) or submitted electronically through the State Electronic Death Registration (EDR) system, within forty eight (48) hours after a death occurs.

10.4 RELEASE OF BODY

All policies with respect to the release of dead bodies shall conform to local law.

PART XI
INFECTION CONTROL

11.1 GENERAL AUTHORITY

The Clinical Quality Committee has the authority to institute appropriate control measures or studies when it is reasonably felt there may be a danger to patients or personnel from an infectious source.

PART XII
AMENDMENT

12.1 AMENDMENT

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by one of the following mechanisms:

a. A resolution of the Medical Executive Committee (MEC) recommended to and adopted by the Board; or

b. Action by the Board on its own initiative after notice to the MEC of its intent and in accordance with the procedures outlined in Article VIII of the Medical Staff Bylaws.

12.2 RESPONSIBILITIES AND AUTHORITY

The procedures outlined in Article XI, Section 11.1(c) of the Medical Staff Bylaws shall be followed in the adoption and amendment of these Rules and Regulations, provided that the MEC may act for the staff in making the necessary recommendations.

PART XIII
ADOPTION

These Rules and Regulations may be amended by a majority vote of the Medical Executive Committee and shall become effective upon approval of the Board of Directors.

THIS REVISED RULES AND REGULATIONS OF THE MEDICAL STAFF DOCUMENT IS APPROVED by the Medical Executive Committee on: 4/19/2023.

THIS REVISED RULES AND REGULATIONS OF THE MEDICAL STAFF DOCUMENT IS APPROVED AND ADOPTED by the Board of Directors on: _____.

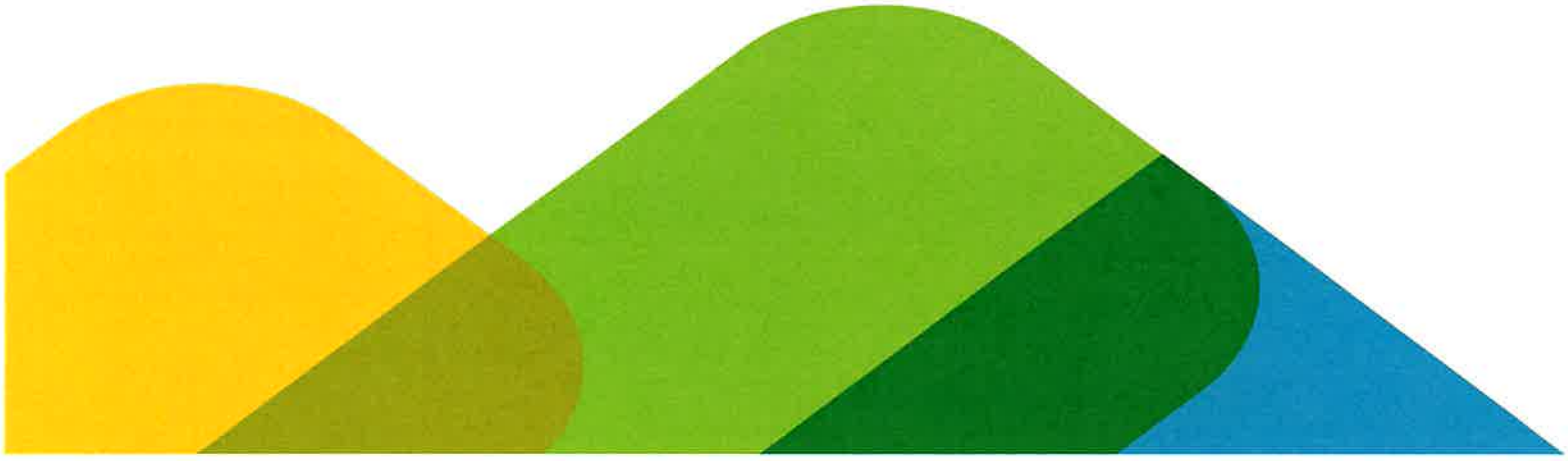
Approved by the Medical Staff: 9/2/92; 7/2/03; 10/1/14
Approved and Adopted by the Board: 10/27/92; 7/29/03; 10/28/14

Quarterly Quality Update

Kendra Simms MS, BSN, RN
Sr. Director of Quality, Patient Safety
& Risk Management

ESTES PARK HEALTH

June 19, 2023

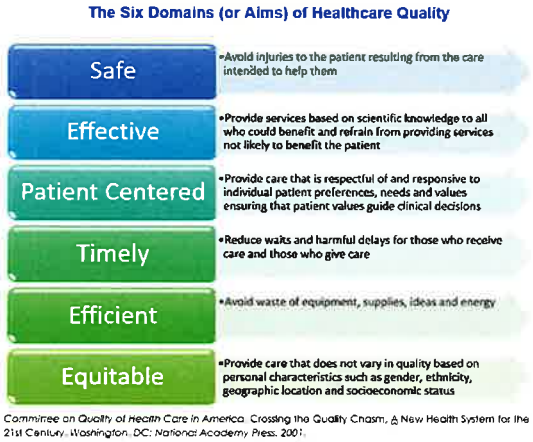


8.2.1

Pursuit of Quality

Facility Strategy

- Facility is committed to improving patient outcomes. We will provide safe and person-centered care. EPH will challenge improvement of patient outcomes through measurement, continuous quality improvement and adoption of best practices.



Committee on Quality of Health Care in America. Crossing the Quality Chasm, A New Health System for the 21st Century. Washington, DC: National Academy Press. 2001.

Quality Strategy

- ISO certification
  - DNV "tracers" by all units
- Clinical depts defined metrics by June 15, 2023, with Power BI implementation by August 30, 2023

ESTES PARK HEALTH

8.2.2

Developing People Resources

Facility Strategy

- Developing People Resources

Quality Strategy

- Senior Leaders, Senior Directors and Directors will have initial training on Just Culture by September 1, 2023 and mid level leaders will be educated by September 30, 2023

ESTES PARK HEALTH

8.2.3

Information Technology Improves Patient Outcomes

Facility Strategy

- Increase & leverage IT systems to effectively manage & improve care

Quality Strategy

- Continue to obtain baseline data sepsis data with implementation of BPA on June 1, 2023.
  - To include the first 24 hours of care, blood culture contamination rate and antibiotic usage.
  - Data will be converted to Power BI by September 30, 2023

ESTES PARK HEALTH

8.2.4

Fiscal Health

Facility Strategy

- Identify opportunities to increase services to the community.

Quality Strategy

- Home oxygen dispensing
- Therapeutic Phlebotomy
- Supplies in the OR

ESTES PARK HEALTH

8.2.5

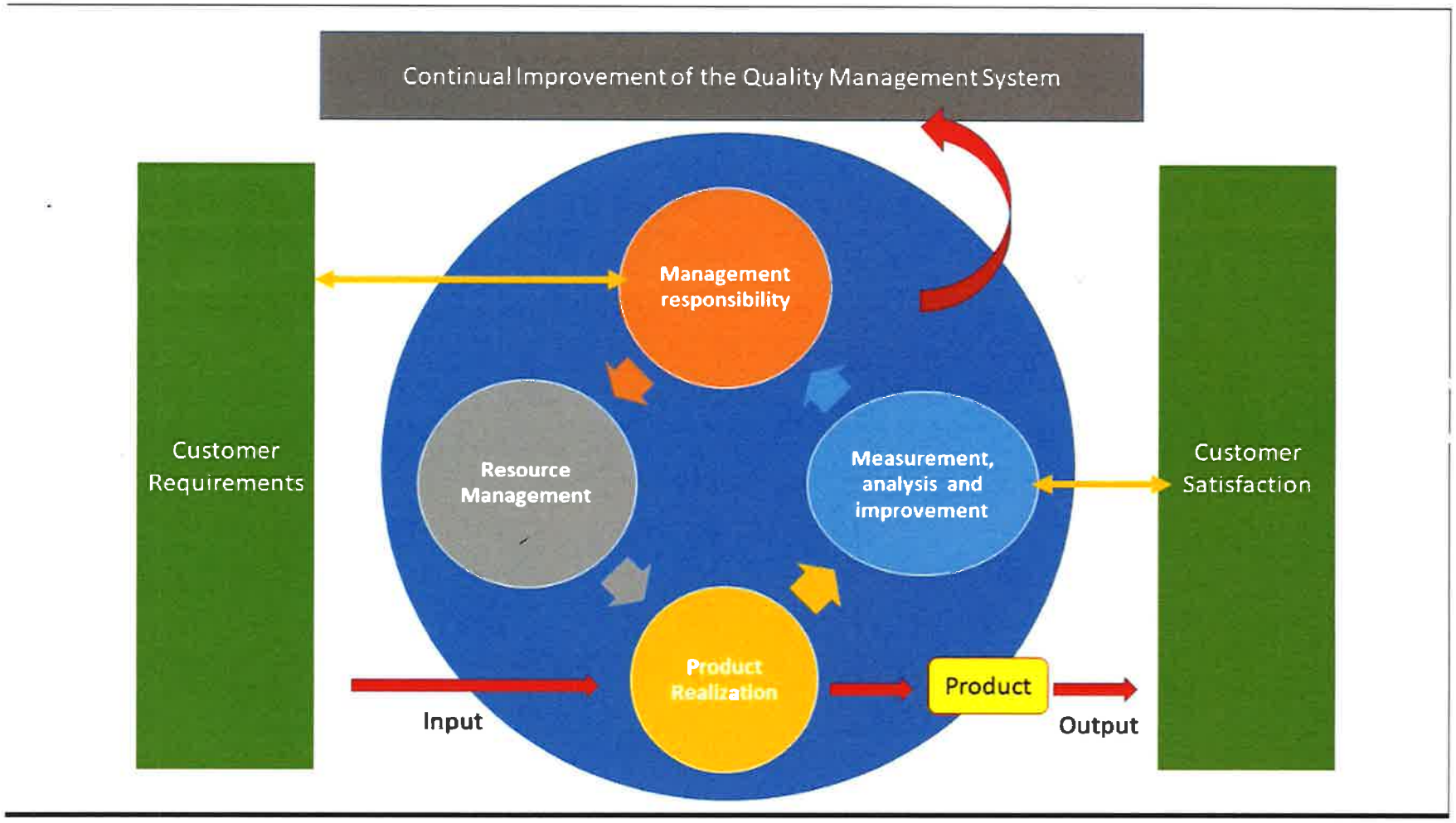
What is ISO 9001

- World's most recognized **QUALITY MANAGEMENT SYSTEM**
  - Set if requirements that guide an organization in standardization implementation with the goal of

8.2.6


1.
Customer Focus
2.
Leadership
3.
Engagement
of People
4.
Process Approach
5.
Improvement
6.
Evidence-Based
Decision Making
7.
Relationship
Management
ISO 9001

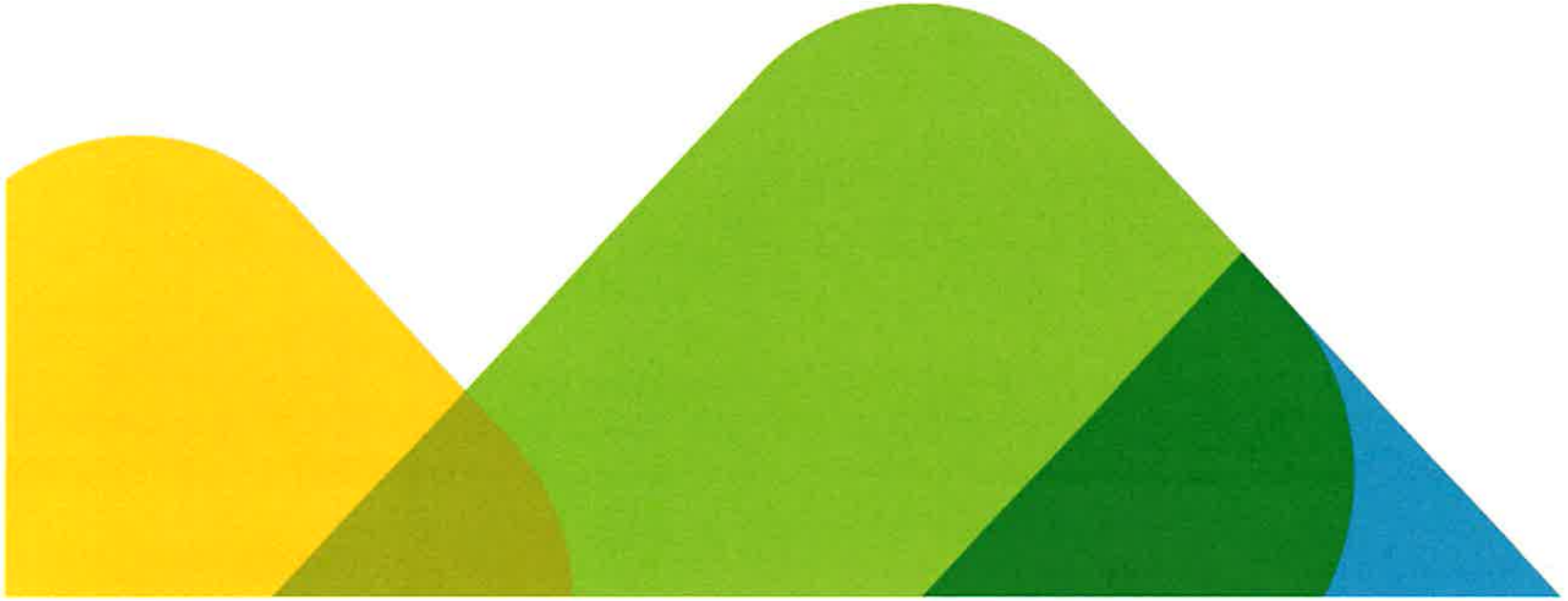
8.2.7


Continual Improvement of the Quality Management System
Customer Requirements
Management responsibility
Resource Management
Measurement, analysis and improvement
Product Realization
Input
Product
Output
Customer Satisfaction

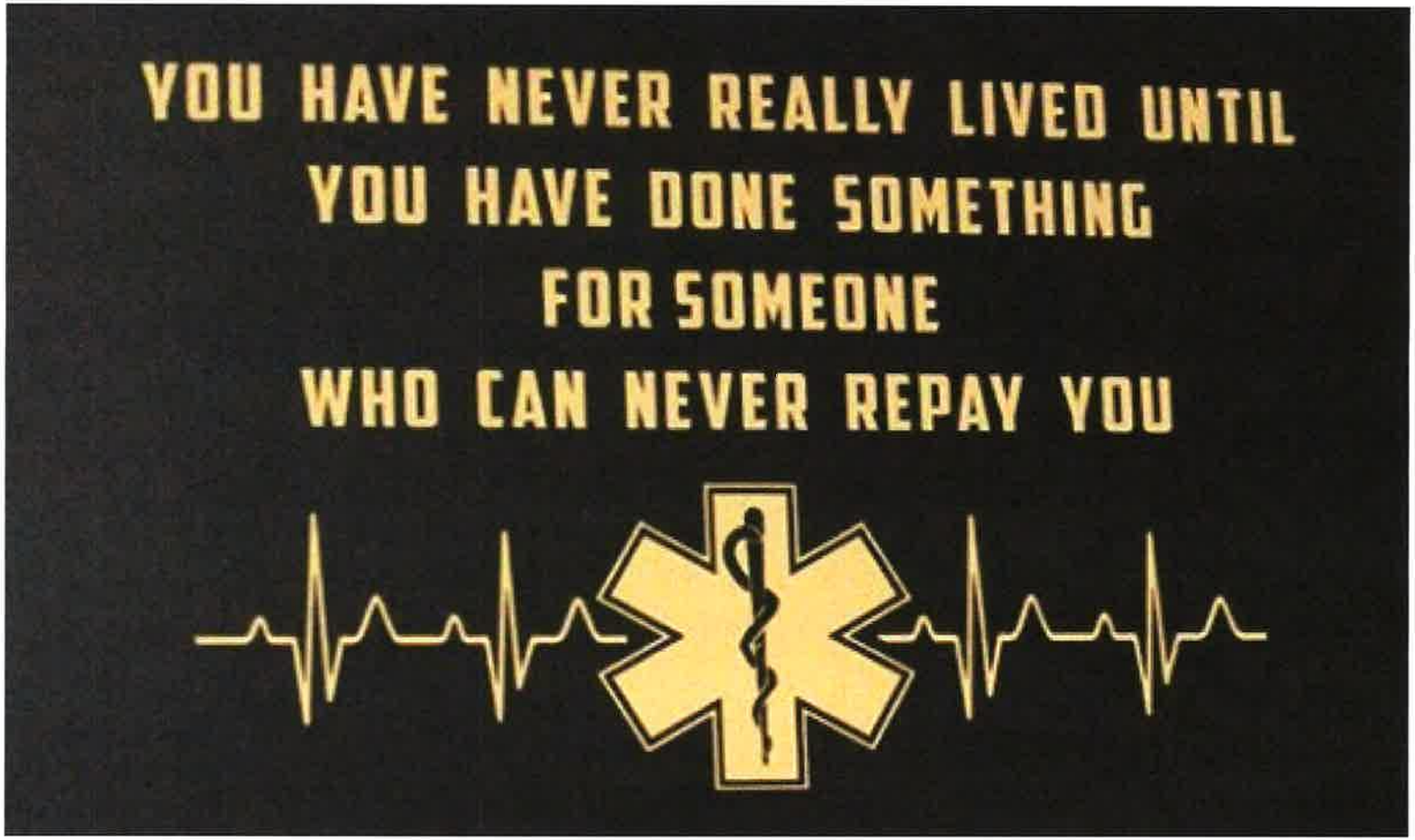
8.2.8

ESTES PARK
HEALTH

EPH CNO Update 6-2023



8.3.1



ESTES PARK HEALTH

EPH updates…

- Celebrated Hospital Week and Nurses' Day.
- Added an interim manager to Perioperative Services to assist with team development and growth with new surgeons onboarding.
- Urgent Care increased hours to 10hrs day/7 days a week starting 6/17.

ESTES PARK HEALTH 8.3.3

Covid/pandemic updates…

- Vaccine requirement lifted at this time by CMS/State of Colorado.
- EPH continues to return to practices/processes pre-pandemic.
- COVID Governance continues to meet regularly
  - Monitor incident rates at EPH and Larimer County.
  - Develop a pandemic emergency management plan for EPH-state requirement.
  - Revise policies and practice as identified.

ESTES PARK HEALTH 8.3.4

Pursuit of Quality…

- DNV
  - Accrediting agency.
  - Surveyed on site May 9th and 10th.
    - Great survey and survey process. New leaders were able to participate and learn.
  - Received 6-NC-1's and 7-NC-2's, challenging one of the NC-2's
    - No conditional or immediate jeopardy.
    - Many were addressing consistent practice and documentation to our policies and procedure.
  - 2022 results – NC-1's-10 and NC-2's-7; no conditionals or immediate jeopardy.
  - 2021 results – NC-1's–6 and NC-2's–13: no conditionals or immediate jeopardy.
  - Submitted action plan June 9th.

ESTES PARK HEALTH 8.3.5

Pursuit of Quality…

- Continue to collaborate and focus on Patient Safety/Quality with each department, identifying quality improvement programs per each department and solidify data management and reporting. More per Kendra's presentation.

- Laboratory
  - CAP complete, action plan implemented.

- Emergency Management
  - Working on Emergency Management Plan for a pandemic – per state requirements.

- Medical/Surgical/Emergency Department
  - Working on sepsis BPA, Pain documentation, medication scanning rates.

Pursuit of Quality…

- Diagnostic Imaging
  - Fluoroscopy replacement process in progress.
  - Implementing process improvements to enhance patient care and efficiency.
- Perioperative service line
  - Medication scanning rates, Pre-operative calls-patient preparation, process improvement of pain documentation.
- Overhaul and revisions to policy and procedures process (and forms) per regulations. DNV complimented our revisions/managing of the process.
- Environment of Care (EOC) team developed and implementing construction and maintenance projects efficiently and effectively.

Developing People Resources…

- Environment of Care Program Manager implemented, focus on workplace violence and building safety.
- Registered Dietitian-building an outpatient program.
- Lab-re-organized leadership to support CAP input, implementing well.
- Leadership Development initiated for Sr. Directors, Directors and Managers/Supervisors.
- Recruitment/retention team very successful. Filling hard to fill positions, decreasing contract labor and identifying new ways to support retention of staff.

ESTES PARK HEALTH

8.3.8

Leveraging Technology to Improve Outcomes…

- Care of the patient with Sepsis-Nurses and Physicians
  - Best Practice Alert (BPA turned on)
    - Analyzing the data with our clinical informaticist.

- Emergency Department
  - Implementing the BPA along side our providers.
  - Prioritization and placement of patients, using EPIC to support.

- Medical/Surgical
  - Implementing best practice for documentation of pain management, supported by 'brain' in EPIC.
  - Utilizing other EPIC AI in patient care (fall risk, change in clinical status, etc).

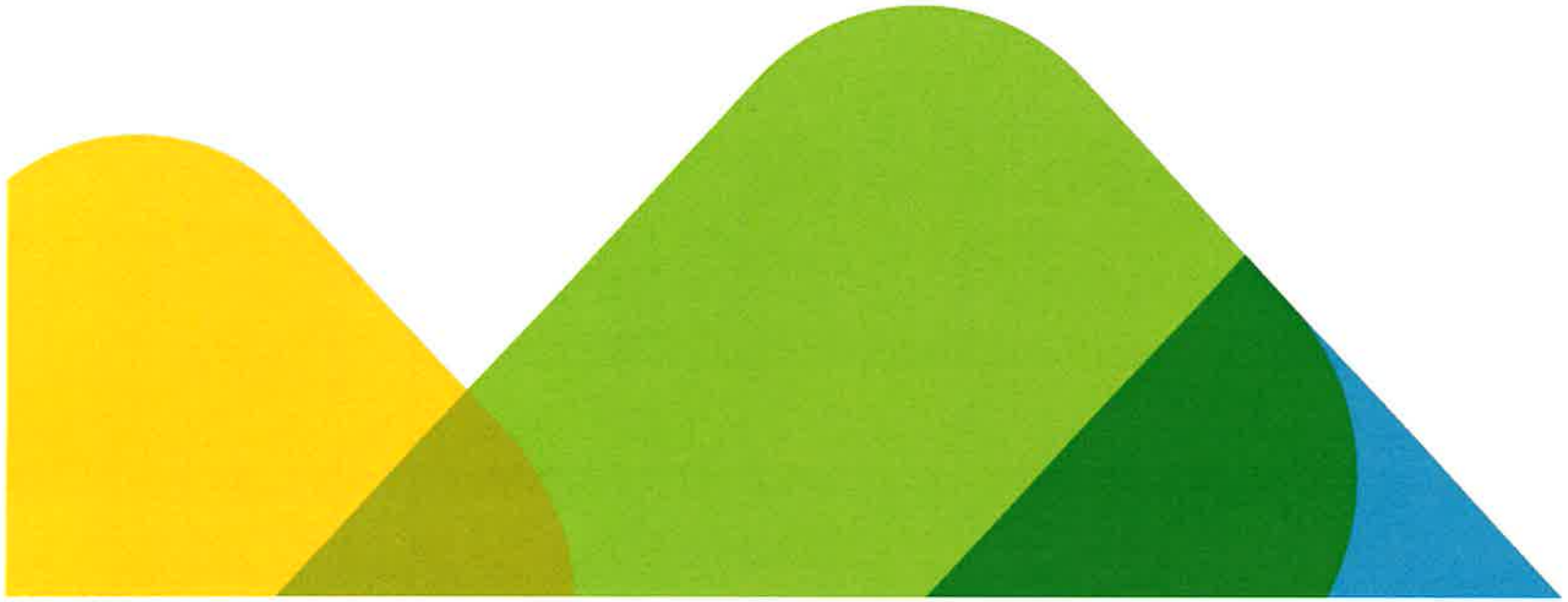
ESTES PARK HEALTH 8.3.9

Fiscal Health…

- Robust recruitment plan being implemented with senior directors and HR business partner.
- Diligence from senior directors/directors in expense management.
- Senior Directors and Directors working to hire permanent staff.
  - Converting travelers to full time positions.
  - Creative staffing.
  - Hiring seasonal staff to meet increase volume during our season. (May-October).
- Respiratory Therapy and Infusion Team continue to build outpatient volume.

ESTES PARK HEALTH 8.3.10

QUESTIONS?



8.3.11

ESTES PARK HEALTH

Population Health Board Presentation

06/19/2023

8.4.1

Defining Population Health

- Population health management refers to the process of ***improving clinical health outcomes*** of a defined group of individuals ***through improved care coordination*** and ***patient engagement*** supported by ***appropriate financial and care models***. AHA 2023

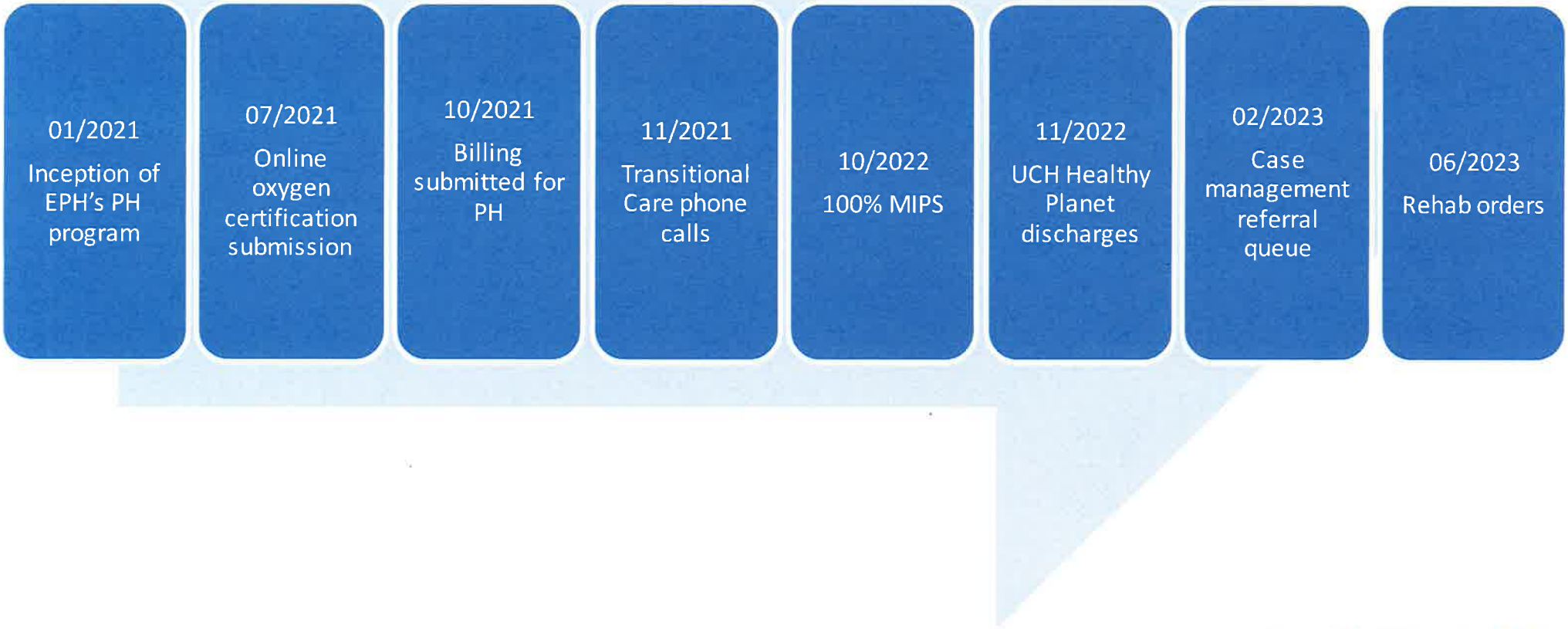
ESTES PARK HEALTH 8.4.2

Steering Committee

Quarterly meetings directing program development and goals

ESTES PARK HEALTH 8.4.3

Milestones

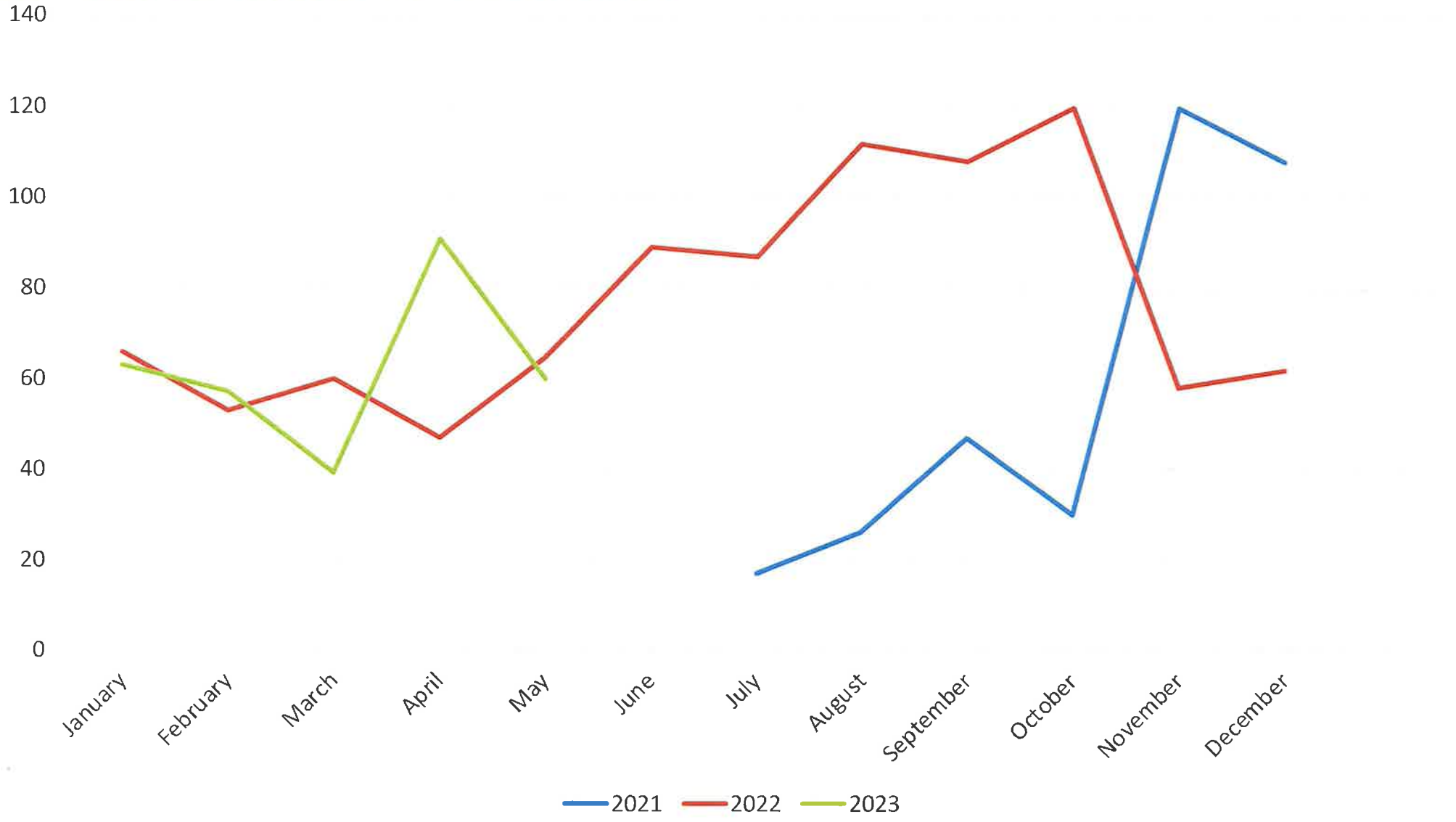


ESTES PARK HEALTH

8.4.4

PH Encounters

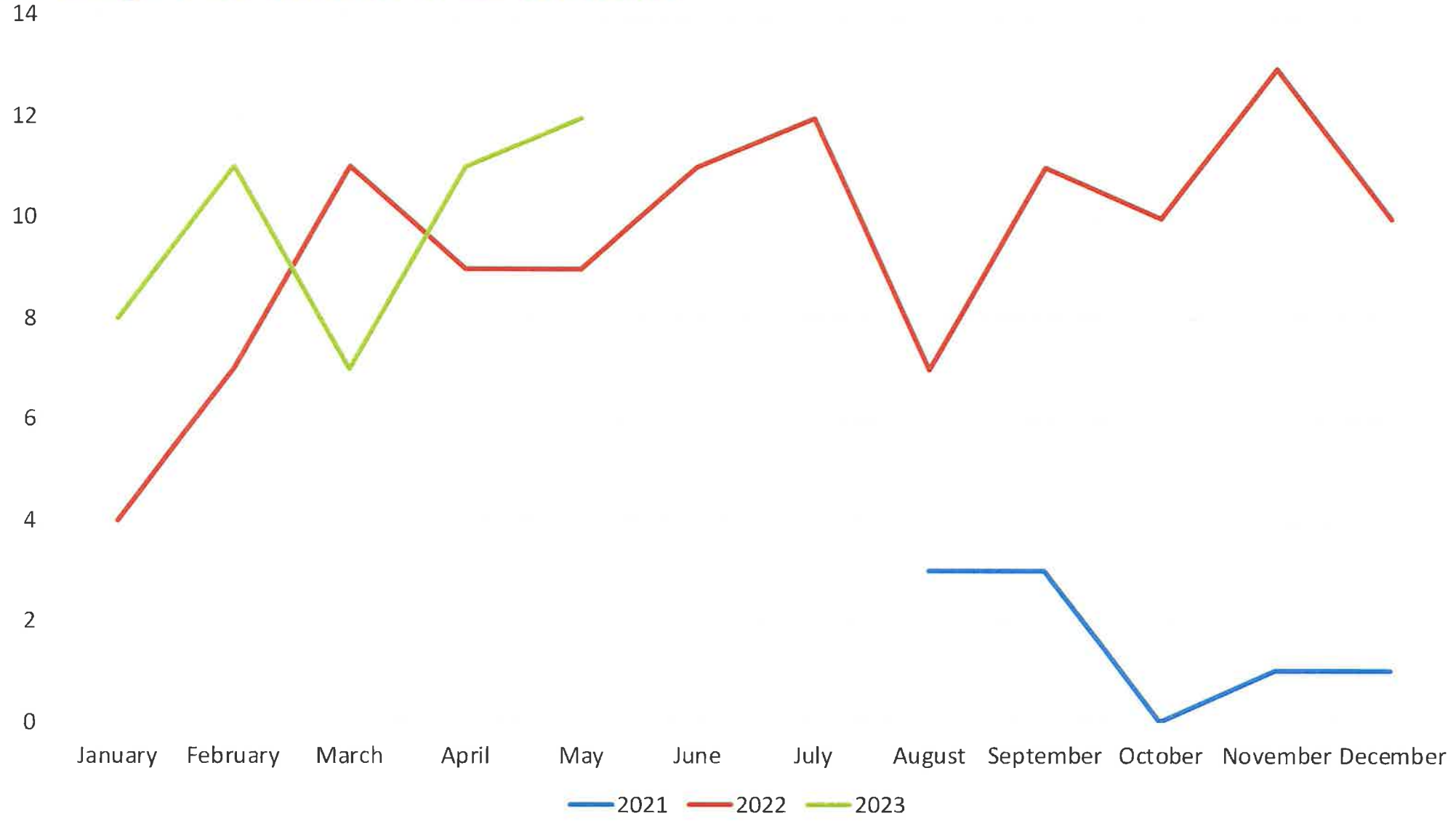
Average 69/month over 23 months



ESTES PARK HEALTH 8.4.5

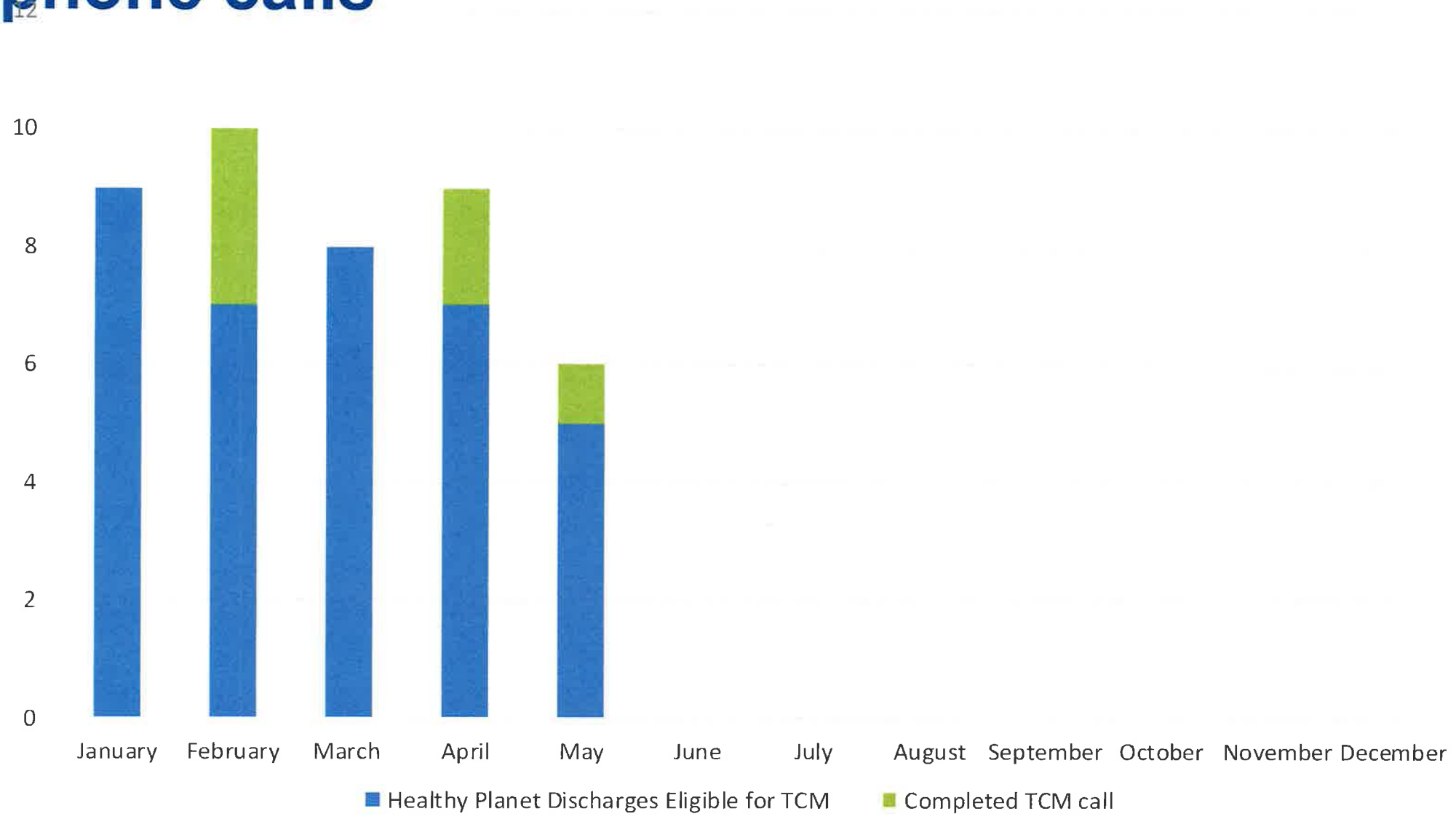
Billable Encounters

Average 8/month over 22 months



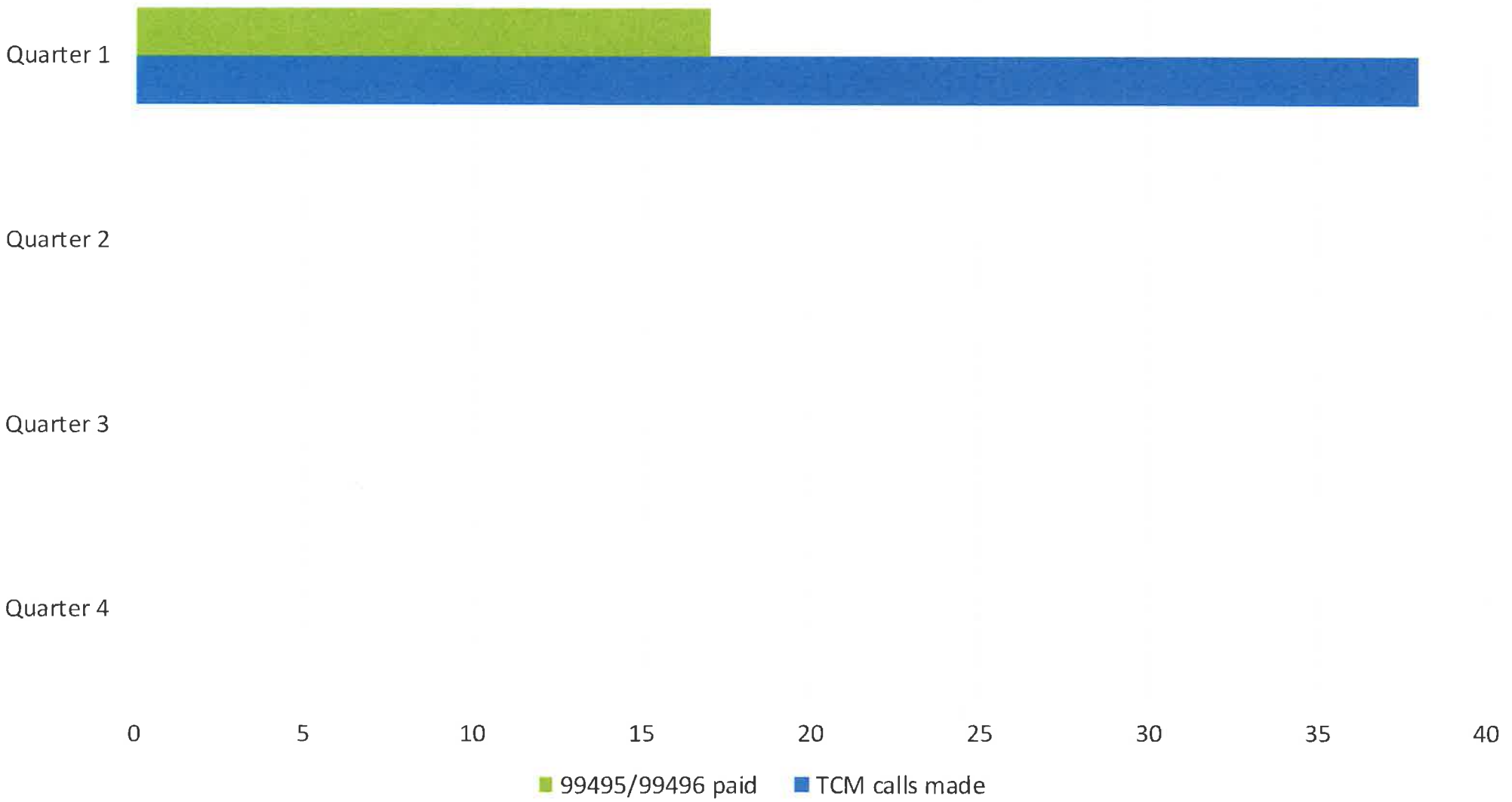
ESTES PARK HEALTH 8.4.6

Opportunities-Healthy Planet discharges phone calls



ESTES PARK HEALTH 8.4.7

Financial Impact v Patient Experience



ESTES PARK HEALTH 8.4.8

Patient stories

January 26, 2023

Me to [redacted]

It was my pleasure! That's what I'm here for :)

Let me know if there's anything else you need.

8:18 PM

Wendy, RN
Population Health Manager

Last read by [redacted] at 12:44 PM on 1/27/2023.

[redacted] to Me

[redacted]

We got it--so glad we reviewed my meds so we saw it was missing.

Thanks so much.

[redacted]

6:56 PM

Me to [redacted]

[redacted]

Thanks for your time tonight on the phone.

I was able to reach Dr. Zehr. She will order your Augmentin now and hopefully you can pick it up tonight. I would call the pharmacy before you drive down there to be sure they have it filled before you leave home.

She is waiting to hear from Dr Fonken about the HCTZ and will contact you tomorrow with clarification.

6:07 PM

Wendy, RN
Population Health Manager

Last read by [redacted] at 12:44 PM on 1/27/2023.

ESTES PARK HEALTH 3.4.9

2023-Ongoing Quality Improvement

- Oxygen order documentation
- Hospice admits
- Tracking missed transitional care phone calls
- Scheduling Transitional Care visits
- Outpatient case management referral queue
- Healthy Planet Discharge Report
- Quarterly Steering Committee meetings
- PH Standards of Practice
- Park School District Cultural Coalition
- Utilize Pop Health Dashboard

ESTES PARK HEALTH 8.4.10

Possible Health Care System Affiliation Activity Update

June 19, 2023

ESTES PARK HEALTH

8.5.1

Brief Review

Goals:

- Ensure excellent healthcare services to address our community's healthcare needs for many years to come
- Access to outstanding healthcare service providers for services we do not offer

Stronger and deeper affiliation with a major healthcare system is the best way to accomplish these goals

ESTES PARK HEALTH 4.5.2

Affiliation Steps

1. Initial assessment and review.
2. Negotiations exploring possible mutual interest and benefits.
3. Negotiation of a "Letter of Intent" & Nondisclosure Agreement
4. Due Diligence – both parties assess benefits/challenges
5. Negotiate "Definitive Agreement"
6. Colorado Attorney General review.
7. Possible Antitrust review
8. "Definitive Agreement" implementation and integration

ESTES PARK HEALTH 8.5.3