Board of Directors
Regular Meeting & Executive Session
July 24, 2025 6:00 p.m.

AGENDA

I. Regular Meeting Open Session Call to Order 6:30 p.m.

1. Agenda - Corrections or Additions (action)

II. Consent Agenda

1. Meeting Minutes
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2. Board Counsel Invoice – Robert S. Miller III Attorney – #1081 9
4. **Motion to Approve Consent Agenda** (action)

III. New Business

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2. Consideration of FY 2026 Public Meeting Calendar (action)11

IV. Old Business

1. None

V. Staff Reports-Discussion

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9. Strategic Plan Update (under separate cover)

VI. Monthly Financial Statements: Review & Discussion

1. Month End Summary 135
2. Month End Statements for Period Ending June 30, 2025 137

VII. Open Discussion

VIII. Executive Session

Executive Session Under 192.660(2)(c) to consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 Licensing of facilities and health maintenance organizations, and under ORS 192.660(2)(f) to consider information or records that are exempt from disclosure by law, including written advice from legal counsel. No decision will be made in Executive Session.

IX. Return to Open Session

Action from Executive Session

1. Motion to Approve Executive Session Minutes-06/26/25 (action)
2. Motion to Approve Reports from Executive Session: (action)
   a. Quality & Patient Safety, Risk & Compliance
   b. Medical Staff Report

X. Adjournment

Southern Coos Health District
Board of Directors Meeting
Open Session Minutes
June 26, 2025

I. Open Session Call to Order at 6:00 p.m.

Roll Call – Quorum established; Thomas Bedell, Chairman; Mary Schamehorn, Secretary; Pamela Hansen, Treasurer/Foundation Liaison, Kay Hardin, Quality Liaison, and Robert Pickel, Directors. **Administration:** Raymond Hino, CEO; Antone Eek, CFO; Cori Valet, CNO; Scott McEachern, CIO; David Serle, Clinic Director; Philip J. Keizer, MD, Chief of Staff. **Others present:** Amanda Bemetz, Quality/Risk/Compliance Director; Katelin Wirth, Financial Analyst; Colene Hickman, Revenue Cycle Director; Robert S. Miller, Counsel; Kim Russell, Executive Assistant. **Via Remote Link:** Joe Kunkel, Consultant; Alden Forrester, MD, Chief Medical Officer; Stacy Nelson, HR Director; Alix McGinley, SCH Foundation Executive Director. **Press:** None.

1. **Agenda - Corrections or Additions** – None.

2. **Public Input –** None.

II. Consent Agenda

1. **Open Session Meeting Minutes (Executive Session Minutes are Reviewed in Executive Session):**

   a. **Regular Meeting–05/22/25**
   b. **Budget Committee Meeting-06/12/25**

Kay Hardin **moved** to approve the Consent Agenda. Mary Schamehorn **seconded** the motion. **All in favor. Motion passed.**

III. New Business

1. **ACO (Accountable Care Organization) Education and Compliance Presentation & Self Test & Attestation**

Mr. Hino requested Board member review and attestation as required for CMS and ACO and provided a summary of the purpose and benefits of joining an Accountable Care Organization. ACOs assist primary care practices and health systems transition from traditional fee-for-service models to value-based care. This shift focuses on improving patient outcomes and quality of care while reducing costs. Southern Coos Year 1 participation was from January 1 to December 31, 2024. We should learn in September if we will be eligible for a Medicare Savings payment this year and are optimistic as the ACO, Wellvana, has a 100% history of success. Mr. Bedell had forwarded a news article for board members that was critical of ACO's, with the article suggesting that costs may change. Southern Coos is now eligible for a third year. In Year 1 the agreement had 100% upside; in Year 2 we had a

maximum downside of $17,000 if the ACO did not meet minimums. The Year 3 opportunity will once again be 100% upside opportunity. Our representative is happy to provide a presentation for the board if so desired. The overall formula is the experience of all participating hospitals for shared savings. If Southern Coos drops, we realize no savings. 25% is retained by Medicare and 75% is split with the member facilities. Quarterly ACO meetings include Dr. Webster, Clinic Medical Director and David Serle, Clinic Director. One example of a quality measure provided is the number of annual well visits for straight Medicare only. **Discussion:** Board opinion is that as long as there is only upside (one-way) Administration has board support to continue, but as soon as there is potential for or change to downside (two-way), this needs to return to the Board for review and approval.

2. New CAH Requirement for Emergency Services for Obstetrics Patients

The CMS Conditions of Participation for Critical Access Hospitals have recently been changed to add new requirements for Emergency services readiness, which go into effect on July 1. Specifically, CMS now requires that Critical Access Hospitals be prepared to provide care for obstetrics patients that arrive in the emergency room, even if the hospital is not licensed for and does not routinely provide obstetrics and maternity care services. CMS recognizes that obstetrical emergencies can happen, regardless of whether the hospital is a licensed obstetrical provider or not. In preparation, the governing body must identify and document which staff must complete such training. The management team at Southern Coos is proposing the following list for the approval by the Board of Directors of staff identified to receive training for Obstetrical Emergencies, Complications and Post-Delivery Care:

- RN, Emergency Department
- LPN, Emergency Department
- Emergency Department Physicians
- Emergency Department Nurse Practitioners
- Nurse Manager, Emergency Department
- Charge Nurse, Med-Surg
- Float Nurse, Med-Surg
- Ultrasonographer, Medical Imaging
- CT Technician, Medical Imaging
- X-Ray Technician, Medical Imaging
- Medical Imaging Manager
- Medical Laboratory Assistant I, Laboratory
- Medical Laboratory Assistant II, Laboratory
- Medical Lab Scientist, Laboratory
- Medical Lab Technician, Laboratory
- Laboratory Manager, Laboratory

Mary Schamehorn **moved** to approve the list of OB staff to be trained as presented. Bob Pickel **seconded** the motion. **All in favor. Motion passed unanimously.**

IV. Old Business

1. Facility Master Plan Architect Recommendation

Ray Hino, CEO, provided a summary of the architect selection process and request to award the contract for architectural and engineering services for the Master Facility Plan to the architectural firm of Davis Partnership Architects of Denver, Colorado at a contracted price of $112,000. Consultant Joe Kunkel was present via remote link to answer any questions. Three bids were received for the competitive bidding process for architectural and engineering firms received by the deadline of April 11, 2025. All 3 firms were determined to be qualified. Two firms were selected to make on-site presentations, concluded in June. The Davis Partnership presentation was well organized with detailed drawings of potential options derived from preliminary research. Two Board members attended both presentations. A 3rd Board member attended one of the 2 presentations. After final bid adjustments, Administration seeks approval to exceed the original budget of $171,000, to approve a new budget of $194,000, and to accept the proposal from Davis Partnership.

Pam Hansen **moved** to select Davis Partnership Architects and approve the new budget of $194,000. Bob Pickel **seconded** the motion. **Discussion:** Questions about medical equipment planning were addressed; a site visit will include interviews with each clinical department. Mr. Kunkel provided a positive professional reference or The Davis Partnership. **All in favor. Motion passed.**

V. Open Budget Hearing

1. FY26 Budget Contingency Plan

At a previous meeting, Board members had requested that a contingency plan outline be presented to support the proposed budget should there be unanticipated budget shortfalls. Mr. Hino opened by noting that initial focus will be placed on delivery of proposed strategic initiatives, pausing expenses and continued focus on revenue cycle, while monitoring financial targets and milestones. Additional actions, if needed, may include streamlining human resources with overtime and leave management, consideration of shared personnel pools, consideration of self-funded health insurance, and quarterly assessments, also recognizing national-level fiscal uncertainties. Board members requested that trigger points or benchmarks be added for the next piece. Mr. Eek reminded the group that seasonality of revenue must also be recognized. **Discussion:** The 18% increase in proposed revenue was derived from increased charges, trending increased inpatient utilization, stabilization of clinic providers, increasing ancillary utilization, and better coding practices. The new retail pharmacy has already reached 43 prescriptions per day, a level not projected to have been met until February 2026. Katelin Wirth provided an explanation of ramp up projections of new initiatives/service lines. Mr. Hino added that in the last year as SCHHC transitioned to the new Electronic Health Record, decommissioning of former software platforms occurs over time, and the delay in billings lead to the undesirable revenue deduction percentage, but it was not unexpected. Inpatient and Swingbed utilization and their impact on Medicare

days and how that effects receivables was also reviewed. Mr. Hino noted that this has been an unusual year with the number of strategic initiatives completed and accomplishments that add value moving forward, adding that the key is to manage the revenue deductions. The next phase of the contingency plan development is to include specific data tracking with preliminary numbers provided next month. Mr. Hino thanked Antone Eek, Scott McEachern, and Katelin Wirth and other members of the finance team for their work on this plan. Mr. Eek also reminded that cost report impacts must also be calculated. Mr. Miller asked Ms. Schamehorn about the impact of the property tax revenue, to which she responded that as the Bandon population increases and new homes are built, the tax revenue will also increase to help support Health District growth. New Oregon hospital charity care and community benefit requirements were also discussed. Southern Coos remains focused on assisting uninsured patients with enrollment in the Oregon Health Plan. The Hospital Association of Oregon (HAO) is working to help relieve Oregon hospitals from burdensome regulations.

2. FY26 Proposed Budget Resolution 2025-01 – Adoption of Budget

Mary Schamehorn **moved** to adopt Resolution 2025-01 Adoption of Proposed Budget for Fiscal Year 2026. Kay Hardin **seconded** the motion. **Discussion:** The Form LB-1 detail was reviewed. **All in favor.** Motion passed unanimously and Budget Hearing Closed at 7:17 p.m.

VI. Staff Reports

1. CEO Report

In the interest of time, Mr. Hino provided a brief review of his written report, noting Clinic provider updates with the departure of Dr. Wong, DO, and onboarding of Kim Bagby, FNP, Felisha Miller, FNP and renewal of a 2-year contract with Paul Preslar, DO.

2. CMO Report

Dr. Forrester, Chief Medical Officer, offered to answer any questions relating to his printed report that included status report on the current review of the Medical Staff Bylaws and Medical Staff Rules and Regulations that if ready will be presented to the Board for approval in July. An agreement is in process with OHSU Telemedicine Collaboration for Treatment of Pediatric and Neurology Emergencies. Southern Coos is the designated medical provider for the 125th US Women's Amateur Championship at Bandon Dunes in August, with special thanks to a number of providers and staff who have volunteered to participate or are assisting with preparations.

3. CNO Report

Cori Valet, Chief Nursing Officer, provided a summary of her report, opening with a staffing update; working to fill five full time night shift positions in Med/Surg. We are very happy with our contract nurses. The Emergency Department is fully staffed,

with some providing assistance in Med/Surg at night. A new Lab Tech will onboard soon. The Emergency Department census has hit a new record high. Only five out of 42 transfers were due to limited bed capacity.

4. CFO Report

Antone Eek, Chief Financial Officer, reviewed highlights from his report for Finance operations for the month of May. Work concentrated on the end of fiscal year closing both month-end and year-end books. The team is gearing up to start work with the new Audit firm CLA, showing us how efficient they are. Inventory completion included adjustments and process improvements. Revenue Cycle recorded record cash collection. Over $500K was returned to the state investment pool. Claims and billing can go up to 90-days, with Average Claim Payment Turnaround increased slightly from 18.5 days to 18.9 days due to rising payer diversity and increased volume. Colene Hickman, Director of Revenue Cycle, described migration of data with new Electronic Health Record transition, noting that we should be through the worst of it. **Additional Discussion:** Logs are maintained and Providence has a strong disaster recovery bridge.

5. CIO Report

Scott McEachern provided a summary of department operations in the month of May noting development of a data governance structure with a data analytics workgroup comprised of members of the quality, clinical informatics, information systems, and finance departments. The workgroup is engaged with training on data analytics fundamentals such as SQL database training. Help desk analysts, led by Chris Cox, Jeff Weymouth, and Kyle Gonzales, fielded 186 tickets last month. Clinical Informatics has been focused on onboarding clinic providers and Epic stabilization, noting that a system update effected getting claims out the door as timely as possible. The new phone agent has been live for two weeks with routing protocols still being refined but overall the system has stabilized with the average number of calls per day at 147.8.

6. Clinic Report

David Serle, Clinic Director, presented a summary of May Clinic operations, confirming new FNPs and recruitment for a full time physician, to equal 4 clinic providers. Mr. Hino added that core staffing will be 4 providers, we currently have two with Dr. Webster and Dr. Preslar. Volume continues to increase, presently up 5.25%. July will incur a drop with scheduled provider vacations. The deduction rate of 59% was noted. Chronic Care Management is up 39% from prior month.

7. SCHD Foundation Report

Alix McGinley, Foundation Executive Director, provided a recap of the 2nd annual Living and Aging Well event held on May 24. Southern Coos will continue to sponsor, but event coordination will now be managed by Lualhati Anderson of Older Adult Behavioral Health Initiative of Coos Health and Wellness. Preparations continue for the 18th annual Southern Coos Health Foundation Golf for Health

Classic Fundraiser at Bandon Crossings, with commitments now at $74,000 (up from $62,550 in the printed report) in commitments toward our goal of $125,000. Jeremy Brown, Director of Pharmacy was our speaker at the June community "Meet and Greet" at the Bandon Fisheries Warehouse, also attended by his team, David and Christina, representing our new retail pharmacy and answering questions from the audience. Karen Reber will be retiring from running out gift shop but she and Steve will continue to volunteer their time for the hospital. Recruitment has begun for a new Development Coordinator who will oversee the gift shop, grants, events and donor administration. Amy Moss Strong will continue as Marketing Coordinator for both SCHHC and SCHF full time and will continue to coordinate the quarterly art show. The June 18 Chamber Mixer, Retail Pharmacy ribbon cutting, and employee recognition ceremony at Southern Coos was very well attended.

8. Strategic Plan

New this month, Ray Hino, CEO, provided a summary of activities represented in the Strategic Plan working spreadsheet. The current strategic plan was created less than one year ago following a community forum and board approval in August 2024, as of today with 37 activated initiatives are at 60% completion. The plan includes 41 goals in 10 categories; People, Service, Quality, Growth, Finance, Accreditation, General Projects, Community Health Needs Assessment, Health Equity & Social Drivers of Health, and Health Foundation. As of today we have completed 5 goals: to develop and Implement an organization-wide Risk Management Strategy, ERP Implementation, upgrade Sterile Processing department, improve service offerings to patients, restructure Southern Coos Foundation and fundraising. Highlighted activities in the last 30 days include postponement of employee survey to next fiscal year for cost savings, community collaboration updated with being named as healthcare partner for the USGA Women's Amateur golf tournament in August at Bandon Dunes, case management activities include completion of the Community Resource Directory, and Level IV Trauma designation is updated with the hiring of a part-time Trauma Coordinator, expansion of access to care updated with recruitment of new clinic provider, opening of the Retail Pharmacy and addition of regional food bank cooperation. Next month we anticipate closing the Electronic Health Record implementation with with a final agreement on migration of electronic health records from former to new system and final selection of architecture firm for the Master Facility Planning process.

VI. Monthly Financial Statements Review & Discussion

1. Month End Financial Summary

Antone Eek, CFO, provided a summary overview of the financials for the month of May. Gross Revenue exceeded budget by close to $200K, with efforts to continue to reduce Deductions from Revenue currently at 39.8% compared to 36% forecast. The higher deduction from revenue contributed to a operating loss of $430K compared to the budgeted gain of $179K. The anticipated Medicare Cost Report settlement for FY25 was reduced in May from $500,000 to $243,000 based on a significant increase in swing bed patient days which are paid at a lower rate than

inpatient days. Labor expenses were below budget. Total operating revenues for FY25-to-date stand at $31M, a significant increase of $2.1M over prior year. Financial Health Indicators trending favorably include Days of Cash on Hand in May increasing to 72.8 from 71.9 in April, and Days in Accounts Receivable decreased from 57.7 to 56.7. **Discussion:** Staffing and services were discussed further including preparation of mitigation planning where open positions that may effect services provided.

2. Month End Statements for Period Ending May 31, 2025

In the interest of time, Mr. Eek reviewed highlights from the financial statements. An expanded income statement and balance sheet are to be included in future reporting. Colene Hickman, Director of Revenue Cycle, provided an update on patient billing, charges and claims processing, referencing Epic migration stabilization and chart on page 72, with request from board members to update the notes on that page. Legacy accounts receivable collections are favorable as of mid-June, with legacy days in A/R below projected percentage of baseline.

VII. Executive Session

At 8:15 p.m. the board moved into Executive Session Under ORS 192.660(2)(c) to consider matters pertaining to the function of the medical staff of a public hospital licensed pursuant to ORS 441.015 Licensing of facilities and health maintenance organizations, under ORS 162.660(2)(i), and 192.660(2)(h) to consult with counsel concerning the legal rights and duties of a public body with regard to current litigation or litigation likely to be filed. No decisions will be made in Executive Session.

Attendees not staying for Executive Session were excused at this time. **Remaining in attendance:** Thomas Bedell, Chairman; Mary Schamehorn, Secretary; Pamela Hansen, Treasurer/Foundation Liaison, Kay Hardin, Director/Quality Committee Liaison, and Robert Pickel, Director. **Administration:** Raymond Hino, CEO; P.J. Keizer, Medical Staff Chief of Staff. **Via Remote Link:** Alden Forrester, MD, Chief Medical Officer; Amanda Bemetz, Director Quality Risk & Compliance. **Others in attendance:** Robert S. Miller, Counsel; Kim Russell, Executive Assistant. **Press:** None.

VIII. Return to Open Session

At 8:58 p.m. the meeting returned to Open Session.

1. Consideration of Executive Session Minutes

a. Regular Meeting Executive Session 05/22/25

Bob Pickel **moved** to accept Executive Session Minutes as presented. Mary Schamehorn **seconded** the motion. **All in favor. Motion passed.**

2. Consideration of Monthly Reports from Executive Session

a. Quality, Risk & Compliance Report

b. Medical Staff Report

i. Credentialing

2-Year Privileges – New
Jourdan Hull, MD – Appointment (Hospitalist)
Justin Hull, MD – Appointment (Hospitalist)
Kim Bagby, NP – Appointment (Family Medicine)

2-Year Privileges – Reappointments
None

Direct Radiology Appointments – After Hours Reading Radiology
None

Medical Staff Status Change
None

ii. Biennial Election of Medical Staff Officers Term 7/25 – 6/27

The election of officers is held every odd year in June to begin in the new fiscal year beginning July 1, with the following unanimous results:

Chief of Staff: Philip J. Keizer, MD
Vice Chief of Staff: Douglas Crane, MD

Bob Pickel **moved** to accept the Quality & Patient Safety and Medical Staff Reports as presented. Mary Schamehorn **seconded** the motion. **All in favor. Motion passed.**

IX. Open Discussion

None.

X. Adjournment. The meeting adjourned at 9:05 p.m. The next regular will be held on July 24, 2025 at 6:00 p.m. at the Southern Coos Hospital & Health Center main conference room.

_____ _____

Thomas Bedell, Chairman 07-24-2025 Mary Schamehorn, Secretary 07-24-25

INVOICE

Robert S. Miller III, Attorney
1010 1st St SE
Ste 210
Bandon, OR 97411-9309

rsmiii@aol.com
+1 (541) 347-6075

Bill to
Southern Coos Hospital & Health Center
900 11th Street SE
Bandon, OR 97411 USA

Ship to
Southern Coos Hospital & Health Center
900 11th Street SE
Bandon, OR 97411 USA

Invoice details
Invoice no.: 1081
Terms: Net 60
Invoice date: 06/27/2025
Due date: 08/26/2025

#	Product or service	Description	Qty	Rate	Amount
1.	**Attorney ($300/hr)**	June 26, 2025 Board Meeting and Executive Session, Attendance and Participation.	3	$300.00	$900.00

Total **$900.00**

Ways to pay

View and pay

District Update Information Form

Contact Information - update as needed

Phone (541) 329-1031
Fax
Email RHINO@SOUTHERNCOOS.ORG
(CC:KRUSSELL@SOUTHERNCOOS.ORG)

SOUTHERN COOS HEALTH DISTRICT
ATTN: RAYMOND HINO
900 11TH ST SE
BANDON, OR 97411

Very Important! If a vacancy has occurred the position will appear at the next election.

Next Election : MAY 20, 2025

This form must be received by the election officer by : _____

Send completed, signed form to : COOS COUNTY ELECTIONS
250 N BAXTER ST
COQUILLE, OR 97423

PHONE (541) 396-7610
FAX (541)-396-1013
EMAIL
ELECTIONS@CO.COOS.OR.US

[ ] The information below is correct as given

[ ] Additions or corrections to the information below should be made as indicated

[X] All appointments have been verified as qualified to hold the office

Signature & Title of Contact Person X _____ **Date** 3/18/2025

FORM MUST BE SIGNED TO BE COMPLETE.

Part I: Current Position Holder

Position	Name	Start Date	Status	Term Expires	Next Election
SOUTHERN COOS HEALTH DISTRICT, DIRECTOR, POSITION 1	TOM BEDELL 89048 SUNNY LOOP LN BANDON, OR 97411 (541) 347-4740	07/01/2023	E	06/30/2027	2027
SOUTHERN COOS HEALTH DISTRICT, DIRECTOR, POSITION 2	MARY SCHAMEHORN PO BOX 521 BANDON, OR 97411 (541) 404-7291	07/01/2023	E	06/30/2027	2027
SOUTHERN COOS HEALTH DISTRICT, DIRECTOR, POSITION 3	PAMELA HANSEN 2880 BEACH LOOP DR SW BANDON, OR 97411 (541) 290-8408	07/01/2023	E	06/30/2027	2027
SOUTHERN COOS HEALTH DISTRICT, DIRECTOR, POSITION 4	CATHERINE (KAY) HARDIN 1140 7TH ST SW BANDON, OR 97411-9544	02/27/2025	A	06/30/2025	2025
SOUTHERN COOS HEALTH DISTRICT, DIRECTOR, POSITION 5	ROBERT BREESE PICKEL PO BOX 84 BANDON, OR 97411 (541) 892-7496	06/13/2024	A	06/30/2025	2025

Part II: Complete the following for appointments or vacancies only

Name of Replaced Position Holder and/or Position Number	Name of Appointee	Appointment Date

Southern Coos Health District

Board Calendar
FY 2025-2026

2025		2026	
July		**January**	
Board Meeting	7/24	Board Meeting	1/22
August		**February**	
Board Meeting	8/28	Board Meeting	2/26
September		**March**	
Board Meeting	9/25	Board Meeting	3/26
October		**April**	
Board Meeting	10/23	Board Meeting	4/23
November		**May**	
Board Meeting	11/20*	Budget Committee	TBA
***Holiday is Thursday 11/27**		Board Meeting	5/28
December		**June**	
Board Meeting	12/18*	Board Meeting & Budget Hearing	6/25
***Holiday is Thursday 12/25**			

**** Regular meetings are held the 4th Thursday of each month except November and December when rescheduled due to winter holidays.***

Chief Executive Officer Report

To: Southern Coos Health District Board of Directors
From: Raymond T. Hino, MPA, FACHE, CEO
Re: CEO Report for SCHD Board of Directors, July 2025

Providers:

- Temporary Family Nurse Practitioner, Kim Bagby, began last week and started seeing patients earlier this week. I personally enjoyed getting to know her and all reports from our staff have been very positive about her.

- Full-time Family Nurse Practitioner, Felisha Miller, has signed a contract and is due to start in either late August or early September.

- We have also added another hospitalist. Her name is Dr. Monika Mehrens. She is full-time at the Asante Rogue Regional Medical Center in Medford, Oregon. She sought out Southern Coos Hospital to work at, because she loves coming to Bandon and the coast. Her first shift will be in August. She has indicated that she will be a regular on the schedule going forward.

Other Additions:

- We have also contracted a new consulting Registered Dietitian, to replace the service that we have been receiving from Bay Area Hospital for many years. Our new Dietitian is Stephanie Shiu-DeLaRosa. She will begin working at Southern Coos Hospital in August.

DNV Survey:

- We had another great Quality & Patient Safety Committee meeting this month. We continue to report excellent staff engagement in the internal auditing program. 9 more internal audits were conducted this month. Our Quality team is working with every department to help them prepare for our next DNV survey.

- To aid us in compliance with the CMS and DNV requirements for our contract management system, we have contracted with a company called Cobblestone Software Systems for contract creation, contract record storage, contract evaluation management and contract retrieval. We are currently using a combination of our MCN document management system and a manual system for compliance. The new system is going to make compliance with the contract management system requirements easier.

Coast Community Health Center:

- I continue to meet weekly with CCHC CEO, Kendra Newbold. Kendra has recently informed me that the expected start date for the newly merged entity with Adapt Integrated Health is in September.

She says that the recent delays are due to delays in getting the CCHC Pharmacy approved under new ownership with Adapt.

- We are continuing to work on a laboratory services agreement with CCHC.

Facility Expansion:

- In the past 30 days we have moved 8 employees over to the office building that we acquired earlier this year on Second Street (Highway 101) on the north side of town. The departments that have moved have included our accounting department and many members of our revenue cycle department. There is still a plan to move our walk-in payments department over to the new building as well. All employees that have moved to the new building are reporting that the building is bright and provides ample space for work functions. These moves are opening space in the current Business Office building on our main hospital campus that will be needed for clinical space expansion from our clinic.

Federal Budget Reconciliation Act, HR 1:

- I have been on several calls with our representatives at the Hospital Association of Oregon (HOA) and the Oregon Office of Rural Health (ORH) since the passage and the signing into law of the Federal Budget Reconciliation Act, HR 1. In short, none of the changes in the bill will have an effect on the FY 2026 Budget that we at SCHHC just approved. One of the biggest changes, the reductions in the Provider Tax Program, begins in FY 2028 with a 0.5% reduction and then additional 0.5% reductions each year until 2032.

- Some of the health care-related provisions in the bill include:

    - **Medicaid enrollment, eligibility, and revalidation**: The bill contains a number of policies that will revise how states conduct enrollment, eligibility checks, and revalidation of Medicaid or potential Medicaid recipients. Most of these provisions go into effect at the end of 2026.
    - **Provider taxes**: The bill amends the statutory provision that allows states to use provider taxes to finance their non-federal share of Medicaid costs by phasing down the maximum tax that a state can impose. Currently, the maximum tax rate is 6%. Beginning in FY 2028, the maximum tax rate will be reduced by 0.5% per year to a maximum rate of 3.5% in FY 2032.
    - **Medicaid community engagement requirements (also known as work requirements):** Beginning no later than Dec. 31, 2026, states—as a condition of Medicaid eligibility for able-bodied individuals—will require at least 80 hours of work or qualifying activities per month. Exceptions and additional specifications to this provision are detailed in the bill.
    - **Rural health transformation fund:** The bill appropriates $10 billion each year over five years beginning in FY 2026 to this fund. Through a plan developed by each state, the CMS administrator will provide funds for rural health facilities for specified health-related activities.
    - **Staffing standards:** Delays implementation of the staffing standards for long-term care facilities until Sept. 30, 2034.

Chief Medical Officer Report

To: Southern Coos Health District Board of Directors
From: Alden Forrester, MD, Chief Medical Officer
Re: CMO Report for SCHD Board of Directors, July 2025

Medical Staff Bylaws and Rules and Regulations:

Revised Bylaws and Rules and Regulations for the medical staff were approved at this month's medical staff meeting. The purpose of these revisions was to update terminology, remove unneeded duplication, add items required by DNV, and align the documents with our current practices.

The revised Bylaws and Rules and Regulations will need to be approved by the SCHD board prior to becoming official.

OHSU Telemedicine Collaboration Update:

The agreement for OHSU telemedicine neurology and pediatrics support for our emergency department has been signed. We are in the implementation phase and plan to have this service active in September or October.

125th US Women's Amateur Championship:

Work continues on the logistics of providing medical support for the 125th US Women's Amateur Championship this August. This is an excellent opportunity to support women's sports, assist Bandon Dunes by filling a need, and showcasing the compassionate, quality care that we provide. Thank you to the multiple individuals and departments that are assisting with this project including Materials, Plant Operations, ED, Nursing, Pharmacy, Finance, and IT.

Southern Coos Hospital & Health Center

900 Eleventh Street SE, Bandon, Oregon 97411

Medical Staff Bylaws

Published 1995

Revised
July 2008

Amended
July 2011

Amended
December 2016

Revised
January 2018

Amended
February 2018

Amended
April 2018

Amended
September 2019

Amended
March 2020

Amended
March 2023

Revised
July 2025

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BYLAWS OF THE MEDICAL STAFF
of
Southern Coos Hospital & Health Center

ARTICLE I: NAME

1.1 NAME: The Medical Staff of Southern Coos Hospital & Health Center.

ARTICLE II: PURPOSE AND RESPONSIBILITIES OF THE MEDICAL STAFF

21 PURPOSES: The purposes of the Medical Staff are to:

2.1-1 To constitute a professional body, providing mutual consultative and professional support.

2.2-2 To ensure, at time of initial appointment and reappointment, that members adhere to standards of care, certification, and licensure as set forth in these bylaws and the Policies and Procedures of the medical staff and Southern Coos Hospital and Health Center (SCHHC) in order to promote the highest possible standards of quality of care.

2.1-3 To provide a structure through these bylaws, rules and regulations, and related manuals which define the responsibility, authority, and accountability of each individual appointee of the Medical Staff.

2.1-4 To provide a mechanism for appropriate delineation of clinical privileges and a means for the ongoing evaluation of performance of all providers authorized to practice in the hospital; and,

2.1-5 To provide a means by which the Medical Staff can participate in the Hospital's policy making and planning processes and through which such policies and plans are communicated to appointees.

22 RESPONSIBILITIES: To accomplish the above purposes, it is the responsibility of the Medical Staff:

2.2-1 To participate in the quality assurance/performance improvement program in conjunction with the Hospital in order to maintain Federal or State compliance standards by:

A. Evaluating provider and institutional performance and utilization review through sound measuring systems including OPPE and FPPE programs;

B. Monitoring patient care practices and enforcement of Medical Staff

and Hospital policies.

C. Assisting in the evaluation of provider credentials for initial and continuing Medical Staff appointment and for the delineation of clinical privileges in a manner that is thorough, effective and timely. The Medical Staff, in its majority, acts as the Credentials Committee.

2.2-2 To make recommendations to the Board regarding appointments and reappointments to the Medical Staff, including staff category, and clinical privileges to all practitioners.

2.2-3 To participate in the Hospital Board's planning activities by helping to identify community health needs and suggesting to the Board appropriate policies and programs to meet those needs.

2.2-4 To develop, administer, recommend amendments to and enforce compliance with these Bylaws, its supporting manuals and the Rules and Regulations of the Staff, and with the Hospital Bylaws and Policies.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP: Membership on the Medical Staff of Southern Coos Hospital & Health Center is a privilege which shall be extended only to professionally competent Providers who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated policies, rules and regulations of the Medical Staff and Hospital.

3.2 REQUIREMENTS AND QUALIFICATIONS OF MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

An applicant for membership on the Medical Staff shall:

A. Be currently licensed by the State of Oregon to practice his/her profession and to exercise privileges applied for or granted.

B. Adequately document in the Electronic Health Record sufficient information to allow the Medical Staff and the Governing Body to assess the Member's proficiency in quality medical care consistent with the Member's background, experience, training and demonstrated competence,

C. Be capable, with reasonable accommodation, if necessary, of discharging the responsibilities of Medical Staff membership, including the rendering of patient care and the maintenance of cooperative working relationships necessary to the rendering of such care, and of doing so without posing a significant risk to the health and safety of patients, coworkers, members of the public or

him or herself.

D. Be free of or have under adequate control any significant physical or mental behavioral impairment that interferes with or presents substantial probability of interfering with patient care, the exercise of privileges, the assumption and discharge of responsibilities or cooperative working relationships.

E. Follow the requirements of Articles VI of these Bylaws for Appointment and Reappointment.

F. Providers must be a graduate of an approved medical/professional program and have passed any required certification exams or to be in the process of certification.

3.2-2 PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance is a standing requirement for appointees to the Medical Staff. The minimum amounts will be at least $1 million per occurrence and $3 million in the aggregate. All the members of the Medical Staff will have malpractice insurance provided by an insurance company licensed by or approved by the State of Oregon. Appointees must notify the Chief of Staff immediately of any changes resulting in noncompliance. Loss of malpractice insurance immediately and automatically results in privilege suspension.

3.2-3 NONDISCRIMINATION

Medical staff membership or particular clinical privileges shall not be denied on the basis of gender, race, creed, color, national origin, age, sexual orientation, gender identification, marital status or solely because of the school of medicine/training program to which the Provider belongs. The basis for denial may include any other criteria related to the delivery of quality patient care in the Hospital, professional qualifications, community need, and/or for the Hospital's purposes, needs and/or capabilities.

3.2-4 SEXUAL HARASSMENT

Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature are incompatible with the cooperative working relationships necessary to provide quality care. Such behavior shall not be tolerated or condoned.

3.2-5 NON-ENTITLEMENT

No Provider shall be entitled to membership on the Medical Staff or the exercise of specific clinical privileges in the Hospital merely by virtue of

being duly licensed in this or any other State, being a member of any professional medical organization, or by having had, or currently possessing, such privileges at another hospital. Medical Staff membership and/or the exercise of specific clinical privileges in the Hospital are a privilege and not a right.

3.2-6 MEMBERSHIP

A staff member shall:

A. Abide by the ethics of his/her profession, avoid acts and omissions constituting unprofessional conduct and comply with federal and state laws and regulations.

B. Provide patients with care at the generally recognized professional level of quality and efficiency.

C. Abide by the Medical Staff Bylaws and Medical Staff Rules and Regulations and other pertinent established standards, policies and rules of the Hospital.

D. Accept and appropriately discharge such Medical Staff and Hospital assignments and obligations for which he/she is responsible by appointment, election or otherwise, including peer review, quality assurance review and service on hearing panels.

E. Prepare and complete in a timely fashion medical records in the Electronic Health Record for all patients in whose care he/she is involved and in accordance with the Medical Staff Rules and Regulations.

F. The Attending Provider of a hospitalized patient must arrange appropriate patient coverage and give appropriate sign out to the covering provider if they are going to be unavailable. If the Attending Provider is unable to arrange for care of their patient, care will be transferred to the hospitalist, but this provision for transfer of care to the hospitalist shall not be construed as releasing the Attending Provider from the aforementioned responsibility to arrange coverage.

G. Notify the Medical Staff Chief of Staff and the Hospital Administrator immediately of: any change in licensure status or professional liability insurance coverage; of any restriction, denial or surrender of the Provider's Hospital privileges or membership elsewhere; of any professional liability claim, criminal charge, or any drug or alcohol charge; of any revocation, suspension or voluntary relinquishment of the Provider's DEA certification, or any adverse determination by the Oregon Medical Professional Review Organization, or the commencement of a formal investigation or the filing of charges by

any federal or state agency against the Provider, unless such information is exempt from disclosure by law.

H. Work cooperatively with Medical Staff members, nurses, Hospital administration and others so as not to adversely affect patient care or disrupt the operation of the Hospital.

I. Provide information and/or testimony regarding any matter under investigation pursuant to Article IX and matters subject to hearing under the Fair Hearing Plan in Article X.

J. Continuously maintain and provide written evidence to the Medical Staff Office of professional liability insurance specific to privileges requested with minimum limits of at least $1 million per occurrence and $3 million in the aggregate. Applicants to the Medical Staff shall furnish evidence of insurance coverage with the application for membership, at reappointment, and whenever there is a change, renewal, or expiration of the most recently submitted insurance face sheet. If a Provider is contracted with the hospital and said contract provides malpractice insurance, the hospital will provide written evidence to the Medical Staff. Providers shall notify the Medical Staff Office in writing of termination or change of insurance coverage within one week of receiving notice of such termination or change.

K. Exhaust available procedures and remedies provided in these Bylaws and Rules and Regulations before resorting to judicial action.

L. Provide a health care service which is consistent with the purposes, philosophy, methods, resources and capabilities of the Hospital, and for which the Hospital has a current need.

M. Appear as required for any committee meetings or hearings that involve the Provider's clinical work.

3.3 CONDITIONS AND DURATION OF APPOINTMENT

3.3-1 Initial appointments and reappointments to the Medical Staff shall be made by the Southern Coos Health District Board, hereafter referred to as the "Governing Body." The Governing Body shall act on appointments, reappointments or revocation of appointment only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of a delay in excess of ninety (90) days on the part of the Medical Staff, the Medical Staff C h i e f o f S t a f f shall review and make recommendations to the Governing Body within thirty (30) days. The Governing Body may act without recommendations on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable, professional medical sources other than the Medical Staff.

3.3-2 Initial appointments and reappointments shall be for a period of two years.

3.3-3 Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body, in accordance with these Bylaws.

3.3-4 Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of her/his patients. To abide by the Medical Staff Bylaws, Rules and Regulations, to accept committee assignments, and to accept consultation assignments.

3.4 MEDICAL STAFF MEETINGS

3.4-1 MEDICAL STAFF YEAR: The Medical Staff year will begin on July 1 of every odd-numbered year.

3.4-2 MEDICAL STAFF MEETINGS

A. REGULAR MEETINGS: Eleven (11) monthly regular Medical Staff meetings will be held per calendar year. The Medical Staff may authorize the holding of additional general Staff meetings by resolution.

B. SPECIAL MEETINGS: A special meeting of the Medical Staff may be called by the Chief of Staff of the Medical Staff and must be called by the Chief of Staff at the written request of the Board of Directors or two (2) members of the Active Medical Staff. A call of a special meeting shall require notice specifying the place, date, time and purpose of the meeting.

C. PEER REVIEW MEETINGS: Peer Review meetings shall be held at least quarterly to review the appropriateness and quality of care provided by members.

3.4-3 ATTENDANCE REQUIREMENTS

A. GENERAL: Attendance at Medical Staff meetings is encouraged but not required; however, Active Medical Staff members shall attend at least 50% of their scheduled meetings. If absent more than 50% in previous six months, the member will no longer be counted toward a quorum when not in attendance.

B. SPECIAL APPEARANCES OR CONFERENCES: Whenever a pattern of suspected deviation from standard clinical practice is identified, the Chief of Staff may require the Provider to confer with him/her or with a committee that is considering the matter. The Vice

Chief of Staff or the Chief Medical Officer may stand in for the Chief of Staff if the Chief of staff is unavailable or chooses to delegate this duty to the Vice Chief of Staff or the Chief Medical Officer. The Provider will be given Special Notice of the conference at least five days prior to the conference, including the date, time and place, and a statement of the issue involved, and that the Provider's appearance is mandatory. Failure of the Provider to appear at any such conference unless excused by the Medical Staff upon showing good cause, will result in an automatic suspension of all or such portion of the Provider's clinical privileges as the Medical Staff may direct. A suspension under this section will remain in effect until the matter is resolved by subsequent action of the Medical Staff and the Governing Body or through corrective action, if necessary. Such resolution shall be made in a timely manner.

3.4-4 MEETING PROCEDURES

A. ORDER OF BUSINESS AND AGENDA AT GENERAL STAFF MEETINGS: The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least;

1. Reading and acceptance of the minutes of the last regular and all special meetings since the last regular meeting.

2. Administrative Report.

3. Reports on the overall results of reviews of patient care quality and appropriateness and other quality reviews, evaluation and monitoring activities of the staff and on the fulfillment of the other required functions.

4. Recommendations for improving patient care within the Hospital.

5. Open Discussion.

B. NOTICE OF MEETINGS: Written notice of all meetings will be given in a format determined by the Medical Staff. Written or oral notice of any cancellation will be given at the earliest opportunity.

C. MINUTES: Minutes of all meetings will be prepared and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the Medical Staff. A permanent file of the minutes shall be maintained.

D. MANNER OF ACTION: A quorum is comprised of 50% of the Active Medical Staff. A quorum must be present in order to vote or take action on a matter. Except as otherwise provided, the action of a majority of the Medical Staff present and voting at a meeting, shall be

the action of the group.

ARTICLE IV: CATEGORIES OF APPOINTMENT

4.1 CATEGORIES

The Medical Staff is composed of Physicians and Independent Licensed Practitioners practicing within their scope of practice and will include the following: Active, Provisional, Courtesy and Telemedicine.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS FOR ACTIVE STATUS

The active staff shall consist of members who:

A. Meet the criteria for membership set forth in Sections 3.2 and 3.3.

B. Regularly admit patients, or if emergency physicians, work a minimum of an average of 24 hours per month on site in the SCHHC Emergency Department or are otherwise involved in the care of patients in the Hospital or Clinic as demonstrated by performing at least six (6) patient contacts per year to permit the Medical Staff to assess the member's current competency and qualification for privileges, or demonstrate by way of other substantial involvement in the activities of the Medical Staff or Hospital a genuine concern and interest in Medical Staff and Hospital functions;

C. Are located in proximity to the hospital while exercising clinical duties so as to provide timely and appropriate continuity of patient care; and

D. Shall satisfactorily complete any assigned proctoring or initial professional practice evaluation process.

4.2-2 PREROGATIVES OF ACTIVE STAFF

Except as otherwise provided, the prerogatives of an active Medical Staff member shall be to:

A. Admit patients and exercise such clinical privileges as are granted pursuant to Article VII.

B. Attend and vote on matters presented at general and special meetings of the Medical Staff.

C. Hold Medical Staff office and serve as a voting member of the Medical Staff.

4.2-3 OBLIGATIONS OF ACTIVE STATUS

An active Staff member must:

A. Serve on appropriate Hospital Medical Staff committees.

B. Reasonably participate as requested in the quality review, risk management and utilization management activities of the Hospital as may be required of the Medical Staff.

C. Satisfy the meeting attendance and special appearance requirements as found in these Bylaws and Rules and Regulations of the Medical Staff.

D. Perform proctoring as required either by Medical Staff, Chief of Staff, CMO, or CEO request and if no appropriate proctoring provider is available, then proctoring will need to be done at another facility.

4.2-4 LEAVE OF ABSENCE: Leave of absence notification should be submitted to the Chief of Staff of Medical Staff and/or CEO of the Hospital. An absence over one (1) year will require that the professional submit a new application for reinstatement to the Medical Staff.

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS FOR PROVISIONAL STATUS

All new members of the Medical Staff requesting clinical privileges, will initially be appointed to the Provisional Staff. The Provisional Staff shall consist of members who:

A. Meet the criteria for membership as set forth in Sections 3.2 and 3.3.

B. Each provisional staff member shall undergo a period of observation by members of the Medical Staff or their designees. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of each provisional staff members shall follow the frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, Focused Professional Practice Evaluation, mandatory consultation and/or direct observation. Appropriate legible records shall be maintained by the provisional staff person. The results of the observations shall be communicated to the Medical Staff, as the Credentials Committee on the whole, and the provisional staff member.

4.3-2 PREROGATIVES OF PROVISIONAL STATUS

The Provisional Staff member shall be entitled to:

A. Exercise such clinical privileges as are granted pursuant to Article VII; and

B. Attend, in a nonvoting capacity, general and special meetings of the Medical Staff, committee meetings and educational programs. Provisional staff members may only attend committee meetings by invitation of the Chief of Staff or by the Chairperson of the committee but shall have no right to vote at such meetings.

C. Provisional Staff members shall not be eligible to hold any Medical Staff office.

D. The restrictions of this section do not apply to an individual holding the position of Chief Medical Officer who, by virtue of that position, shall have the right to sit as a voting member on committees of the medical staff and to vote on all matters of business before the general medical staff while on Provisional status. However, the proctoring and initial evaluation provisions of section 4.3-1 shall still apply to the Chief Medical Officer while on Provisional status.

4.3-3 OBLIGATIONS OF PROVISIONAL STATUS

A Provisional Staff member must:

A. Serve on appropriate Hospital Medical Staff Committees as appointed.

B. Reasonably participate as requested in the quality review, risk management and utilization management activities of the Hospital as may be required of the Medical Staff.

C. Satisfy the meeting attendance requirements as found in these Bylaws and Rules and Regulations of the Medical Staff.

D. Arrange appropriate proctoring of requested privileges as required by the Medical Executive Committee.

4.3-4 TERM OF PROVISIONAL STAFF STATUS

A Staff member shall remain on the provisional staff for a period of twelve (12) months.

4.3-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

A. If the provisional staff member has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement on the active or courtesy staff as appropriate, upon review and recommendation of the Credentials Committee. The Medical Staff shall vote and make its final approval and forward its final approval to the Governing Body; and

B. In all other cases, the Medical Staff shall make its recommendations to the Governing Body regarding continued provisional status, modification, or termination of Medical Staff membership. In this case, the member is entitled to the hearing rights as provided in the Fair Hearing Plan.

4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS FOR COURTESY STAFF

The courtesy staff shall consist of members who:

A. Meet the criteria for membership as set forth in Section 3.2 and Section 3.3;

B. Do not regularly care for patients at the Hospital or are not regularly involved in Medical Staff functions as determined by the Medical Staff.

C. Courtesy Surgical Services privileges require the courtesy staff members to perform five cases or patient contacts per year to maintain credentialing status.

4.4-2 PREROGATIVES OF COURTESY STATUS

A courtesy staff member may:

A. May provide patient care, admit patients or perform surgery within their approved scope of clinical practice.

B. Attend in a non-voting capacity meetings of the Medical Staff including open committee meetings and educational programs but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

4.5 TELEMEDICINE STAFF

4.5-1 QUALIFICATIONS FOR TELEMEDICINE STAFF

The telemedicine medical staff shall consist of a member who:

A. Has contracted with or is an employee or principal of an entity that has a contractual relationship with or has otherwise been engaged by the Hospital to provide medical services and/or to provide medico-administrative services at the Hospital.

B. Provides diagnostic or treatment services from the distant site to Hospital patients at the originating site via telemedicine devices. Telemedicine devices include interactive audio, video, imaging, or data communications (other than telephone or electronic mail communications) between physicians regarding patients.

C. Meets the General Qualifications as set forth in Section 3.2.

D. Performs a sufficient number of services, or cases at this Hospital and/or other hospitals, to permit the appropriate Medical Staff Service Committee to assess the member's current competency and quality for privileges granted. Alternatively, the Medical Staff may accept ongoing documentation of competency from the primary site of the clinician's practice through a "Delegated Privileging" model where data on quality and competence of the provider is provided to the medical staff by the clinician's primary practice site.

4.5-2 PREROGATIVES OF TELEMEDICINE STATUS

The telemedicine staff members:

A. May render tele-medicine medical services to patients at the Hospital or outpatient clinics in accordance with the agreement or other arrangement with the Hospital and approval of Medical Staff.

B. May exercise only those clinical privileges granted to him/her consistent with these Bylaws; and

C. Will comply with the terms and conditions of any contractual or other arrangement with the Hospital for the providing of services at the Hospital and acknowledge that the hearing rights specified in these Bylaws shall not be available nor will they apply to the Provider as acknowledged by the Provider in his/her application for membership.

D. May attend meetings of the Medical Staff and the service of which the Provider is a member; including open committee meetings and educational programs

4.5-3 LIMITATIONS OF TELEMEDICINE STATUS

Telemedicine staff members may not:

A. Admit patients; or

B. Hold any office in the medical staff organization; or

C. Vote; or

D. Serve on Medical Staff Committees

E. Participate in the call list for emergency medical coverage.

ARTICLE V: LICENSED INDEPENDENT PRACTITIONERS (LIP)

5.1 LICENSED INDEPENDENT PRACTITIONERS (LIP)

A. Licensed independent practitioners are licensed health care professionals who are authorized by Oregon statute to independently diagnose and treat and provide care and services within the scope of their individual license without direction or supervision. Examples of Licensed Independent Practitioners include, but are not limited to: Nurse Practitioners, Physician Associates, CRNAs, and LCSWs.

B. A LIP shall meet the criteria for medical staff membership, be subject to the requirements and processes for medical staff membership, credentialing, and privileging as described in the Medical Staff By-Laws. Once credentialing and privileging is complete, the LIP will meet the obligations and be afforded the prerogatives of their determined medical staff category. Medical staff bylaws and Medical Staff rules and Regulations apply to LIPs except to the extent that doing so conflicts with the licensure of the LIP.

C. If a physician associate or other Allied Health Professional is operating under the supervision of a physician member of the medical staff, the supervising physician of that individual shall be responsible for requesting medical staff privileges for the Allied Health Professional if that AHP is expected to provide clinic services in SCHHC clinics or hospital. The supervising physician shall present a written statement of the clinical duties and responsibilities of said individual to the Medical Staff for its approval. Individuals providing clinical care under the supervision of a physician member of the SCHHC medical staff are hereafter referred to as a "Professional Assistant." Application and reapplication for privileges to use a Professional Assistant shall be processed in accordance with the procedures set forth in these Bylaws for delineation of privileges. The application must be approved prior to granting professional assistant privileges within the Hospital or SCHHC clinics. The supervising physician shall complete such forms as may be requested by the Credentials Committee. Nothing in this paragraph or other sections of this document shall be construed to mean that a Physician's Associate is required to have a supervising physician in order to provide clinical services at SCHHC. This paragraph and

other sections of this document related to supervision of professional assistants only apply to Physician's Associates and other Allied Health Professionals who already have or subsequently enter into a supervisory relationship with a physician member of the SCHHC medical staff.

D. The supervising physician of the professional assistant shall assume full responsibility and be fully accountable for the conduct of said individual within the Hospital or SCHHC clinics. It is the full responsibility of the supervising physician of the professional assistant(s) they supervise to acquaint such individual with the appropriate Rules and Regulations of the Medical Staff and Hospital as well as the appropriate members of the Medical Staff, Hospital, and Clinic personnel with whom said individual shall have contact .Said supervising physician will provide malpractice insurance, the minimum amounts (**$1,000,000 /$3,000,000)** will be determined by the Board based on the recommendation of the Medical Staff.

E. The clinical duties and responsibilities of a professional assistant within the Hospital or SCHHC clinic shall terminate if the Medical Staff appointment of the supervising physician is terminated for any reason or if the supervising physician's clinical privileges are curtailed to the extent that the professional services of said individual within the Hospital are no longer necessary or permissible to assist the supervising physician. If the professional assistant's provider relationship which he/she has been under is terminated, all privileges and staff status are automatically terminated.

5.2 REMOVAL PROCEDURES AND STATUS OF PROFESSIONAL ASSISTANTS

A. SCHHC has the right, either through the Administration or upon the recommendation of the Medical Staff, to suspend or terminate any or all of the privileges or functions of a professional assistant.

1. Where a professional assistant is terminated or has privileges curtailed, the supervising physician shall be notified as to the reasons for such action and, if requested, within thirty (30) days, be afforded opportunity of review by the Medical Staff prior to final action by the Board.

ARTICLE VI: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1 APPLICATION FOR APPOINTMENT

A. All applicants will be subject to a pre-application process including background checks, verification of appropriate licensure, verification of malpractice insurance coverage, and other elements.

All applications for appointment to the Medical Staff shall be in writing—preferably submitted via our electronic portal. SCHHC uses the Oregon Practitioner Credentialling Application. This application must be filled out in its entirety.

B. The applicant for Medical Staff membership or affiliation shall supply, in writing, information relating to:

1. continuing medical education related to the clinical privileges being requested by the applicant,

2. specialty board certification where appropriate,

3. the existence of previous or present involvement in, as party, any professional liability actions,

4. signed Physician's Attestation Statement,

5. the existence of previous successful or pending challenges to any licensure or registration,

6. existence of any voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital,

7. a specific request for staff membership categories, services, and clinical privileges,

8. physical and mental health status, including without limitation health impairments which would affect ability to perform specific privileges requested,

9. a certificate of professional liability insurance in such amounts as may be required by the Governing Board.

C. The completed application shall be submitted to the Medical Staff Services Office. The Chief of Staff or designee shall review the application for completeness and review references, other pertinent material and information and shall transmit the application and supporting materials to the Medical Staff for evaluation of the applicant's credentials.

D. By applying for appointment to the Medical Staff, each applicant authorizes the Hospital, the Medical Executive Committee, the Credentials Committee and the appropriate service to consult with members of the Medical Staff and other Hospitals with which the applicant had been associated, and with others who may have information bearing on his/her professional qualifications, competence, character and ethical standing. By applying for

appointment to the Medical Staff, each applicant also consents to the Hospital's inspection of all records and documents material to an evaluation of his/her professional qualifications, including but not limited to the National Practitioner's Data Bank; consents to appear interviews in regard to his/her application, releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges. In addition, by applying for appointment to the Medical Staff each applicant attests to the correctness and completeness of all information furnished by the applicant; agrees to abide by these Bylaws and the Rules and Regulations of the Medical Staff and the Southern Coos Health District Board; consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying; acknowledges those provisions in these Medical Staff Bylaws for release and immunity from civil liability; consents to the disclosure to appropriate licensing boards or other organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and the Hospital from liability for so doing to the fullest extent permitted by law; agrees to cooperate openly and fully in an impartial physical or mental examination; and pledges to provide continuous care for his/her patients.

E. The applicant will be provided with a copy of the Medical Staff Bylaws, and Rules and Regulations and the Southern Coos Health District Board Bylaws, Rules, and Regulations. The application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and the Board, and agrees to be bound by and to comply with the terms thereof if he/she is granted membership, affiliation and/or clinical privileges, and agrees to be bound by and to comply with the terms thereof without regard to whether or not he/she is granted membership, affiliation, and/or clinical privileges in all matters relating to consideration of his/her application.

F. The above information requested defines the characteristics of a complete application, however, other information may be required. Action on an individual's application for appointment or initial clinical privileges is withheld until such is available and verified.

G. BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of

producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff or the MEC, which may select the examining physician after conferring with the Provider being reviewed. No application is complete or deemed received, until all requested information is provided.

6.2 APPOINTMENT PROCESS

6.2-1 CLINICAL SERVICE ACTION

Upon receipt of the application, the Medical Staff Credentials Committee, shall personally review the application and supporting documentation. A personal interview with all applicants for appointment or reappointment may also be conducted.

Upon completion of the evaluation and after presenting the application, the Medical Staff Credentials Committee shall recommend to the Medical Staff Committee, on the basis of the application and supporting materials, whether or not the applicant should be appointed or reappointed to the Medical Staff, and if so, to which category the applicant should be appointed or reappointed and what privileges should be granted. The Medical Staff Committee as a Whole shall review the application and recommendations of the Credentials Committed and vote regarding whether or not to recommend the applicant be granted (or retain) membership on the medical staff with the privileges requested. Membership on the Medical Staff and privileges are ultimately granted by the Governing Body. The Medical Staff Committee may recommend limits to privileges requested by the applicant even when recommending that the applicant be granted (or retain) medical staff membership.

6.2-2. CREDENTIALS COMMITTEE ACTION

When the recommendation of the Medical Staff is adverse to the applicant, either in respect to the appointment or the clinical privileges, the Administrator shall so notify the applicant by Special Notice. No such adverse recommendation shall be forwarded to the Board until after the applicant has exercised or has been deemed to have waived any right to review afforded the applicant as provided in the Fair Hearing Plan in Article X of these Bylaws.

6.2-3. BOARD ACTION ON THE APPLICATION

A. When the recommendation of the Medical Staff is favorable to the Provider, the Governing Body shall consider it at its next scheduled

meeting. If the Governing Body's decision is favorable to the applicant, the applicant will be notified of the Governing Body's decision by the Administrator within two weeks of the decision.

B. If the Governing Body's decision is adverse to the Provider, the Administrator shall notify the Provider within two weeks of the adverse decision by Special Notice, and such adverse decision shall be held in abeyance until the Provider has exercised or has been deemed to have waived his/her rights under Article X of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges when none existed before.

6.3 TIME PERIODS FOR PROCESSING

A. Applications for Medical Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this subsection.

B. The Medical Staff Services Office shall transmit the application to the Credentials Committee upon completing the information collection and verification tasks. If there is any dispute as to whether the application is complete and ready for review by the Credentials Committee, the final determination of completeness shall be made by the Chief of Staff or their designee. If 60 days have passed since the submission of an application and the application is deemed incomplete despite reasonable efforts to obtain requested information from the applicant, the application shall be considered voluntarily withdrawn. Within (60) days after receiving a completed application. The Medical Staff Credentials Committee shall review the application and make its recommendations. The application shall then be considered by the full Medical Staff Committee and recommendations made to the Board within thirty (30) days review by the Credential's Committee.

C. The time periods specified herein are to assist those named in accomplishing their tasks. Failure to process an application within the time period specified shall not grant to an applicant the appeal rights specified in the Fair Hearing Plan in Article X of these Bylaws.

6.4 REAPPOINTMENT PROCESS

6.4-1 REAPPOINTMENT: Reappointments to any category of the Medical Staff will be for a period of not more than two years unless stated otherwise in these Bylaws. When a Provider submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of Staff status or clinical privileges, the Provider shall be subject to an in-depth review generally following the procedures set forth in Sections 6.1 through 6.3, in addition to reviewing the information found in the

Provider's credentials file.

A. At least ninety (90) days prior to the expiration date of the current Medical Staff appointment of each professional, the Medical Staff Office shall provide each professional with an application for reappointment. This application shall be the Oregon Practitioner Credentialling Application which must be filled out in its entirety. The professional shall submit the completed application form, with copies of their current DEA license and liability insurance coverage, to the Medical Staff Office at least sixty (60) days prior to the expiration date of his/her appointment.

Failure to submit an application for reappointment without good cause shall be deemed a voluntary resignation from the Medical Staff and voluntary resignation does not give rise to Fair Hearing rights. After verification of the completion and collection of the necessary information, the Medical Staff Services Office shall refer the application to the Credentials Committee.

6.4-2 BASIS OF RECOMMENDATIONS

Each recommendation concerning the reappointment of the Provider and the clinical privileges to be granted upon reappointment shall be based upon such Provider's:

A. Demonstrated current competence, professional performance, and judgment; and

B. Clinical and/or technical skills as indicated in part by the results or conclusions drawn by quality assessment and improvement activities; and

C. Sanctions imposed or pending, voluntary terminations of medical staff memberships or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and

D. Previously successful and currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration; and

E. Participation as a staff official, committee member or chairman, and in on-call coverage rosters; and

F. Timely and accurate, preparation and completion of medical records; and

G. Physical and mental health (with the exception of physical and mental

health conditions for which reasonable accommodation can be made without compromising patient safety); and

H. Ethics and conduct; and

I. Continuing medical education, attendance at Medical Staff meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations of the Medical Staff; and Cooperation with Hospital personnel, use of the Hospital's facilities for patients, relations with other Providers; and

J. Peer recommendations; and

K. Other reasonable indicators of continuing qualifications, such as board certification.

6.4-3 MEDICAL STAFF ACTION: The Medical Staff Committee will act upon the recommendations and shall make written recommendations to the Governing Body, through the Administrator, concerning the appointment or non- appointment of each applicant, including the specific clinical privileges to be granted to each applicant. Where non-reappointment or change in clinical privileges is recommended, reasons for such recommendation shall be stated.

In acting on matters of reappointment, all Medical Staff members and other professionals and all appropriate Hospital personnel, including members of the Board and Hospital management, shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided in Article XI.

6.5 REAPPLICATION AFTER ADVERSE ACTION

A professional who has received a final adverse decision from the Governing Body regarding his/her appointment or reappointment to the Medical Staff shall not be eligible to reapply to the Medical Staff for a period of twelve (12) months. Any such reapplication shall be processed as an initial application, and the applicant shall submit additional information sufficient to demonstrate that the basis for the earlier adverse action no longer exists.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6-1 QUALIFICATIONS AND SELECTION

A Provider who is or who will be providing specified professional services pursuant to a contract or employment with the Hospital must meet the same appointment qualifications, must be evaluated for appointment, reappointment and clinical privileges in the same manner and must fulfill all of the obligations of the Provider’s category as any other applicant or Staff member.

6.6-2 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

Upon termination or expiration of a written exclusive contract to provide medical services, the Provider's appointment to the Staff and clinical privileges will be voluntarily relinquished. Upon termination or expiration of all other contracts, the Provider's appointment or clinical privileges will not be affected except to the extent such issues are governed by the terms of the Provider's contract.

6.6-3 APPLICABILITY OF CORRECTIVE ACTION AND FAIR HEARINGS PROCEDURES

A Provider providing contractual professional services is obligated to fulfill the obligations of the Provider's appointed Staff category and therefore is subject to the grounds for corrective action as any other Staff member. As such, the Provider has the right to the fair hearings procedure in Article X of these Bylaws. Matters of an administrative nature or those other issues addressed by the terms of the contract do not entitle the Provider to the Article X fair hearings process.

ARTICLE VII: CLINICAL PRIVILEGES

7.1 CLINICAL PRIVILEGES RESTRICTED

7.1-1 Every professional practicing at this Hospital and associated clinics by virtue of Medical Staff membership, affiliation or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Governing Body, except as provided in Section 7.4.

7.1-2 Every initial application for staff appointment must contain a request for the specific privileges desired by the applicant. Requests for clinical privileges shall be evaluated on the basis of clinical training, experience, demonstrated competence, references and other relevant information, including an appraisal by other professionals in the service in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competence in the clinical privileges he/she requests. Specific privileges may be denied in those circumstances where they cannot be adequately supported by Hospital clinical and support staff, and may be denied based on the competence or professional conduct of a Provider.

7.1-3. Periodic re-determination of clinical privileges and the increase or curtailment of clinical privileges shall be based upon the direct observation and evaluation of care provided, review of the records of patients treated in this or other Hospitals, and review of the records of the Medical Staff which documents the evaluation of the member's participation in the delivery of medical care. Where appropriate, such decisions may be based upon additional review by a qualified professional outside the organization.

7.2 PROCEDURE TO BE FOLLOWED IN PROCESSING REQUESTS FOR INCREASED HOSPITAL PRIVILEGES

7.2-1 Professionals who presently hold privileges on the Medical Staff but wish to attain additional privileges may apply to the Credentials Committee, in writing, outlining the additional privileges requested and their qualifications for being granted privileges.

7.2-2 Medical Staff members who are requesting increased privileges will be asked to comply with the following:

1. Apply in writing for the specific procedures/privileges requested.

2. The Medical Staff will determine the amount of training and number of procedures performed under proctorship to qualify for further privileges.

7.2-3 The professional shall have the burden of establishing his/her qualifications and competence in the clinical privileges he/she requests.

7.3 TEMPORARY PRIVILEGES

TEMPORARY PRIVILEGES: Temporary Privileges will be granted only after all pre-applicant and application information requested has been received, reviewed, recommended and approved by the Chief of Staff and the CEO. These privileges will be valid for up to sixty (60) days, pending approval by the Medical Staff Committee and the Governing Body. This same process is followed for all applicants.

7.3-1 TERMINATION OF TEMPORARY PRIVILEGES: The Medical Staff must on the discovery of any information or the occurrence of any event of a nature which raises questions about a Provider's professional qualifications or ability to exercise any or all of the temporary privileges granted, terminate any and all of the Provider's temporary privileges, provided that if the life or well- being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension under these Bylaws. In the event of any such termination, the Provider's patients then in the Hospital will be assigned to another Provider by the Medical Staff Chief of Staff or designee. The wishes of the patient shall be considered, where feasible, in choosing a substitute Provider.

7.3.2 RIGHTS OF THE PROVIDER: Where a Provider's request for temporary privileges is refused or such privileges are terminated or suspended, the affected Provider is entitled to prompt review, within 30 days, by the Medical Staff. The personal presence of the Provider is required at the review. The Provider may submit evidence and speak on the Provider's own behalf. The review shall not constitute a hearing and shall not entitle the Provider to any

rights under the Fair Hearing Plan. Within ten days of completing its review, the Medical Staff Committee shall make its recommendation to the Governing

Body whether the denial, termination or suspension of temporary privileges is warranted. The Governing Board shall make its decision within thirty days. The Governing Body's decision is final.

7.3-3 LOCUM TENENS: Temporary privileges may be granted to a Provider who will be serving as a locum tenens for a staff member or under the direction of a Staff member, but only after receipt of a complete application for appointment as locum tenens, including a request for specific privileges. The locum tenens may not exceed sixty (60) days unless approved by the Medical Staff.

7.4 EMERGENCY PRIVILEGES

7.4-1 In the case of emergency, any Staff Provider to the degree permitted by his/her license and regardless of service or Staff status or lack of it, shall be permitted and assisted to do everything possible to prevent the potential loss of life of a patient using every facility of the Hospital necessary, including calling for any consultation necessary or desirable.

7.4-2 When an emergency situation no longer exists, such professional must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff by the Chief of Staff or his/her designee.

7.5 DISASTER PRIVILEGES

7.5-1 When a local, state or national disaster emergency situation has been declared and/ or the facility's emergency management plan has been activated, Disaster privileges may be granted to eligible Licensed Independent Practitioners on a case-by-case basis to meet the demand for health care services. Disaster privileges may be granted by the Chief Executive Officer, Chief Medical Officer, Chief of Staff, or Chairperson of the Credentials Committee (or their designees) and will be active only for the duration of the emergency management plan.

7.5-2 Any of the following may be used to identify eligible Licensed Independent Practitioners for the granting of Disaster Privileges in addition to a valid government - issued photo ID.

A. A current hospital picture ID card that clearly identifies professional designation;

B. A current medical license to practice;

C. Primary source verification of licensure;

D. Identification indicating that the individual(s) have been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

E. Identification and attestation signed by current hospital staff member(s) who possess;

F. Personal knowledge regarding volunteer's ability to act as a Licensed Independent practitioner during a disaster.

ARTICLE VIII: OFFICERS

8.1 GENERAL OFFICERS OF THE STAFF

8.1-1 The general officers shall be:

1) Chief of Staff; 2) Vice Chief of Staff.

8.1-2 QUALIFICATIONS: General officers must be appointees of the active category at the time of their nomination and election and must remain appointees in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff and Vice Chief of Staff must be Providers with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience, and have the ability to direct the medico-administrative aspects of Hospital and staff activities.

8.1-3 ELECTION: Officers shall be elected at the first meeting of the Medical Staff year. Only appointees to the active category shall be eligible to vote. Voting shall be by the members in attendance. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving over fifty percent of the valid votes cast by a quorum of voting members. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

8.1-4 TERM OF ELECTED OFFICE: Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following election. Each officer shall serve until the end of the elected term and until a successor is elected, unless otherwise unable to serve.

8.1-5 RECALL OF ELECTED OFFICERS: Except as otherwise provided, recall of a Medical Staff officer may be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members who actually cast votes at a special meeting in person, provided that those present constitute a quorum of eligible members.

8.1-6 VACANCIES: Vacancies in elected office shall be filled by another member of the Medical Staff by means of a special election to be conducted as soon after the vacancy occurs as possible, following the general mechanisms outlined in Section 8.1-3. A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff until a special election can be held.

8.2 DUTIES OF GENERAL OFFICERS

8.2-1 The Chief of Staff serves as the principal elected official of the staff. The Chief of Staff shall:

A. Aid in coordinating the activities and concerns of the Hospital administration and the nursing and other patient care services with those of the Medical Staff.

B. Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Governing Body and officials of the staff, personally or through a designee.

C. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

D. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

E. Consult with the Administrator on matters of special concern to staff appointees and maintain liaison with the Administrator to assist in settling grievances and problems of the staff.

F. Be or appoint a spokesperson for the Medical Staff in external professional and public relations.

8.2-2 The Vice Chief of Staff shall be an active member of the Medical Staff and an ex officio member on all other staff committees. His/her duties shall be to:

A. Perform the duties of the Chief of Staff should they be unavailable or unable to perform their duties.

B. Assure that proper notice of all staff meetings is given.

C. Assure that accurate and complete minutes for all meetings are prepared.

D. Perform such other duties as ordinarily pertain to the office.

8.3 MEDICAL STAFF COMMITTEE (MEDICAL EXECUTIVE COMMITTEE)

8.3.1 Membership:

A. Membership of the Medical Staff Committee shall consist of all Active Category members of the Medical Staff. No one staff member may occupy more than one voting position on the Medical Staff Committee.

B. Fifty (50) percent of the voting members of the Medical Staff constitutes a quorum regarding Medical Staff decision making.

8.3-2 Duties: The duties of the Medical Staff Committee shall be to:

A. Receive or act upon reports and recommendations from the departments, committees and officers of the staff concerning patient care quality and appropriateness reviews, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities and recommend to the Governing Body specific programs and systems to implement these functions.

B. Coordinate the activities of and policies adopted by the staff, departments and committees.

C. Recommend to the Governing Body all matters relating to appointments, reappointments, staff category, clinical privileges and corrective action.

D. Account to the Governing Body and to the staff for the overall quality and efficiency of patient care in the Hospital.

E. Take reasonable steps to promote professionally ethical conduct and competent clinical performance on the part of staff appointees including initiating investigations and initiating and pursuing corrective action, when warranted.

F. Make recommendations on medico-administrative and Hospital management matters.

G. Participate in identifying community health needs and in setting organizational goals and implementing to meet those needs.

H. Formulate Medical Staff Rules and Regulations.

I. The Medical Staff is responsible for making recommendations directly to the Governing Body for its approval in regard to: Medical Staff structure; the mechanism used to review credentials and to delineate individual clinical privileges; recommendation of individuals for Medical Staff membership and for delineated clinical

privileges for each eligible individual; participation of the Medical Staff in organizational performance/improvement activities as well as the mechanism used to conduct, evaluate and revise such activities; the mechanism by which Medical Staff membership may be determined; and regarding the mechanism for Fair Hearing Procedures.

8.4 STAFF FUNCTIONS: Provisions shall be made in these Bylaws or by resolution of the Medical Staff approved by the Governing Body for the effective performance of the staff functions specified in this Section 8.4 and of such other staff functions as the Medical Staff or the Board shall reasonably require:

8.4-1 Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as intensive or coronary care units and surgical services; patient care support services, such as respiratory therapy; and other ambulatory care services.

8.4-2 Conduct, coordinate and review patient care quality and appropriateness and monitoring activities, including tissue, blood usage, antibiotic drug usage reviews, medical record and surgical case review, using independent consults where appropriate.

8.4-3 Coordinate and review utilization review activities.

8.4-4 Conduct, coordinate and review credentials investigations and recommendations regarding staff membership and grants of clinical privileges and specified services.

8.4-5 Develop and maintain surveillance over drug utilization policies and practices.

8.4-6 Investigate to reduce and control nosocomial infections and monitor the Hospital's infection control program.

8.4-7 Plan for response to fire and other disasters, for organizational growth and development, Medical Staff growth and development and for the provision of services required to meet the needs of the community.

8.4-8 Direct staff organizational activities, including staff Bylaws review and revision, staff officer and committee nominations, liaison with the Governing Body and Hospital Administration, and review and maintenance of Hospital accreditation.

8.4-9 Coordinate the care provided by Providers with the care provided by the nursing service and with the activities of other Hospital patient are and administrative services.

8.4-10 Participate in the Quality Assurance/Improvement program, Peer Review program, and the Hospital's Risk Management program.

8.5 PARTICIPATION ON INTERDISCIPLINARY HOSPITAL COMMITTEES:

Staff duties, functions and responsibilities relating to liaison with the Board and Hospital Administration, Hospital accreditation, disaster planning, facility and services planning and financial management shall be discharged by the appointment of Medical Staff members to such Hospital liaison functions by the Chief of Staff of the Medical Staff, when requested.

ARTICLE IX: CORRECTIVE ACTION

9.1 TYPES OF CORRECTIVE ACTION:

Types of corrective action include:

1) Routine corrective action (9.2),
2) Automatic suspension (9.3), and
3) Summary suspension (9.4)

9.2 ROUTINE CORRECTIVE ACTION:

9.2-1 GROUNDS FOR: Routine corrective action may be initiated whenever a Provider with clinical privileges engages in, makes or exhibits acts, statements, demeanor or unprofessional conduct either within or outside Hospital and associated Clinics, and the same is, or is likely to be detrimental to the quality of patient care or safety, unreasonably disruptive to the Organization's operations, or an unreasonable impairment to the community's confidence in the Organization.

Any person may provide information to the Medical Staff, the Administrator, or the Governing Body about the conduct, performance, or competence of a Provider. Grounds for corrective action include, but are not limited to, a reasonable belief in the following:

A. Acts, demeanor or conduct below applicable professional standards.

B. Conduct detrimental to patients' safety or the delivery of substandard quality patient care within the Hospital or associated Clinics.

C. Unethical practice. Conduct that has been addressed as outlined in the Provider Code of Conduct in the Rules and Regulations and has either been of a repeated nature (thereby rising to the level of "disruptive behavior") or is so disruptive so as to constitute an imminent danger to the health of an individual or individuals; the processing and handling of the complaint relative thereto shall proceed as set forth in these Bylaws.

D. Conviction of a felony.

E. Violation of these Bylaws and Rules and Regulations of the Medical Staff.

F. Personal abuse of drugs and/or alcohol.

G. Notification by an appropriate agency of the revocation or suspension of a person's license, or of being placed on probation; and/or

H. Failure to maintain professional liability insurance in amounts as may be required by the Governing Body.

9.2-2 WHO MAY INITIATE: Routine corrective action may be initiated by a member of the Medical Staff, by the Administrator, or by the Governing Body.

9.2-3 INTERVIEWS PRIOR TO CORRECTIVE ACTION: When considering initiating corrective action, the initiating individual (or group), or person(s) delegated by the Chief of Staff, may arrange for an interview with the involved Provider. At the interview, circumstances prompting the consideration of corrective action are discussed and the Provider asked to present relevant information on his/her behalf. A written record is maintained reflecting the substance of the interview, and copies are sent to the Provider, Chief of Staff of the Medical Staff, and the Administrator. If the Provider fails or declines to participate in the interview, the next step in the appropriate corrective action is initiated. This interview is not a procedural right of the Provider, is not a hearing, and will not be conducted according to the procedural rules provided in Article X of these Bylaws or in the Fair Hearing Plan.

9.2-4 REQUESTS AND NOTICES: All requests for corrective action must be in writing by one of the persons in Section 9.2-2, submitted to the Medical Staff and supported by reference to specific activities or conduct which constitutes grounds for the request. The Chief of Staff of the Medical Staff promptly notifies the Administrator in writing of all requests. The Chief of Staff shall inform the Provider, in writing, of the request for corrective action within a reasonable time frame.

9.2-5 INVESTIGATION: After deliberation, the Medical Staff Committee may either act on the request, or direct that an investigation concerning the grounds for the corrective action request be undertaken. The Medical Staff Committee may conduct such investigation itself or may assign this task to another organization or professional resource. If so requested, the investigative committee may require the affected Provider to attend and participate in an investigatory interview after reasonable notice. Failure by the affected Provider to do so without good cause shall result in immediate

summary suspension until such time as the Provider participates in the interview. The investigative process is not a "hearing" as that term is used in the Fair Hearing Plan. It may involve a consultation with the Provider involved and with the individual or group making the request, or with other individuals who may have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the Medical Staff Committee, that group or individual will forward a written report as soon as practicable after the assignment to investigate has been made. The Medical Staff Committee may at any time within its discretion, and shall at the request of the Governing Body, terminate the investigation process and proceed with action as provided below.

9.2-6 MEDICAL STAFF ACTION: As soon as practical after conclusion of the investigative process, if any, but in any event within twenty-one days after the request for corrective action, unless extended by the Medical Staff Committee, the Medical Staff Committee shall act upon such request. Its action may include without limitation:

A. Recommending rejection of the request for corrective action.

B. Recommending a warning or a formal letter of admonition, censure, or reprimand.

C. Recommending additional training, retraining, or continuing education.

D. Recommending a probationary period with retrospective review of cases but without special requirements for concurrent consultation or direct supervision.

E. Recommendation of proctoring in which the Provider cannot perform certain procedures without proctor approval or without the proctor being present and watching the Provider.

F. Recommending suspension of appointment prerogatives that do not affect clinical privileges.

G. Recommending the suspension, termination or reduction of temporary privileges.

H. Recommending individual requirements of consultation or supervision.

I. Recommending reduction, suspension or revocation of clinical privileges; Recommending reduction of staff category or suspension or limitations of prerogatives related to the provider's provision of patient care.

J. Recommending suspension or revocation of staff appointment.

The Administrator shall give Special Notice of the action of the Medical Staff Committee to the affected Provider.

9.2-7 DEFERRAL: if additional time is needed to complete the investigative process, the Medical Staff Committee may defer action on the request. The Chief of Staff shall inform the affected Provider and the Administrator, in writing, of the deferral within a reasonable time frame. A subsequent recommendation for any one or more of the actions provided above must be made within thirty days of the deferral.

9.2-8 PROCEDURAL RIGHTS: A recommendation for individual consultation, rejection of a request for increase in privileges, reduced category, diminished or suspended patient care prerogatives, suspended or revoked appointment, or reduction, suspension or termination of clinical privileges, including temporary privileges, for longer than fourteen (14) days for reasons of competence or professional conduct, is deemed adverse, and in any of such cases described in this Section 9.2-8, the Special Notice shall advise the affected Provider of the Provider's procedural rights contained in the Fair Hearing Plan, and shall be accompanied by a copy of the Fair Hearing Plan.

9.2-9 OTHER ACTION: A Medical Staff Committee recommendation for rejection of request for corrective action, warning/reprimand, probation with retrospective monitoring, suspension for failure to complete medical records, or diminished prerogatives that do not affect clinical privileges is not deemed adverse and is transmitted to the Governing Body together with all supporting documentation. The Provider may protest or appeal the recommendation. This protest appeal will be heard at the Medical Staff Meeting prior to transmittal to the Governing Body. The protest appeal shall not constitute a hearing or entitle the Provider to the procedural rights in the Fair Hearing Plan.

9.2-10 If the reason for the recommendation is that the Provider is or may be medically incompetent or is or may be guilty of unprofessional or dishonorable conduct or is or may be an impaired Provider unable safely to engage in clinical practice of his/her profession, the information or other statutory grounds shall be reported to the Oregon Medical Board, or to the appropriate licensing board at the appropriate time as provided by statute

9.3 AUTOMATIC SUSPENSION:

9.3-1 AUTOMATIC SUSPENSION: Automatic suspension shall be initiated whenever there is revocation, suspension, restriction or probation of the Provider's state license or DEA number; whenever there is failure to satisfy a special appearance requirement; whenever the Provider fails to maintain malpractice insurance required by these

Bylaws and Rules and Regulations and whenever a Provider's medical records are not completed in a timely manner.

Revocation: Whenever a Provider's license to practice in the State of Oregon is revoked, there is immediate and automatic revocation of staff appointment and all clinical privileges.

Restriction: Whenever a Provider's license is partially limited or restricted in any way, those clinical privileges which he/she has been granted that are within the scope of the limitation or restriction are similarly limited or restricted, automatically.

Suspension: If a license is suspended, the Provider's staff appointment and clinical privileges are automatically suspended effective upon and for at least the term of the suspension.

Probation: If a Provider is placed on probation by his/her licensing authority, his/her voting and office-holding prerogatives are automatically suspended effective upon and for at least the term of the probation.

9.3-2 DRUG ENFORCEMENT AGENCY (DEA): If a Provider's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation, by a proper licensing authority, privileges to prescribe such substances in the Hospital and associated Clinics will also be revoked, restricted, suspended, or placed on probation automatically and to the same degree. This will be effective upon and at least for the term of the imposed restriction.

9.3-3 MEDICAL RECORDS

A. Timely completion: The failure to prepare and/or to complete medical records in a timely fashion, within thirty (30) days, may result in limitation or automatic suspension of some or all of a Provider's prerogatives and clinical privileges. Suspension will not occur if there are reasonable extenuating circumstances that lead to the delay in medical records completion and the provider makes a good faith effort to complete such records as soon as possible. Suspension will not occur without written warning and the provider will be given sufficient warning and time so that this will not constitute a hardship.

B. Membership Status Review: Six suspensions within any twelve-month period for failure to complete or prepare records will be deemed a voluntary resignation from the Staff. Providers who so resign may immediately submit a new application.

C. Justifiable Reasons for Delay in Completing Records: Include, without limitation:

1. The Provider is ill or otherwise unavailable, for a period of time due to circumstances beyond his/her control. Other extenuating circumstances will be considered by the Medical Staff Chief of Staff;

2. The Provider has dictated reports and is waiting or completed transcription.

9.3-4 PROFESSIONAL LIABILITY INSURANCE: For failure to maintain a minimum amount of professional liability insurance required under these Bylaws, a Provider's Medical Staff appointment and clinical privileges are immediately suspended. Each Provider granted privileges in the Hospital and associated Clinics shall maintain at least that amount of liability insurance that is required by the Governing Body.

9.3-5 REPORTING AGREEMENT: In the event that any action is taken by a proper licensing authority or a Provider's liability insurer as described in Sections 9.3 and 9.3-4, it is the responsibility of the Provider to immediately report such action to the Chief of Staff and to the Hospital's administrator. Failure to do so will result in automatic revocation of Staff membership and all clinical privileges.

9.3-6 AUTOMATIC SUSPENSION REVERSAL: If the reason for the automatic suspension is reversed, the Medical Staff Committee, upon a request from the Provider, will at its next meeting, decide whether, or not, to recommend the reinstatement of the Provider. If the reinstatement of the Provider is not recommended by the Medical Staff Committee (or approved by the Governing Body), the Provider may invoke provisions of the Fair Hearing Plan.

9.4 SUMMARY SUSPENSION

9.4-1 GROUNDS FOR: Summary suspension shall be initiated whenever a provider's conduct requires that immediate action be taken where the failure to take such an action may result in an imminent danger to the health of any individual, including without limitation immediate danger to life or the substantial likelihood of injury to patients, employees, or other persons present in the Hospital or associated Clinics.

9.4-2 PROCEDURE TO INITIATE A SUMMRY SUSPENSION:

A. When any member of the SCHHC Clinical Staff becomes aware of a situation where the actions or behavior of a clinician member of the Medical Staff poses an immediate danger to patients, staff, visitors, or other individuals, that member of the Clinical Staff shall immediately inform the clinician of the concern.

B. The person identifying the concern shall then immediately contact the supervisor of the clinician to arrange for alternate coverage for

care of the clinician's patients until the situation is resolved.

C. The person identifying the concern shall then immediately inform the Administrator (or administrator on call if the Administrator is not available) and the Medical Staff Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is not Available) of the concern especially the circumstances that may cause immediate jeopardy to patients, staff, or visitors if the clinician is allowed to continue their current activities.

D. The Administrator and Chief of Staff (or their designees if either is unavailable) shall immediately consider the matter. They have the authority to summarily suspend the Medical Staff status or any portion of the clinical privileges of the clinician. Other possible actions include placing the clinician on Administrative Leave without suspension of privileges while further investigation is conducted. Factors that may be taken into consideration include whether the activities of the clinician are due to impairment due to physical, mental health, or substance use disorders.

E. Any summary suspension is effective immediately and the Administrator or an officer of the Medical Staff shall give prompt Special Notice of the suspension to the Clinician and the Chair of the Governing Body. A suspended Clinician's patients then in the Hospital must be assigned to another Clinician by a Medical Staff designer. This assignment should consider the wishes of the patient in choosing a substitute when feasible.

9.4-3 MEDICAL STAFF ACTION: As soon as convenient after the summary suspension, but in any event, within seventy-two hours after the summary suspension has been imposed, the Medical Staff Committee convenes to review and consider the action taken. Upon request, the Clinician may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Staff Committee may impose, although in no event shall any meeting of the Medical Staff Committee, with or without the Clinician, constitute a "hearing" within the meaning of Article X, nor shall any procedural rules apply. The Medical Staff Committee shall issue its decision within five (5) days of the meeting. The Medical Staff Committee may also modify, continue, or terminate the summary restriction, subject to review by the Governing Body, but in any event, it shall furnish Special Notice to the affected Provider of its decision. If the Medical Staff Committee does not terminate the summary restriction or suspension, the affected Clinician is entitled to the procedural rights contained in the Fair Hearing Plan.

9.4-4 OTHER ACTION: A Medical Staff Committee recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights is transmitted immediately, together with all supporting documentation, to

the Governing Body. In this instance, the Medical Staff Committee recommendation will have the effect of revoking the summary suspension completely or reinstating the Clinician with whatever corrective action was assessed by the Medical Staff Committee preceding the final decision of the Governing Body.

ARTICLE X: PROCEDURAL RIGHTS: FAIR HEARING PLAN

10.1 INITIATION OF HEARING

10.1-1 GROUNDS FOR HEARING

The following recommendations shall, if made or proposed to be made by the Medical Staff Committee, be grounds for hearing upon timely and proper request by the affected Provider:

A. Denial of initial staff appointment;

B. Denial of reappointment;

C. Suspension of staff membership or clinical privileges, but only if such suspension is for more than 14 calendar days and is not caused by the Provider's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

D. revocation or termination of medical staff membership;

E. denial of requested appointment in staff classification or failure to advance;

F. reduction in staff classification;

G. suspension or limitation of the right to admit patients;

H. denial or restriction of requested clinical privileges;

I. involuntary reduction or revocation in clinical privileges;

J. suspension of clinical privileges;

K. revocation of clinical privileges;

L. denial of request for modification of privileges;

M. imposition of a requirement for retraining, additional training, or continuing medical education;

N. application of a mandatory concurrent consultation requirement; or proctoring where the Provider cannot perform certain procedures without proctor approval or without the proctor being present and

watching the Provider; or an increase in the stringency of a pre-existing mandatory concurrent consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than fourteen (14) calendar days.

10.1-2 UNAPPEALABLE ACTIONS

When imposed by the Medical Staff Committee, or the Governing Body, the following shall not constitute grounds for a hearing, but shall take effect without hearing or appeal:

A. Voluntary restriction or relinquishment of Medical Staff membership or privileges, as provided for elsewhere in these Bylaws.

B. Automatic restriction or relinquishment of Medical Staff membership or privileges, as provided for elsewhere in these Bylaws.

C. The imposition of any consultation and/or monitoring or proctoring requirement, except as provided in Section 10.1-1(n).

10.1-3 WHEN DEEMED ADVERSE

A recommendation or action listed in Section 10.1-1 above is adverse only when it has been:

A. recommended or approved by the Medical Staff Committee for forwarding to the Governing Body as provided in the appointment, reappointment, corrective action and hearing provisions of these Bylaws; or

B. taken by the Governing Body under circumstances in which no prior right to request a hearing existed.

10.1-4 NOTICE OF RIGHT TO REQUEST HEARING

In all cases in which the Medical Staff Committee has or may recommend, or the Governing Body may take, those actions constituting grounds for hearing, the affected Provider shall be given Special Notice of his/her right to request a hearing. This Special Notice shall:

A. Advise the Provider of the recommendation or action and fully inform the Provider of the exact nature of all the charges against the Provider that may be raised at the hearing and include copies of or reference to the evidence forming the basis of the charges and the reasons therefor and the Provider's right to request a hearing pursuant to these Bylaws;

B. Summarize the rights of the Provider in the hearing;

C. Specify that the Provider has thirty (30) days after receiving the notice within which to submit a written request for a hearing to the Administrator who will promptly deliver the request to the chair of the Governing Body;

D. State that failure to request a hearing within the specified time period and in the proper manner will result in loss of all rights to a hearing on the matter that is the subject of the notice and that the Provider will be deemed to have accepted the action taken;

E. State that any higher authority required or permitted under these Bylaws to act on the matter will not be bound by the Medical Staff Committee's recommendation or action, but may take any action, whether more, or less, severe, where it deems warranted by the circumstances;

F. State that upon the receipt of the Provider's written request, the Administrator will notify the Provider of the date, time and place of the hearing. The hearing request must be in writing and delivered in person or by registered or certified mail to the Administrator of the Hospital;

G. State that the recommendation, if finally adopted by the Governing Body, or as otherwise required by law, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

H. The individual shall receive a copy of this Fair Hearing Plan.

10.2 HEARING PREREQUISITES

10.2-1 HEARING COMMITTEE

When a proper request for hearing is received, the Administrator of the Hospital shall promptly deliver the request to the chair of the Governing Body. Upon receipt of the hearing request, the chair of the Governing Body after conferring with the Chief of Staff of the Medical Staff, shall appoint either:

A. A hearings officer who need not be a member of the medical staff and who is not in direct competition with the Provider involved;

B. A hearing committee composed of not less than three;

C. members of the active Medical Staff, who are not in direct economic competition with the Provider, one of whom shall be appointed as chair. If the requesting Provider is an AHP, then at least one of the members must be an AHP and, if possible, an AHP of the same specialty.

Pursuant to ORS 441.055, upon request by all of the following:

A. Physician whose practice is being reviewed;

B. the Medical Staff Committee; and

C. the Governing Body, the Governing Body shall appoint a hearing committee from a list of persons consisting of representatives of the Oregon Medical Board.

10.2-2 NOTICE OF TIME AND PLACE FOR HEARING

The chair of the Governing Body shall within ten (10) days after appointment of the hearing officer or committee, schedule a hearing and notify the affected Provider of the time, place and date. A hearing shall be scheduled on a date not less than 30 days from the date appearing on the face of the notice.

10.2-3 CONTENT OF HEARING NOTICE

The notice of hearing shall be prepared by the Chief of Staff their designee and shall state in concise language:

A. The criteria, bylaws or other requirements relied on in the adverse recommendation, decision or act;

B. The name of the hearing officer or the composition of the hearing committee;

C. The time, place and date of the hearing;

D. Notification that the right to the hearing may be forfeited if the Provider fails without good cause to appear;

E. Notification that the Provider has the right to have a record made of the proceedings, copies of which may be obtained by the Provider upon payment of any reasonable charges associated with the preparation thereof;

F. Notification that the Provider has the right to call, examine and cross-examine witnesses;

G. Notification that the Provider has the right to present evidence determined to be relevant by the presiding officer, regardless of its admissibility in a court of law;

H. Notification that the Provider has the right to submit a written statement at the close of the hearing;

I. Notification that upon completion of the hearing the Provider

involved has the right to receive the written recommendation of the hearing officer or committee, including a statement of the basis of the recommendations, and shall receive a written copy of the hearing decision, including a statement of the basis of the decision;

J. The name of the person to contact for access to the record on which the adverse recommendation was based;

K. The names of witnesses then contemplated; and

L. The name of the person appointed to present the evidence of the proponents of the adverse recommendation, if any.

10.2-4 CHALLENGE OF HEARINGS OFFICER OR COMMITTEE MEMBER

A Provider who has requested a hearing may challenge the impartiality of a hearings officer or hearings committee member for demonstrated bias or direct economic competition and for no other cause. Challenges shall be in writing, stating the grounds for challenge, and delivered to the Chief of Staff, or his designee, and the Administrator within three (3) days after the Provider has been notified of the identity of the hearings officer or committee members. The Chief of Staff or designee shall decide challenges, within five days of the receipt of the challenge. All parties shall be notified, in writing, of the Chief of Staff's decision and the name(s) of the replacement(s), if any.

10.3 HEARING PROCEDURE

10.3-1 PERSONAL PRESENCE

Failure of the Provider to appear at the hearing without good cause, shall constitute a waiver of the right to a hearing and a voluntary acceptance of the recommendations or actions involved.

10.3-2 PRESIDING OFFICER

The hearing officer or chair of the hearing committee shall preside over the hearing. The hearing officer or chair shall act to ensure that decorum is maintained and that all persons who participate in the hearing have a reasonable opportunity to be heard, and to present oral and documentary evidence.

10.3-3 REPRESENTATION

The affected Provider shall be entitled to have an attorney or other person of the Provider's choice present to advise, and actively participate with, the Provider at the Provider's own expense. The MEC shall be entitled to have an attorney and shall appoint a representative(s) to represent the interests of the MEC and the Medical Staff, to present evidence, and to examine

witnesses. The name of such representative(s) shall be given to the affected Provider.

10.3-3 RIGHTS OF THE PARTIES

The parties to the hearing shall have the right to:

A. Call and examine witnesses;

B. present evidence determined to be relevant by the presiding officer;

C. cross-examine on any matter determined to be relevant by the presiding officer. If the Provider does not testify in the Provider's own behalf, the Provider may be called and examined as if under cross-examination; and

D. obtain a copy of the hearing record upon payment of any reasonable charges associated with its preparation.

The Administrator shall do whatever is reasonably necessary to have records available that are relevant and necessary to the issues at the hearing produced, and witnesses, who are employees of the Hospital or associated Clinics, appear and testify at the hearing upon request of either party. A witness refusal to testify shall not be a reason to end the proceeding unless the parties so agree in writing.

10.3-4 PROCEDURE AND EVIDENCE

The hearing need not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons are accustomed to relying on in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. The hearing officer or committee is also entitled to consider all other relevant information that can be considered under these Bylaws in connection with credential matters. Each party shall be entitled prior to or during the hearing to submit memoranda concerning any issue of law or fact and those memoranda shall be part of the hearing record. Oral evidence shall be taken only on oath or affirmation.

10.3-5SCOPE OF REVIEW AND BURDEN OF PROOF

When a hearing relates to an application for membership under Article IV of these Bylaws, the applicant has the burden of proving by the more convincing evidence that the Provider is qualified for or entitled to Staff membership. In all other matters, the individual who requested the hearing has the burden of proving that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

10.3-6 HEARING RECORD

An accurate record of the hearing must be kept. The hearing officer or chair of the hearing committee may select a method to be used for making a record, such as a court reporter, electronic recording unit, detailed transcription or minutes of the proceedings. If the hearing committee does not elect to use a court reporter, the Provider may arrange for a court reporter at the Provider's own expense, but shall consent to the Hospital's right of access to any such transcription with the Hospital to bear one-half the cost of producing the record and the entire cost for the Hospital's copy. The hearing record shall also contain all exhibits or other documentation considered, written statements or memoranda submitted by the parties and correspondence between the parties or between the hearing committee and the parties if any during the hearing process.

10.3-7 POSTPONEMENT

Request for postponement of a hearing may be granted by the hearing officer or chair of the hearing committee only upon showing of good cause, and only if the request is made as soon as is reasonably practical.

10.3-8 PRESENCE OF THE HEARING COMMITTEE AND VOTE

If the hearing is conducted by a hearing committee, the entire hearing committee must be present throughout the hearing and deliberations unless the committee member reviews the written transcript of the proceeding and exhibits presented during his/her absence.

10.3-9 RECESSES AND ADJOURNMENT

The hearing officer or chair of the hearing committee may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing must be reconvened in a timely manner and in any event the recess must not exceed 10 days except by consent of the affected Provider. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The hearing officer or committee shall, at a time convenient, conduct the deliberations outside the presence of the parties. Upon conclusion of the deliberations, the hearing shall be adjourned. The adjournment shall be not later than 10 days after the hearing is closed.

10.3-10 EX-PARTE COMMUNICATIONS

Once a hearing officer or hearing committee is appointed, neither party may discuss any matter related to the hearing with the hearing officer or any member of the committee outside of the hearing procedure except in the presence or with the written consent of the other party.

If an ex-parte communication is received by any member, it must be immediately reported to the other members of the committee, and reported to all parties except if it is made or given in the presence or with the written consent of the other party.

Such communication shall not be considered or received as evidence until rebuttal or argument is presented by the parties during the hearing process and then admissibility is solely at the discretion of the presiding officer.

10.4 HEARING OFFICER OR COMMITTEE REPORT AND FURTHER ACTION

10.4-1 HEARING OFFICER OR COMMITTEE REPORT

Within 10 days after adjournment of the hearing, the hearing officer or committee shall make its written report and recommendations and shall assemble the report along with the record and any other documentation in the matter. The materials shall be sent to the Governing Body, with a copy of the report and recommendations to the Provider by Special Notice, and an informational copy to the Medical Staff Committee.

10.4-2 ACTION BY GOVERNING BOARD

Within 10 days after receipt of the hearing officer or committee report, the Governing Body shall act upon the recommendation(s) of the hearing officer or hearing committee. It may either affirm, modify, or reject the decision of the hearing officer or hearing committee. If the decision of the Governing Body is in accord with the last recommendation of the hearing officer or committee, then the Administrator shall give written notice of the decision to the Provider within 5 days by Special Notice. If the action of the Governing Body has the effect of changing the hearing officer's or committee's last recommendation, the matter shall be referred to a joint review committee as provided in Section 10.4-3 below. The Governing

Body shall inform the parties of its decision and the basis there of, by Special Notice.

10.4-3 JOINT REVIEW COMMITTEE

In the event the decision of the Governing Body differs from that of the hearing committee, the Governing Board decision shall not be final until the matter shall be referred to the joint review committee for consideration. The joint review committee shall consist of six members. The chair of the Governing Body shall appoint three Board members and the Chief of Staff shall appoint three members not in direct economic competition with the Provider from the active Medical Staff. Within 30 days after receiving the matter referred to it under this article, the joint review committee will consider the matter. Within 15 days after the joint review committee has considered the matter it shall prepare and submit its recommendations to

the Governing Body with a copy to the affected Provider.

A. In regard to the matter to be considered by the joint review committee: The affected Provider may submit written statements covering any matters raised at any step in the hearing process. The Administrator shall submit the statement to the joint review committee and other parties within 20 days after the matter is sent to the joint review committee, except if the joint review committee waives the time limit. The proponents of the challenged action may also submit a written statement covering any matters raised at any step in the hearing process within 20 days after the matter is sent to the joint review committee.

B. Oral statements: The joint review committee, at its sole discretion, may allow the parties of their representatives to personally appear and make oral statements in favor of their positions. Any such appearances and statements shall not constitute a hearing under the procedural rules provided for hearings under these Bylaws. Any party appearing may be required to answer questions by any member of the joint review committee.

C. Consideration of new or additional matters: New or additional evidence not raised in the original hearing or otherwise reflected in the record may be introduced during the joint review committee only under unusual circumstances and only at the sole discretion of the joint review committee, if the party requesting consideration of the new or additional evidence could not have produced such evidence at an earlier point in the proceedings. The requesting party shall submit to the chair of the Governing Body for the chair's submission to the joint review committee, a written description of the new or additional evidence, as soon as the party becomes aware of the evidence.

10.4-4 FINAL ACTION BY GOVERNING BODY

Within 45 days after receipt of the joint review committee's recommendations, the Governing Body shall make its final decision in the matter and send Special Notice thereof to the Medical Staff Committee and to the affected Provider. The decision of the Governing Body shall be approved by the Administrator in writing within 5 days after a decision is provided to the Provider by Special Notice. No Provider shall be entitled to more than one hearing pursuant to Article X of these Bylaws.

10.5 ADVERSE ACTION REPORT

10.5-1 SUBMISSION TO THE OREGON MEDICAL BOARD OR DENTAL EXAMINERS

Administrator, or designee shall submit the Adverse Action Report to the Oregon Medical Board or appropriate licensing board, within 15 days from the date the decision is approved by the Administrator in writing.

10.5-4 SEPARATE REPORTING FORM

A separate report of the adverse action(s) shall be reported to the appropriate licensing board, in a format different from the form used to report to the National Practitioner Data Bank if so required by the licensing board.

ARTICLE XI: CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 AUTHORIZATION AND CONDITION: By submitting an application for staff appointment, by applying for or exercising clinical privileges, or providing specified patient care services in this Hospital, a practitioner:

11.1-1 Authorizes representatives of the Hospital, associate Clinics, and Medical Staff to solicit, receive, provide and act upon information bearing on his/her professional ability and qualifications.

11.1-2 Authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff.

11.1-3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital, or associated Clinics who acts in accordance with the provisions of this Article;

11.1-4 Acknowledges that the provisions in this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital and associated Clinics.

11.2 CONFIDENTIALITY OF INFORMATION: Information with respect to any practitioner submitted, collected or prepared by any representatives of this or any other health care facility or organization or Medical Staff for the purposes of evaluating and improving quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research and determining that health care services are professionally indicated and performed in compliance with the applicable standards of care shall, to the fullest extent permitted by law, be confidential and privileged and shall not be used in any way except as provided herein or except as otherwise provided in these bylaws. Such confidentiality and privilege shall also extend to information of the kind that may be provided by third parties. This information shall not become a part of any particular patient record. Any such information required or permitted by these Bylaws or law to be disseminated to the Medical Staff, Administrator or others, shall be marked: "Privileged and Confidential" under ORS 41.675.

11.2-1 A Provider may request corrections, deletions or additions to information in the Provider's file. The Chief of Staff or designee shall review the request within a reasonable time and decide whether the request will be granted or denied. If granted, the appropriate action will be taken, and the Provider will be so notified. If the request is denied, the Provider will be notified of the reasons for denial. The Provider may request a review of the Chief of Staff's decision by the Medical Staff Committee. This review is not a hearing pursuant to the Fair Hearing Plan. Notwithstanding the decision of the Chief of Staff and/or the Medical Staff Committee, a Provider may add a short reasonable, relevant, written statement to the Provider's file to support or rebut any information contained therein.

11.3 IMMUNITY FROM LIABILITY

11.3-1 FOR ACTION TAKEN: No representative of the Hospital, associated Clinics, or Medical Staff shall be liable to any Provider for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice after reasonable effort under the circumstances to ascertain the truthfulness of the fact and in reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

11.3-2 FOR PROVIDING INFORMATION: No representative of the Hospital, associated Clinics, or Medical Staff and no third party shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital, associate Clinics, or Medical Staff or to an appropriate State regulatory agency, concerning a Provider who is or has been an applicant to or an appointee of the staff or who did or does exercise clinical privileges or provides specific patient care services at this Hospital or associate Clinics, provided that such representative acted in good faith and without malice and provided further that such information is related to the performance and duties and reported in a factual manner; and provided information will not be provided to any other Hospital, health care facility, organization of health professionals or individuals without the provider's expressed written consent.

11.3-3 INDEMNITY: Any person performing a staff function or duty, in accordance with the Medical Staff Bylaws, Rules and Regulations, shall be an agent of the District. Any such agent is entitled to defense and indemnity by the District as provided in the Oregon Tort Claims Act. A person is not an agent of the Hospital when exercising clinical privileges at the Hospital or associated Clinics in providing patient care, except Southern Coos Hospital and Health Center employees acting within the scope of their employment.

11.4 ACTIVITIES AND INFORMATION COVERED

11.4-1 ACTIVITIES: The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning but not limited to:

A. Applications for appointment, clinical privileges or specified services;

B. Periodic reappraisals for reappointment, clinical privileges or special services;

C. Corrective or disciplinary action;

D. Hearing and appellate reviews;

E. Quality assessment/improvement program activities;

F. Utilization and claims reviews;

G. Malpractice loss prevention;

H. Other Hospital and staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

I. Peer review organizations, Board of Medical Examiners, and National Practitioners Data Bank or similar reports.

11.4-2 INFORMATION: The information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

11.5 RELEASES: Each applicant and Provider with clinical privileges shall, upon request of this Hospital or associate Clinics, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Oregon. Execution of such releases is not a prerequisite to the effectiveness of this Article.

11.6 CREDENTIALS FILE

11.6-1 CREDENTIALS FILE: There shall be one for each Provider with clinical

privileges and it shall be deemed confidential pursuant to ORS 41.675.

11.6-2 CONTENT:

A. Applications, reapplication

B. License, DEA number

C. Evidence of education, experience, Board Certification (if any)

D. Reference and correspondence related to professional qualifications

E. Professional liability coverage and experience

F. National Practitioners Data Bank queries and responses

G. Other documents and correspondence related to past practice including records of procedures performed, FPPE, and OPPE.

H. Other information a provider requests to be included.

11.6-3 ACCESS: Access to such records is limited to the following people with a need to know, i.e., Medical Staff Chief of Staff, Administrator, Chief Medical Officer, Governing Body members and Medical Staff Services Coordinator, and only or the purposes of discharging authorized activities and responsibilities.

A practitioner may have access to his or her own credentials file, subject to the following conditions:

A. Review shall take place in the office where the records are maintained, during normal business hours with a member of the Medical Staff Services office or administration present. Review is limited to those documents prepared or provided personally by the Provider.

All other information shall be disclosed only in written summary form. The summary shall contain the substance, but not the source of the information.

B. A provider may request copies of those documents available for review. A provider shall not remove, cancel, destroy, obliterate or change any documents in the file.

11.7 ACCUMULATIVE AFFECT: Provisions in these Bylaws and applications forms relating to authorizations, confidentiality of information in records, and immunities from liability shall be in addition to the protection provided by law and not in limitation thereof.

ARTICLE XII: GENERAL PROVISIONS

12.1 STAFF RULES, REGULATIONS AND POLICIES: Subject to approval by the Governing Body, the Medical Staff will adopt such Medical Staff Rules, Regulations, Credentials Policies and Procedures, Organization and Function Manual or Fair Hearing Plan as may be necessary to implement more specifically the general principles found in these Bylaws. The procedures outlined in Article XIII of these Bylaws will be followed in the adoption and amendment of the Rules, Regulations and policies except that staff action to modify, reverse or reject a decision of the Medical Staff may occur at any regular or special meeting of the Medical Staff in which a quorum is present, with previous notice, by a two- thirds majority vote of those present who are eligible and qualified to vote.

12.2 CONSTRUCTION OF TERMS AND HEADINGS: Words used in the Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires.

ARTICLE XIII: ADOPTION AND AMENDMENT

13.1 MEDICAL STAFF RESPONSIBILITY: Amendments to Medical Staff bylaws and the Rules, Regulations and Policies adopted thereunder shall be accomplished through a cooperative process involving both the Medical Staff and the Governing Body. Medical Staff Bylaws and the Rules, Regulations and Policies thereunder shall be adopted, repealed or amended when approved by the Medical Staff and the Governing Body. Approval shall not be unreasonably withheld by either. Neither the Medical Staff nor the Board shall withhold approval if such repeal, amendment or adoption is mandated by law, statute or regulation or is necessary to obtain or maintain accreditation or to comply with fiduciary responsibilities.

13.2 METHOD OF ADOPTION AND AMENDMENT: All Medical Staff Bylaw changes must be initiated by action of the Medical Staff or the Governing Body in consultation with the Medical Staff. Medical Staff Bylaws may be adopted, amended or repealed by the following action:

13.2-1 MEDICAL STAFF ACTION: The Medical Staff may make minor Corrections and Bylaw changes when such correction or change is necessary due to spelling, punctuation, grammar, context or if required by law. No prior notice of such change is required. All changes thus made will be reported at the next regular Staff meeting. The affirmative vote of two-thirds of the Medical Staff eligible or qualified to vote on Bylaws, when cast at a regular or special meeting, at which a quorum is present, provided that a copy of the proposed documents or amendments was given to each Medical Staff member entitled to vote thereon within the notice of the meeting. There will be a twenty-one (21) day written notice for all Bylaw amendments prior to vote of the Medical Staff.

13.2-2 GOVERNING BODY ACTION: The affirmative vote of a majority of the Governing Body upon the recommendation or action of the Medical Staff.

13.2-3 RELATED PROTOCOLS AND MANUALS: For the purpose of the adoption and amendment of the protocols and manuals provided in these bylaws, "Medical Staff action" means action by the Medical Staff.

DEFINITIONS AND USAGE, AND REQUIREMENTS RELATED THERETO or the purpose of these Bylaws and unless stated otherwise, the following definitions will apply.

A. **GOVERNING BODY** means the Southern Coos Health District Board of Directors.

B. **HOSPITAL** means Southern Coos Hospital & Health Center, Bandon, Oregon.

C. **ADMINISTRATOR OR CHIEF EXECUTIVE OFFICER (CEO)** means the individual appointed by the Governing Body to act on its behalf in the overall administrative management of the Hospital and associated Clinics.

D. **MEDICAL STAFF** or **STAFF** means the formal organization through which all Physicians, and, in accordance with Oregon State law, other Practitioners who have been granted membership on the Medical Staff by the Governing Body to carry out the functions of the Medical Staff, and/or exercise specific clinical privileges or provide other diagnostic or therapeutic services in the Hospital or associated Clinics. Membership on the Medical Staff of the Hospital and associated Clinics is a privilege that shall be extended only to those professionally competent and Oregon- licensed or certified Physicians (M.D. or D.O.), dentists, oral maxillofacial surgeons, podiatrists, nurse practitioners, physician associates, licensed clinical social workers, certified nurse midwives, and certified registered nurse anesthetists. The preceding list is not to be considered exhaustive and other categories of healthcare professionals may be considered for membership in the Medical Staff as need and changing regulatory requirements may dictate.

E. **GOOD STANDING** means the Medical Staff member is in compliance with the requirements and responsibilities of the Medical Staff Membership.

F. **MEDICAL STAFF COMMITTEE:** a body of the medical staff composed of all current active members of the medical staff.

G. **PHYSICIAN** means an individual with an M.D. or D.O. degree who is licensed to practice medicine in the state of Oregon, pursuant to ORS Chapter 677.

H. **PROVIDER** or **PRACTITIONER** means, unless otherwise expressly provided, any a licensed independent practitioner applying for or exercising specific clinical privileges or providing other diagnostic or therapeutic services in the Hospital or associated clinics

I. **APPOINTEE** means, unless otherwise expressly provided, any Licensed Independent Practitioner who has applied for appointment to the Medical Staff and who has been granted such appointment by the Governing Body.

J. **LICENSED INDEPENDENT PRACTITIONER** (**LIP**) means any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner license and consistent

with individually assigned clinical responsibilities.

K. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the rights granted by the Governing Body to a Practitioner to provide those diagnostic, therapeutic, medical or surgical services specifically delineated to him/her with reasonable access to Hospital or Clinic equipment, facilities, and Hospital or Clinic personnel necessary to effectively exercise such privileges.

L. **PREROGATIVE** means a participatory right granted, by virtue of Staff category or otherwise, to a Staff appointee and exercisable subject to the conditions and limitations imposed in these Bylaws and in other Hospital, Clinic and Medical Staff policies, and/or imposed by the Governing Body.

M. Medical Staff **YEAR** means the period from July 1 of any odd-numbered year to June 30 of the succeeding odd-numbered year.

N. **EX OFFICIO** means a person who serves as a member of a body or committee by reason of holding another office or position. An ex-officio member of a body or a committee shall not vote on matters for the body or committee unless the Bylaws, Rules and Regulations, or other policies pertaining to the Medical Staff allow such voting in a specified committee.

O. **SPECIAL NOTICE** means written notification by certified or registered mail, return receipt requested, dated the day of mailing and addressed to the affected Practitioner at either the office or home address stated on his/her most recent application for Staff appointment or such other address as contained in the Hospital files relating to that person, or personal hand delivered written notification to the affected Practitioner dated the day of delivery. Special notice shall be deemed to have been given as of the date appearing on the face of the notice.

P. **DENTIST** means an individual with a DDS or DMD degree who is licensed to practice dentistry in the state of Oregon.

Q. **QUORUM** Fifty (50) percent of the voting members constitutes a quorum of the Medical Staff for voting purposes at Medical Staff meetings.

R. **THIRD PARTIES** means both individuals and organizations providing information and their respective representatives.

S. **CLINICAL STAFF:** Any person with clinical training employed or contracted by SCHHC to provide care to patients at SCHHC facilities. This includes members of the Medical Staff, Nurses, CNA's, Respiratory Therapists, Physical Therapists and other individuals with clinical training and experience.

ADOPTED by the Southern Coos Hospital and Health Center Medical Staff on July 9, 2025.

_____

Chief of Staff, Medical Staff

APPROVED by the Southern Coos Health District Board of Directors July 24, 2025.

_____

Chair, Board of Directors

Southern Coos Hospital & Health Center

900 Eleventh Street SE
Bandon, OR 97411

Medical Staff Rules & Regulations

Chapter 1017, J Amended
July 12, 2016

Revision
October 10, 2012

Approved by the Medical Staff
July 12, 2016

Approved by the Medical Staff
June 9, 2020

Revision May
11, 2021

Revision
April 2023

Revision Approved by the Medical Staff
July, 2025

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Appendix B: Code of Conduct & Expectations of Practitioners

Appendix C: Medical Student and Resident Privileging Rule

Appendix D: Impaired Professional Program

1001 PURPOSE AND CONDITIONS

The purpose of these Rules and Regulations is to promote high standards of medical and surgical care of patients in Southern Coos Health District facilities. Furthermore, these Rules and Regulations shall serve as a guide for accomplishing this purpose, as well as to provide certain protections for the patient, hospital and associated clinics, personnel and physicians. Each staff member shall be required to abide by the Bylaws and Rules & Regulations of the Medical Staff of Southern Coos Health District, and to assist in achieving the standards set forth by State and Federal regulatory bodies. These Rules and Regulations shall not be interpreted as prohibiting the provision of care to patients as may be reasonably required by outside laws, guidelines, or standards of medical ethics.

A. Medical Staff Rules & Regulations

1. The name of this organization is the Southern Coos Health District Medical Staff hereafter referred to as “Medical Staff.”

2. In accordance with the Medical Staff Bylaws, the following Rules and Regulations are adopted. These Rules and Regulations are binding to all members of the Medical Staff. The collective functions of the Medical Staff and the independent functions of its individual members shall be accomplished in accordance with applicable State and Federal regulatory requirements.

3. The Rules and Regulations relate to the role and or responsibility of members of the Medical Staff with clinical privileges in the care of inpatients, emergency care patients and ambulatory care patients as a whole or to specific groups as designated.

B. Medical Staff Rules & Regulations – Amendment

1. Rules and Regulations shall be developed, as necessary, to implement more specifically the general principles found within the Medical Staff Bylaws. They may be adopted, amended or repealed by *majority* vote of active Medical Staff. Such Rules and Regulations shall not be inconsistent with the Medical Staff Bylaws.

2. Policies and procedures having a significant effect on medical practices of providers will be voted on by the Medical Staff after having been published or otherwise communicated in a manner giving affected members sufficient time and opportunity to comment or participate in the vote and shall require a majority vote in which a quorum (at least 50%) of medical staff members eligible to vote cast votes.

1002 RULES AND REGULATIONS RELATING TO ADMINISTRATIVE FUNCTIONS

A. Rules & Regulations

1. Suggested changes in Medical Staff Rules and Regulations may be initiated by individual staff members.

2. In an emergency, the Medical Staff Chief of Staff is empowered to act on behalf of the Medical Staff, but may not change, amend, suspend, or repeal these Rules and Regulations.

3. Failure of members of the Medical Staff to comply with the Medical Staff Rules and Regulations renders them subject to disciplinary action.

1003 CONFLICTING RULES AND REGULATIONS

These Rules and Regulations shall specifically relate to the role of the Medical Staff in the care of inpatients, emergency patients, surgical patients, and outpatients, as appropriate, and as further specified in Southern Coos Health District policy and/or Federal and/or State regulations. The Rules and Regulations shall not conflict with each other, with the Bylaws of the Medical Staff, with the policies of Southern Coos Health District or the Bylaws of the Hospital and/or Governing Body. If or when conflicts occur, efforts shall be pursued to resolve conflicts in a timely manner with ongoing attention to the best interests of patient care.

1004 RULES AND REGULATIONS RELATING TO PATIENT CARE

A. Policy

1. All patients admitted to Southern Coos Health District facilities must be under the direct supervision of a member of the active, provisional, or courtesy staff. Those Medical Staff members with delineated clinical privileges to admit patients are allowed to do so.

2. Admission, except in an emergency, will be effected only after a provisional diagnosis explaining the reasons for admission is provided.

3. All patients shall be attended by members of the Medical Staff.

4. A thorough history and physical examination shall be present in the chart within 24 hours after admission.

5. The attending physician, emergency provider, or other covering physician, must directly supervise the activities leading to the diagnosis and treatment of the patient. The attending, designated

physician or qualified advanced practice clinician will make rounds on his/her patients and review charts at frequent intervals.

6. Consultation is encouraged for the maintenance of high standards of patient care, professional accomplishment and education. Formal consults should be answered, written and signed without undue delay. If the circumstances are such that a delay is necessary, a brief note should be recorded in the chart pending completion of the consult request. In circumstances where formal consultation is not possible or desired, as in telephone contact with a distant specialist or simple discussion regarding management with a colleague, the attending physician should include notes in the chart regarding the consultation and decision-making process affecting patient treatment.

7. All surgical procedures performed shall be recorded by the operating surgeon or designated representative immediately following the procedure, with a detailed operative report dictated within 24 hours following the procedure. Dictated operative notes are to be signed within 14 days after discharge.

8. All orders shall be entered in the Electronic Health Record.. Verbal orders may be accepted and entered into the Electronic Health Record by a Licensed Practical Nurse or Registered Professional Nurse. In addition, verbal orders relating to medications to include IVs, may be accepted, and entered into the Electronic Health Recrod by a pharmacist. A Certified Respiratory Technician or a Registered Respiratory Therapist may accept and enter into the Electronic Health Record verbal orders related to respiratory therapy treatment. In all circumstances where verbal orders are given, they must be electronically signed in the Electronic Health Record as soon as possible (preferably within 24 hours) by the ordering clinician with the exception that the patient's attending clinician may, at his/her discretion, sign verbal orders given by another covering physician if he/she was providing ongoing care to the patient at the time the orders were given.
9. Automatic drug stop orders are permissible. The mechanisms will be specified by the Pharmacy and Therapeutics Committee and the Nursing Service. The prescribing physician will be notified of the impending termination of a medication order before such an order is automatically stopped. Stop orders do not apply if the medication is ordered for a specific time (time-limited).

10. Discharge notes and summaries should include:
    a. chief complaint, diagnosis,
    b. pertinent laboratory and radiographic results,
    c. treatment including operations,
    d. course and results of treatment,

e. discharge medications
f. disposition.
g. final diagnosis

11. All patients will be given instructions for follow-up care by the physician or a designated Nurse acting on the physician's instruction. This also applies to outpatient and emergency services.

12. The attending physician is responsible for assuring that a discharge summary go to any referring physician as soon as possible. On the ambulatory care services, the referring physician will be kept apprised of developments after the initial visit and at appropriate times.

13. When patients participate in research projects, the procedures must comply with Federal, State and Institutional regulations, including all aspects of informed consent and patient protection. This includes, but is not limited to, use of investigational drugs, materials and/or procedures. All research on human subjects must be approved by the Medical Staff Chief of Staff who shall oversee the appointment of an Institutional Review Board to review the appropriateness, safety, and ethical considerations of any research involving human subjects. Patient participation in research projects is discussed further in section 1039.

14. Access to patients shall be regarded as a privilege and the content of the patient's health record is privileged information. Persons desiring to interview or examine patients other than those directly involved with patient care must obtain the permission of the attending physician, the patient and follow the District's HIPAA and media policies.

15. Medical personnel attending patients or using the patient care areas must observe appropriate dress and decorum per appropriate facility policies and standards.

16. The Medical Staff will be organized for disaster and respond if needed, according to the Southern Coos Health District Disaster Plan.

17. The Medical Staff will carry out all performance improvement activities and quality of medical care review as required by the Southern Coos Health District organizational performance improvement program and in accordance with their Medical Staff Bylaws and Policies.

18. Concerning informed consent:
    a. Assess the patient's mental capacity to assure the patient is mentally able to make an informed consent. Tell the patient in simple, non-technical terms:

1) What is to be done
2) Why the procedure should be done
3) What are the reasonably likely risks and benefits
4) What alternatives and options are available
5) What the possible complications may be
6) What may reasonably happen to the patient if he/she refuses treatment

b. Ensure that a written consent is signed, dated and timed by the patient and that it acknowledges the oral explanation above and the name of the practitioner performing the procedure and the names of any assistants involved in performing the procedure if applicable;
c. The practitioner performing procedures will have the patient sign the written consent so the patient will have a chance to understand what is going on and to ask questions and the physician will be there to answer and explain;
d. There should be no abbreviations on the consent form
e. The practitioner explaining the procedure should indicate date, time and sign the informed consent
f. Informed consent is further discussed in section 1028

19. In circumstances where to or more members of the Medical Staff agree that further life sustaining treatment is futile and mearly prolonging patient suffering, the attending provider of the patient may enter a Do Not Resuscitate order. This provision should only be exercised if reasonable attempts to get the patient's medical decision makers to agree to a Do Not Resuscitate order are not successful.

1005 ADMISSIONS, DISCHARGES AND PATIENT CARE

A. General Rules

1. Southern Coos Health District Hospital can accept only those patients for care who have a medically or surgically justified need for hospitalization, observation, same-day care, or swing bed care. This general requirement of medical necessity does not obviate the responsibility not to discharge patients to unsafe environments in which they have substantial risk of harm to themselves or others and such issues will be considered as part of the medical evaluation. Patients are financially responsible for the cost of hospitalization and must be informed of their financial obligation once medical/surgical screening examinations have been performed. In the case of a medical or surgical emergency, medical/surgical care shall be rendered to all patients on request regardless of ability to meet the financial burden of care until such time as the patient's condition is stabilized to the degree that he/she can be either safely discharged home or is transferred to another healthcare facility.

2. Admitting patients to a setting where a physician's admission history and physical exam is standard of care is restricted to licensed physicians, physician's associates or nurse practitioners subject to statutes, bylaws, rules, and regulation per ORS441.0064 who attend patients. The Emergency Department physician, physician's associate or Registered Nurse Practitioner may admit patients from the ER.

3. Each patient shall be the responsibility of a member of the Medical Staff. Such Medical Staff member shall be responsible for medical care and treatment of the patient, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to any referring Medical Staff member and for communicating to relatives of the patient or other authorized persons, as indicated. Such communications shall be subject to all relevant Federal and State regulations including HIPPAA.

4. In every setting where a clinician's admitting history and physical examination is standard of care, a history and physical examination and initial plan of care shall be written and signed by a physician, physician's associate, or authorized nurse practitioner Medical Staff member within 24 hours of patient admission. In the event a complete medical history and physical examination of the patient has been performed at the facility within seven days prior to the patient's admission, then a history and physical need not be conducted within 24 hours of admission for medical Patients provided that:

    a. a copy of the results of the recent medical history and physical examination is made part of the patient's chart in the Electronic Health Record as part of that admission encounter.
    b. the clinician determines that a complete medical history and physical examination need not be undertaken again at this time,
    c. any changes are recorded at the time of admission, and
    d. a cardiopulmonary system physical is conducted within 24 hours after admission. The Medical Staff member admitting the patient shall be responsible for providing all available information about the patient in order to assure the maximum protection of other patients or of the patient himself/herself. Each patient admitted shall have appropriate laboratory and x-ray examinations performed.

5. The admission and medical care of a dental or podiatric patient shall be the responsibility of a physician, physician's associate, or nurse practitioner member of the Medical Staff. That clinician shall be responsible for the care of any medical problem present on admission or that may arise during the rest of the patient's hospitalization.

6. When patients are admitted primarily for dental and/or podiatric problems, the dentist or podiatrist will be responsible for documenting relevant exam findings, history of present illness and plan of care for the body part for which they will provide care in the patient's history and physical examination within 24 hours of the patient's admission to the hospital.

7. A podiatrist or dentist with clinical privileges may, with the concurrence of an appropriate physician, physician's associate, or nurse practitioner member of the Medical Staff, initiate the procedure for admitting a patient. This Medical Staff member shall assume responsibility for the overall aspects of the patient's care throughout the stay. Patients admitted for dental or podiatric care must be given the same basic medical appraisal as patients admitted for other services. A physician, physicians associate, or nurse practitioner member of the Medical Staff must be responsible for the care of medical problems of hospitalized podiatric or dental patients.

1006 ADMISSION AND CARE OF PATIENTS

A. Admission

1. In the event of the unavailability of the responsible Medical Staff member or the designated covering provider for that Medical Staff member (note that the designated covering provider must also be a member of the Medical Staff), a patient's care and treatment will be assumed, unless otherwise designated, by the Hospitalist if one is employed, and in urgent or emergent situations the emergency provider will provide stabilization and monitoring until the Hospitalist or responsible staff member is available. The Chief of the Medical Staff and CEO will be notified of such events.

2. Except in an emergency, no patient shall be admitted to the hospital until provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such a statement shall be recorded as soon as possible. Southern Coos Hospital shall admit eligible patients (as defined by law and applicable hospital regulations) suffering from any type of disease or injury. The Medical Staff members will examine and make the proper disposition of all eligible applicants. Any patient may be admitted for emergency care.

3. Practitioners admitting emergency cases shall be prepared to justify to the Medical Staff Chief of Staff and the Administration of the hospital that said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be

recorded on the patient's chart as soon as possible after admission.

4. A practitioner who will be out of town or unavailable for a significant period of time shall be responsible for arranging for continuing care of any patients admitted under their care. Exceptions to this provision include Emergency Department providers and Hospitalist providers as ongoing coverage for patients will be provided by providers as scheduled by the designated schedulers for the hospitalist and ED services.

5. The attending practitioner is required to document the need for continued hospitalization if an inpatient stay lasts longer than 96 hours and after any other specific periods of stay as identified by the policies of this Hospital. This statement must contain:
   a. an adequate written record of the reason for continued hospitalization; a simple reconfirmation of the patient's diagnosis is not sufficient,
   b. documentation of patient's clinical progress, and
   c. intended treatment plan as well as data supporting this assessment.

6. Upon appropriate request, each member of the Medical Staff is required to report to the Administration the necessity for continued hospitalization for any patient; including an estimation of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of notice.

7. If a member of the medical staff consistently exhibits a pattern of patient lengths of stay that are significantly longer than that of patients with similar conditions treated by other members of the Medical Staff, Focused Professional Practice Evaluation may recommended by the Medical Staff Chief of staff in order to assist the medical staff member in reducing any inappropriate lengths of stay.

8. Attending Providers, defined as those providing coverage for individual patients or hospital services, are responsible to be available by phone contact and to physically respond to hospital summons within one hour, or otherwise arrange for alternative coverage during periods of unavailability.

9. Self-administration of drugs by hospital inpatients is only allowed when specifically ordered by the responsible medical professional. It is reserved for patients for whom self-administration of drugs is important for their overall medical care.

1007 DISCHARGE

A. Policy

1. Patients shall be discharged only on a verbal or written order of the attending practitioner. Verbal orders shall be entered into the Electronic Health Record and signed by the attending practitioner within 24 hours.
   a. Patients shall be discharged only on the order of a member off the Medical Staff.
   b. Whenever possible, discharge orders will be written in advance of the departure of the patient.
   c. No discharge will be effected without consideration of adequate provisions for continued follow-up care

   Should a patient leave against the medical advice (AMA) of the attending physician or without following the proper discharge procedure, notation of this incident shall be made in the patient's medical record. The attending physician must be made aware of the patient's desire to leave and must demonstrate counseling of the patient as to the risks of terminating care, unless the patient elopes without this opportunity.
2. The attending practitioner is responsible for ensuring that discharge instructions are given to the patient, for ensuring that the record is complete with final diagnosis, that the discharge summary is entered into the Electronic Health Record, and that the record is signed off.

1008 DEATHS

A. Policy

In the event of a hospital death, the deceased shall be pronounced dead by a member of the Medical Staff within a reasonable time except in situations where the patient is on Comfort Care or Hospice Care status in which case the patient may be pronounced dead by a registered nurse as per SCHHC policies. Policies with respect to release of dead bodies shall conform to local law.

1. It shall be the duty of all Medical Staff members to secure autopsies in all deaths that meet criteria adopted by the Medical Staff or regulatory agencies.
2. Typically, Death Certificates are signed by a patient's primary care provider. In cases where a patient has no primary care

provider and the circumstances of the death are such that the death certificate is not required to be signed by the Medical Examiner, the death certificate shall be signed by the Attending Provider or, in cases of death occurring in the emergency department, by the ED provider caring for the patient at the time of death.

1009 PATIENT TRANSFERS

A. Policy

1. Patients shall not be transferred from the Post Anesthesia Care Unit (PACU) without an order in the chart by the Medical Staff member responsible for the patient's care.

2. Southern Coos Hospital, , along with all members of the Medical Staff, will comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) and institutional policies regarding patient transfers and shall comply with all applicable laws regarding patient transfers.

3. For transfers between departments of the Hospital (not including transfers from the ED for purposes of hospital admission), there shall be a transfer note written or dictated in the Electronic Health Record by the transferring Medical Staff member. It shall be a concise recapitulation of the hospital course to date and developed to assist the receiving physician who assumes responsibility for the continuity of inpatient care.

4. No patient will be transferred without such transfer being approved by the practitioner receiving the transferred patient.

1010 CONSULTATIONS

A. Policy

1. All patient admissions, treatment of patients and performance of operative or other procedures, both medical and surgical, will be performed either directly by, or under the supervision of, a licensed practitioner who has been granted delineated clinical privileges through the Medical Staff.

2. The Medical Staff members shall assure that appropriate consultations will be requested. Any member of the Medical Staff may be requested to provide consultation within his/her area of expertise. Consultation is recommended for the following situations:

a. when the patient is not a good risk for an operative procedure;
b. where the diagnosis remains obscure after ordinary diagnostic procedures have been completed;
c. where there are significant differences of opinion as to the best choice of therapy;
d. in unusually complicated situations where specific skills of other practitioners may be helpful;when specifically requested by the patient or his/her family and with concurrence by the attending provider;

3. Each consultation report shall be entered into the Electronic Health Record and contain the consultant's diagnosis and treatment recommendations as well as the underlying exam findings, diagnostic testing results, history, and/or chart review underlying the consultant's recommendations.

4. A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff on the basis of the individual's training, experience and competency.

5. A satisfactory consultation includes an examination of the patient and the medical record. When operative procedures are involved, the results of the consultation, except in an emergency, shall be reported prior to the operative procedure.

1011 MEMBERSHIP REQUIREMENTS

A. Membership

Categories of appointment to medical Staff membership are defined in the Medical Staff Bylaws: Active, Courtesy, Provisional, and Telemedicine.

B. Professional Liability Insurance

1. Medical Staff members must present proof of liability insurance that is representative of the privileges requested/granted. The insurance must be comprehensive enough to cover all reasonable practices specified in rules, regulations, policies, procedures and, if applicable, the provider's employment contract.
The Provider must notify the Medical Staff Services Office immediately of any changes to malpractice insurance resulting in noncompliance.

2. In the event the Medical Staff member is contracted to the hospital, and if the contract stipulates that the hospital will obtain liability

insurance for a provider, it shall be the responsibility of the hospital to ensure the provider's liability insurance is comprehensive enough to cover all reasonable practices specified in Rules and Regulations and Policies and Procedures as specified in the contract.

The CEO must notify the Provider immediately of any changes resulting in noncompliance.

C. Alternative Coverage

1. It is the responsibility of each attending active member to provide alternate coverage for inpatient and Swing Bed patient care when they are not available with appropriate handoff and transfer of patient care. In case of failure to provide alternate coverage by an appropriately credentialed provider, the Medical Staff Chief of Staff and/or the Chief Executive Officer shall call on any member of the Medical Staff, if necessary. Providers participating in the Hospitalist program are exempt from this provision as coverage for patients is automatically transferred to the next scheduled hospitalist at the termination of the hospitalist provider's scheduled shifts.

2. In a situation where a non-hospitalist is the attending for an admitted patient and that provider cannot find coverage for their admitted patient during a period of absence the Hospitalist on duty will be the provider of first resort assume care of the patient In the unlikely event that no hospitalist is available, the ED provider will be the provider of last resort. This shall not obviate the responsibility of each practitioner to arrange appropriate alternative coverage and any repetitive pattern of failing to do so shall be considered patient abandonment which may result in suspension of Medical Staff privileges and report to the Board of Medical Examiners.

1013 TELEMEDICINE

A. Policy

1. It is the policy of the Medical Staff of Southern Coos Health District to provide safe and effective telemedicine services.

B. Procedure

1. The Medical Staff will determine which services can be provided via telemedicine.
2. Telemedicine providers will be credentialed according to the stipulations set forth in the Medical Staff Bylaws for the Telemedicine Medical Staff Membership Category and any and all applicable SCHHC Policies and Procedures. "Delegated Credentialling"

procedures may be used for Telemedicine providers. Under Delegated Credentialling, the telemedicine provider's primary clinical site is responsible for collecting and verifying information regarding licensure, education and experience, and quality and providing that information including FPPE/OPPE to SCHHC for use in decisions regarding credentialling of the provider.

3. Privileging will not be required when telemedicine is used only as an aid to provide additional visual information in what would otherwise be considered routine telephone discussion with a distant provider not providing official Telemedicine consulting services.

1014 PEER REVIEW

A. General Statement

Southern Coos Health District and its Medical Staff are responsible for the quality of care provided to the patient population seen throughout the District's facilities. Therefore, it is the policy of Southern Coos Health District to support the Medical Staff Peer Review process. The Peer Review process is a non-biased activity performed by the Medical Staff to measure, assess and, where necessary, improve performance on an organization-wide basis. Peer Review is confidential and not subject to discovery.

1. Circumstances that require external Peer Review Include, but are not limited to:
   a. the Medical Staff Policies and Procedures mandate an external review;
   b. the practitioner(s) whose case is under review requests external Peer Review;
   c. Medical Staff request external review or Medical Staff Chief of Staff requests;

B. Program Components

1. Participants – A Peer Reviewer shall be defined as a member of the Medical Staff, in good standing, not to include external reviewers.
   a. An individual functioning as a peer reviewer will not be in partnership with the individual whose case is under review. For the purposes of this section clinicians employed by SCHHC shall not be considered "in partnership" solely by virtue of that shared employment.
   b. An individual functioning as an initial peer reviewer may seek opinions and information may be obtained from participants that were involved in the patient's care.
   c. The practitioner(s) whose case is under review has the right to present his or her information regarding case management to the individuals performing peer review.

2. Program Methodology

a. Peer Review shall be conducted in accordance with Peer Review policies and procedures adopted by the Medical Staff.

1015 PROCTORING

A. PRACTITIONERS TO BE PROCTORED SHALL INCLUDE THE FOLLOWING:

Those members and/or applicants identified on a case-by-case basis by the Medical Staff and those identified by policies of the Medical Staff as requiring Focused Practice Performance Evaluation (FPPE).

See also Appendix C – Medical Students/Residents Proctoring

B. PROCTORING DOCUMENTATION

Each individual practitioner case shall be documented by utilizing the FPPE Chart Review Form. This document will include data pertinent to medical and surgical management of each case and shall include a recommendation from the proctor on the status of the individual being proctored. This document will be considered a confidential peer review document, and as such, is not subject to discovery.

C. DURATION OF PROCTORING PERIOD

On the basis of evaluation reports submitted to the Medical Staff for review, a decision to extend or remove proctoring status shall be made. The Medical Staff Chief of Staff shall notify each individual so proctored in writing at the time a decision is made.

1016 IMPAIRED PROFESSIONAL PROGRAM

Southern Coos Hospital, in participation with its Medical Staff will work to institute an Impaired Professional Program. The purpose of the program is to educate hospital leaders and the Medical Staff about licensed independent practitioner health; address prevention of physical, psychiatric or emotional illness; and to facilitate confidential diagnosis, treatment and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition. The goal of this program is assistance and rehabilitation, rather than discipline, and to aid licensed independent practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients.

Refer to Appendix D.

1017 MEDICAL RECORDS

All medical records are protected under the Health Insurance Portability and Accountability Act of 1996 and its amendments. Any authorized user of the record automatically comes under the tenets of this law. Records of psychiatric and/or substance abuse patients shall be protected from disclosure in accordance with the Health Insurance Portability and Accountability Act federal regulations governing the confidentiality of substance abuse patient records. (Ref. CFR 42ChIV 482.25(3)

A. Southern Coos Health District is the custodian of all medical records. A medical record may not be released to outside entities except in accordance with a court order, subpoena, statute, necessary activities for billing or insurance authorization, or properly submitted patient request. Except as otherwise allowed by law, the information contained in the record shall be made available only to persons or agencies to which the patient has specifically authorized the release. See HIM Policy 150.005 for further details.

B. Only generally accepted medical abbreviations approved by the SCHHC Medical Staff may be used in SCHHC medical records.

C. The attending practitioner, consultants, and surgeons shall be responsible for the preparation of a complete and legible Medical Record for each patient. The History and Physical examination, with its required updates, must be performed by a licensed practitioner in good standing with the Oregon Medical Board or Oregon Board of Nursing. If all or part of the History and Physical examination has been done by a licensed dependent practitioner, the findings and conclusions are confirmed or endorsed by a qualified physician. If the History and Physical is delegated to these individuals by the surgeon, then the surgeon needs to verify the information and update it before the surgery or procedure requiring anesthesia.

Oral and Maxillofacial surgeons may perform a History and Physical if they possess privileges to do so, in order to assess the medical and surgical, and/or anesthetic risks of the proposed operative and/or other procedure.

Podiatrists, if they possess privileges to do so, may perform and are responsible for the portion of the History and Physical examination that is pertinent to their practice when granted privileges to do so.

The Medical Record contents shall be pertinent and current. The Electronic Health Record currently in use by SCHHC shall be the repository for records pertaining to the care of patients at SCHHC facilities. This record shall include identification data, History and Physical report, special reports such as consultations, clinical diagnostic reports, (laboratory, radiology and other services) medical or surgical treatment, Progress Notes, operative report, pathological findings, final diagnosis, condition on discharge, Summary or

Discharge Note, Autopsy Report, appropriate operative consent forms and all appropriate COBRA transfer documentation, when performed as well as other information pertinent to the healthcare of each patient. A complete admission History and Physical examination shall be performed, and a record thereof placed in the Electronic Health Record within twenty-four (24) hours of admission or observation, and prior to surgery. This report should include chief complaint, details of present illness, relevant past, social and family histories, review of systems, medications, allergies, summary of patients psychosocial needs, relevant physical examination, initial working diagnoses, and plan of care. A medical history and a completed physical examination completed in the Electronic Health Record no more than 30 days before admission or within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services satisfies the requirement for a History and Physical as long as the following conditions are met. If it has been performed within 30 days of admission, an update note must be entered into the record within 24 hours after admission. Significant changes are updated and recorded at the time of admission. Any updates to the medical History and Physical examination must be placed in the patient's Electronic Health Record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

D. Outpatient surgical procedures require a full or abbreviated pertinent History and Physical Examination completed no more than 30 days prior to the procedure or on the day of surgery prior to the start of the procedure. An update note must be entered into the record on the day of the surgery prior to the start of the procedure.

Abbreviated History and Physical examinations may be used only for outpatient procedures and must contain the following data elements: A chief complaint, details of present illness, relevant past medical, surgical and psycho-social history pertinent to the procedure being performed, medications and allergies, and relevant physical examination of those body systems pertinent to the procedure, statement of the conclusions or impressions, and a statement on the course of action planned for the patient for that episode of care.

E. An Update Note is defined as a statement entered into the patient's Electronic Health Record that the H&P was reviewed and that:

1. there are no significant changes to the findings contained in the H&P since the time it was reviewed, or
2. there are significant changes and such changes are subsequently documented in the patient's Medical Record
3. the Update Note must be performed by the physician.

F. When the History and Physical examination has been dictated but not entered into the Electronic Health Record before an operation or any

potential hazardous procedure, the procedure shall be cancelled unless the attending practitioner states in the Electronic Health Record that the History and Physical has been dictated and the patient is in satisfactory condition for the proposed procedure. When the History and Physical examination has been neither dictated nor written into the Electronic Health Record, the procedure will be cancelled unless the attending practitioner states in the Electronic Health Record that such delay would cause irreparable harm to the patient.

G. Patients shall be seen daily by the attending provider or their designee. Pertinent Progress Notes shall be recorded in the Electronic Health Record at the time of observation or within sufficient time to permit continuity of care and ease of transfer. Whenever possible, each of the patient's clinical problems should be clearly identified in the Progress Notes and correlated with specific orders as well as results of test and treatment.

H. A Brief Operative Report must be placed in the Electronic Health Record immediately following surgery by the provider who performed the procedure unless the provider completes a full Operative Report immediately after the procedure. A Brief Operative Report shall contain at a minimum a brief summary of the procedure performed and description of any complications or unexpected findings encountered. This requirement applies to inpatient and outpatient surgeries, including procedures such as endoscopies and interventional radiology. Full Operative Reports shall be Placed in the Electronic Health Record within 24 hours following the day of surgery. A Full Operative Report shall contain the name of the provider performing the procedure and the names and professional designations of any assistants, A full description of the procedure performed, a full description of any complications and/or unexpected findings, estimate of blood loss (if any), a list of any grafts, transplants, or devices inserted, and the duration of the procedure. Any practitioner who has not placed a full operative report in the Electronic Health Record within 24 hours following the day of the surgery may be suspended temporarily from operative privileges pending completion of records, except for patients who have already been scheduled for surgery.

I. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made part of the patient's Electronic Health Record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the required consultation notes s ha l l , except in emergency situations so verified on the record, be recorded prior to the operation.

J. All clinical entries in the Electronic Health Record shall be, completed, dated, timed, and authenticated by the person responsible for providing or evaluating the service provided. If dictation software is used, the author of

the entry into the Electronic Health Record shall make every effort to correct mistakes made by the dictation software especially those mistakes which may hinder understanding of the author's meaning or intent. Authentication means to establish authorship by use of the Electronic Health Record's procedures for the provision of electronic signature.

K. A Discharge Summary shall be entered into the Electronic Health Record for all acute care, swing bed, and observation discharges. The Discharge Summary should include the reason for admission, new diagnoses made during the hospital stay pertinent laboratory and radiographic results, treatment including operations, course and results of treatment, , discharge medications and diet, disposition, goals, and final diagnosis.

L. The information contained in a patient's Electronic Health Record is the property of the patient, however the means of creating and storing such information belong to SCHHC and/or any agents or entities with whom SCHHC contracts for provision of such services. Members of the Medical Staff shall only access information stored in the Electronic Health Record for which they have a legitimate need. Examples of legitimate need include, but are not limited to, information required to provide safe and comprehensive patient care and information needed for the purpose of quality assessment and/or review.

M. PHYSICIAN SUSPENSION FOR INCOMPLETE CHARTS

DEFICIENT AND DELINQUENT MEDICAL RECORDS

1. Health Information Management will notify the clinician by appropriate means of incomplete records at the following intervals:
   a. 14 days
   b. 15-21 days
   c. 22+ Days
2. In the event of an emergency or disaster situation, the Medical Staff Chief of Staff or Vice Chief of Staff may reinstate the clinician for the duration of the event to prevent the potential loss of life of a patient. The Chief Executive Officer (CEO) maintains the ability to retain Physician at their discretion.

If a record remains incomplete twenty-one (21) days after patient encounter, the HIM Department shall notify the practitioner and the Chief Medical Officer. If the record remains incomplete for seven (7) more days after initial notification, the HIM Department shall notify the Chief Medical Officer for follow- up of indicated actions based on existing policies and procedures.

N. A Medical Record is considered complete when the contents required by the staff Rules and Regulations are assembled and authenticated, all final diagnoses and complications are recorded in the Electronic Health Record.

In some circumstances, such as death or incapacitation of the provider prior to completion of the record, it may not be possible to complete all required documentation for an encounter in the Electronic Health Record. In such cases, the Medical Staff Chief of staff may, at his/her discretion, declare the record complete.

O. Medical records (computerized or paper) contain valuable and confidential information and are to be safeguarded against loss, defacement, tampering or use by unauthorized persons. Nothing shall be maliciously removed nor deleted from a medical record, and no irrelevant or facetious notations may be made in them. Access to computerized records is controlled by assigning specific access procedures.

a. Requests to delete authenticated electronic notes or reports will be made directly to the Health Information Management Department Manager and must be approved by the clinician who created the electronic note.

b. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that an individual has the right to amend protected health information that a covered entity has recorded about the individual in a designated record set. All such requests are to be made directly to the Southern Coos Health Information Office. A patient may amend a record by placing comments in the record regarding information the patient considers erroneous. Any patient requests for deletion of information in the record must be approved by the clinician who created the record.

P. Use of medical records for research shall be governed by procedures adopted by the Medical Staff Committee and approved by the Chief of Staff of the Medical Staff.

Q. Provisions regarding Electronic Health Record Downtime

During periods of time when the Electronic Health Record is unavailable, members of the medical staff shall legibly document on paper or dictate into a dictation service not directly part of the EHR critical information regarding patient history, exam findings, and treatment plans in lieu of formal notes. These notes shall be kept temporarily in the patient's downtime chart. Once the Electronic Health Record is again available, the member of the medical staff who created the temporary documentation is responsible to convert that documentation into formal notes of the appropriate type in the EHR.

Documentation time requirements shall not apply during EHR downtime. For example, if a surgery occurs during downtime, the 24 hour requirement for a full operative note would not start until EHR service was restored.

If a downtime is unplanned, and surgical procedures are scheduled, an attestation by the provider that an H+P was created in the EHR prior to surgery shall suffice to surgery H+P that requirement. The presence of that

H+P in the EHR shall be confirmed once the EHR is again available.

If a downtime is planned, and surgical procedures are scheduled during the downtime, the H+P shall be printed out and placed in the patient's temporary downtime chart.

R. Each Medical Staff section will determine which individuals, if any, that are permitted by law or regulation, but are not licensed independent practitioners, may perform part or all of a patient's medical history and physical examination and other required documentation under the supervision of a qualified clinician member of the medical staff.

These individuals may include medical students and other individuals that have received delegated approval by the Medical Staff to perform history and physical examinations.

The patient's attending clinician will retain responsibility for supervision of the non- independent practitioner and will retain accountability for the patient's medical history and physical examination.

1018 - MEDICAL STAFF COMMITTEES

The Medical Staff functions as a Committee of the whole. If a meeting is required, unless otherwise constituted, it shall consist of the members of the Medical Staff as a whole. The following sections describe idealized recommendations for committees and their composition. Insofar as the committee membership and duties exceed Medical Staff membership and Medical Staff resources, it will be the policy of the Southern Coos Hospital and Medical Staff to, as necessary, modify the requirements of the Medical Staff participation, create new committees on a temporary or permanent basis, combine committee responsibilities and to delegate, as appropriate, review and data collection to other hospital personnel with results and recommendations to be further reviewed at other levels of Medical Staff committee membership and by Administration and reported to the Medical Staff as a whole.

Medical Staff committees shall be governed by majority vote. All members shall have equal vote. Changes to the bylaws will require medical staff approval per bylaws, i.e., require 21-day pre-notification and 2/3rds majority.

The following committees shall be convened on an ad hoc basis.

A. MEDICAL STAFF COMMITTEE - shall evaluate the medical care rendered to all patients. The Medical Staff Committee has transferred data collection responsibilities in the areas of care review, infection control and medical records from standing Medical Staff Committees to subcommittees and teams who are required to report their activities to the Medical Staff Committee on at least a quarterly basis. The results of these activities are

intended to supplement, not to replace, the quality assessment and Peer Review responsibilities of the Medical Staff and their findings are considered confidential. The Medical Staff Committee is composed of all "Active" category medical staff members with the authority to vote as determined by Medical Staff Bylaws. The Chief Medical Officer shall also be a voting member of the Medical Staff Committee even if not a member of the "Active" category of the medical staff.

B. PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee represents the liaison between the Medical Staff, nursing staff, and the SCHHC pharmacy department. The committee assists in evaluating and selecting medical therapies for inclusion in the Medication Formulary of SCHHC as well as developing policies for the selection, procurement, storage, distribution, use and safety procedures for medications used at SCHHC facilities. *The Committee is also responsible for evaluation and approval of medical devices used within the hospital*.

Membership shall include at a minimum one medical staff member, a representative of the SCHHC pharmacy department, representatives from nursing, and other pertinent departments as needed.

C. INFECTION CONTROL COMMITTEE

1. The Infection Control Committee shall consist of at least one Medical Staff member, the Infection Control Nurse, a representative from administration and other representatives as needed from relevant hospital services.

2. The duties of the Infection Control include:
    a. Overseeing a hospital-wide infection control program intended to protect patients, healthcare personnel and visitors from transmission of infection within the hospital environment and monitoring the effectiveness of the program.
    b. Implementing a system for reporting, identifying and analyzing the incidence and cause of infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities.
    c. Implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques and educating staff in current infection prevention methods.
    d. Developing written policies defining special indications for isolation requirements and reviewing departmental infection control policies and procedures.
    e. Acting upon recommendations related to infection control

received from the Chief of Staff, the Chief Medical Officer, the Medical Staff Committee, departments and other committees.

f. Reviewing sensitivities of organisms specific to the facility.

g. Investigating potential outbreaks and taking appropriate preventive action.

D. QUALITY & PATIENT SAFETY COMMITTEE

Evaluation of the efficiency and effectiveness of patient services shall be carried out systematically in an objective manner and appropriately documented. Overall responsibility for the quality of medical care rests with the Medical Staff.

The Quality and Patient Safety Committee shall consist of the Director of Quality, a clinician representative of the Medical Staff, the Chief Nursing Officer, the Infection Control Nurse, and other individuals as determined by the needs of the committee.

E. UTILIZATION REVIEW COMMITTEE

1. The Utilization Review Committee shall consist of at least *one* member of the Medical Staff with representatives from Nursing, Clinical Services, Quality, Medical Records, Pharmacy, Administration, and Physical Therapy. Additional members may be appointed from time to time to assist the Committee in addressing specific issues.
2. The Committee shall track and report to the Medical Staff Committee metrics regarding hospital utilization including:
    a. Inpatient length of stay
    b. Swing Bed utilization
    c. 30 day readmissions
    d. Other metrics determined valuable for determination of appropriate utilization of SCHHC clinical facilities as determined by the committee and/or the Medical Saff
3. The Utilization Review Committee is also responsible for the review and evaluation of medical records, or a representative sample, to determine if the medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results and promote continuity of care among healthcare providers.
4. To fulfill this responsibility the Committee shall:
    a. Review patient records on at least a quarterly basis to assess whether they are complete, timely and accurate;
    b. Identify opportunities for improvement of any aspect of the patient medical record process and recommend amendments to hospital and Medical Staff Rules and Regulations, policies and procedures, support systems, staffing, etc., to facilitate change;

c. Act as an educational resource for hospital and Medical Staff on regulatory agency requirements and accreditation standards and guidelines.

5. The Committee shall meet at least quarterly, keep a record of its activities and report to the Medical Staff Committee as requested.

F. EMERGENCY DEPARTMENT COMMITTEE

1. The Emergency Department Committee shall consist of the Emergency Department Medical Director, the Emergency Department Nurse Manager, the Chief Nursing Officer, the Quality, and Compliance Officer or designees and shall include participation from all Emergency Department providers and staff as available. Other members of the medical staff such as the Chief of Staff or Chief Medical Officer may also be asked to serve on the Committee.

2. The Emergency Department Committee is responsible for input into Emergency Department operations, and review of quality, EMTALA compliance, order sets, policies and procedures and protocols. The Emergency Department may perform case review of selected records.

3. The Emergency Department Committee shall forward their recommendations for approval in these areas to the Medical Staff for final approval.

1019 – PATIENT'S RIGHTS

Respect for human rights shall be a basic tenet of Southern Coos Hospital and its Medical Staff. All programs will support and protect the fundamental human, civil, constitutional and statutory rights of each individual patient.

Patients and/or their designated representatives have the right to:

A. Become informed of their rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire;

B. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care;

C. Considerate and respectful care, provided in a safe environment, free from all forms of abuse or harassment;

D. Remain free from seclusion or restraints of any form that are not medically necessary. Seclusion or restraint shall never be used as a means of coercion, discipline, convenience or retaliation by staff;

E. Knowledge of the name of the clinician who has primary responsibility for coordinating his/her care and the names and professional relationships of other clinicians and members of the healthcare team who will see him/her;

F. Receive information from his/her clinician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand;

G. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse the course of treatment. Except in emergencies where the patient cannot immediately provovide informed consent and any delay could cause significant morbidity or mortality, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment and the names of any assistants present during the procedure;

H. Participate in the development and implementation of his or her plan of care, and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment;

I. Formulate advance directives regarding his or her healthcare, and have hospital staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations);

J. Have a family member or representative of his or her choice notified promptly of his/her admission to the hospital;

K. To create advance directives and have their care team follow those directives, as required by law;

L. Allow a family friend or other individual to be present with them for emotional support and assistance with transitions of care, and to provide advocacy for his/her during the course of stay;

M. Have his/ her primary care provider notified promptly of his/ her admission to the hospital;

N. To be informed of visitation rights, including any clinical restriction or limitation on such right;

O. To give or withdraw consent to receive visitors, including a spouse, domestic partner, family member or friend;

P. To give or withhold consent to have recordings, films, or other images taken

for purposes other than patient care;

Q. To access protective, advocacy, religious and other spiritual services.

R. To receive appropriate pain control.

S. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare;

T. Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the hospital. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care except for disclosure required for quality control reviews and billing;

U. Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of request);

V. Reasonable responses to any reasonable request he/she may make for service;

W. Leave the hospital even against the advice of his/her physician unless declared legally incompetent or otherwise unable to understand the consequences of such an action;

X. Reasonable continuity of care and to know in advance the time and location of appointment as well as the clinician providing the care;

Y. Be advised of the hospital grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels determined discharge date is premature. Notification of the grievance process includes:

Z. Be informed by his/her attending provider or a delegate of his/her attending provider of the continuing healthcare requirements following his/her discharge from the hospital;

AA. Know which hospital rules and policies apply to his/her conduct while a patient;

BB. Have all applicable patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient;

1. Organ/Tissue Donation:
   a. Patients or their legal medical decision maker have a right to

consent to organs/tissue donation, if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donations according to the established criteria.

1020 ADVANCE DIRECTIVE AND POLST FORM

An Advance Directive is a document that states choices about medical treatment or names someone authorized to make decisions about medical treatment if the patient is unable to make these decisions or choices. The document is called an Advance Directive because it is signed in advance to let the person's treatment team know the person's wishes concerning medical treatment. An Advance Directive is essentially any document that states the patient's wishes regarding his/her healthcare choices; however, not every document is legally binding. Many Advance Directives are state specific; therefore healthcare providers are responsible to know which advance directive is legally binding in the state where the patient is receiving treatment.

The POLST (Physician's Orders Regarding Life Sustaining Treatment) is an actual order from a physician. It gives specific directions to medical personnel. It can be filled out by a nurse or social worker, but it must be signed by a physician, physician's associate, or nurse practitioner in order to be activated. The POLST form is different from an advance directive. An advance directive does not have the kind of authority in the healthcare system that a POLST does.

All patients should have both an advance directive and POLST. If patient is no longer able to speak for himself/herself but has an Advance Directive and a healthcare representative, the physician who is preparing the POLST form should consult the healthcare representative. The Advance Directive and the healthcare representative will provide information about the patient's preferences that will be helpful when completing the POLST.

If a patient presents for care in a condition that prevents them from expressing their wishes regarding their care and no medical decision maker has been established via an Advanced Directive or durable medical power of attorney, the medical team shall follow established guidelines including state law to determine who is authorized to make medical decisions for the patient.

On admission, the hospital will give the patient the state-approved brochure on Advance Directives and ask the patient whether they have an Advance Directive and POLST or not.

1021 DO NOT RESUSCITATE ORDERS

A. PURPOSE

1. The purpose of cardiopulmonary resuscitation is prevention of sudden

unexpected death. Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or following prolonged cardiac arrest. Resuscitation in these circumstances may represent a positive violation of an individuals' right to choose not to have disproportionate means used to prolong the process of dying.

B. POLICY

1. It is the policy of Southern Coos Health District is to provide the highest quality medical care to its patients. The presumptive standard of care requires full resuscitative measures if cardiopulmonary arrest occurs. The conditions which justify withholding full resuscitative measures are:

    a. a written Do Not Attempt to Resuscitate (DNR) order or POLST indicating DNR. Admitting physicians should repeat POLST DNR orders with admission orders unless they are changed by the patient or appropriate surrogate on admission, in which case the POLST should also be modified at the earliest opportunity.
    b. a licensed clinician who is part of the patient's care team giving an instruction not to institute resuscitation of a patient who has just experienced an arrest in situations where an attempt to resuscitate would be medically futile or the clinician knows from records review and/or conversations with the patient or appropriate medical decision makers for the patient that the patient does not want to be resuscitated;
    c. a legally binding document indicating the patient's wishes to forgo resuscitative measures.

2. The decision whether or not to resuscitate a particular patient is the responsibility of the attending physician in consultation with the patient. Each case is unique and decisions must be guided by medical, ethical, legal and social factors. Competent adults may choose to accept or reject resuscitation without affecting other modes of therapy. Any other form of 'aggressive' therapy may still be appropriate, including the use of critical care units, transfusion, intubation, or surgery even if patient elects for a DNR code status.

3. In the case of patients who are terminally ill, it is the responsibility of the attending physician to document whether or not cardiopulmonary resuscitation is to be performed.

4. In non-competent patients with a terminal illness, where death is not unexpected, the decision not to resuscitate should be discussed with, and concurred in, by their guardian, or by the person who has been given a legal authority over healthcare decisions for the patient, such as a surrogate named in a legally binding document

signed by the patient. If there is no guardian or legal surrogate, and no document expressing the patient's wishes is available, those closest to the patient as defined by Oregon law should be consulted and their concurrence obtained. Documentation that this discussion has taken place will be made in the patient's chart.

C. IFE SUPPORT AND PRONOUNCEMENT OF DEATH

1. The attending practitioner is responsible for completing the practitioner's order for CPR status-Withholding/Withdrawing Life Sustaining Medical Intervention whenever foregoing life support is contemplated, as defined in these Rules and Regulations.

2. In the event of a hospital death, the attending practitioner or designee shall pronounce the deceased. The body shall not be released until an entry has been made and authenticated in the medical record of the deceased by a clinician member of the Medical Staff except in cases where the patient was on "Comfort Care" status in which case the patient may be pronounced dead by a registered nurse. Policies with respect to release of the remains shall conform to local law.

D. DEFINITION OF TERMS

1. Life Sustaining Treatment**:** Medication or mechanical, or other therapies without which a person would be in imminent danger of death. Other therapies such as dialysis or nutritional support via feeding tube or total parenteral nutrition may also be considered life sustaining treatment even if withholding such treatments may not result in imminent death.
2. Do Not Resuscitate / Do Not Attempt to Resuscitate / No Code (DNR)**:** A written physician order instructing hospital personnel that resuscitation services are not to be provided in the event of cardiopulmonary arrest.

3. Withholding of Medical Treatment: A conscious decision not to provide an intervention that may sustain life.

4. Withdrawing of Medical Treatment: The removal or cessation of any existing intervention that may sustain life.

5. Comfort Care: Treatment focused not on curing any disease or condition, but solely on preventing or alleviating pain, anxiety or other suffering.

1022 - ANESTHESIOLOGY DEPARTMENT

A. SCOPE OF SERVICE

1. Anesthesia care shall be provided by anesthesiologists and/or CRNAs. A qualified member of the anesthesiology staff shall be available to provide anesthesia care for patients on a schedule determined between the Anesthesia Department and the Hospital. Except for specific emergency situations, the administration of anesthesia shall be limited to areas where it can be given safely, in accordance with the policies and procedures of the anesthesia department.

2. Anesthesiologists/CRNAs must be able to perform the independent services usually required in the practice of anesthesiology without supervision as delineated in the Hospital policies/procedures, including but not limited to:
   a. Perform accepted procedures commonly used to render the patient insensible to pain during the performance of surgical and other pain producing clinical maneuvers, and to relieve pain-associated medical syndromes.
   b. Support life functions during the administration of anesthesia, including induction and intubation procedures.
   c. Provide appropriate pre-anesthesia and post-anesthesia management of the patient.
   d. Provide assistance relating to various forms of patient care, such as respiratory therapy, cardiopulmonary resuscitation and special problems in pain relief.
   e. Document according to hospital policy/procedures regarding pre-, intra-, and post-anesthesia services

3. It is recognized that there are times when temporary anesthesiologists/CRNAs may be needed to efficiently run the operative schedule during absences of staff anesthesia providers. Qualified substitute anesthesiologists/CRNAs may be granted temporary privileges in accordance with the Medical Staff Bylaws.
4. Privileges specific to the Anesthesiologist or CRNA performing anesthesia services shall be approved by the governing body for each individual practitioner. The qualifications required for performance of anesthesia services and the scope of privileges granted to each provider as to what procedures the provider may perform shall be specified in the provider's delineation of privileges document. The scope and manner of privileges and whether to grant such privileges to a specific provider shall be recommended to the governing body by the Medical Staff. These privileges will be granted according to the practitioner's scope of practice, state law, the individual competencies of the practitioner, the policies of SCHHC, and credentialling and privileging criteria.

B. CREDENTIALING/PRIVILEGING FOR MODERATE AND HEAVY SEDATION

1. To ensure that all patients receive the same level of anesthesia care throughout the hospital by all practitioners, a standard to credential for such privileges will be established and updated as needed.

1023 MEDICAL IMAGING DEPARTMENT

A. POLICIES AND PROCEDURES

1. There shall be written policies and procedures governing radiologic administrative routines and services and radiation safety practices.

2. These procedures and policies are developed in cooperation with the Medical Staff, Nursing Services and other departments or services as necessary.

3. All radiological studies made in the hospital shall have a written report made by a radiologist member of the Medical Staff, or by a qualified radiologist to whom temporary privileges have been extended.

1024 SURGICAL SERVICES DEPARTMENT

A. SURGICAL SERVICES PRIVILEGES

1. Privileges shall be determined via the Medical Credentialing Procedure.

B. SCHEDULING CONFLICT

1. In cases of an emergent nature which may take precedence over already scheduled procedures, it is the responsibility of the surgeon requesting priority over the elective case to discuss the conflict directly with the scheduled surgeon. In the event of an impasse between the surgeons, the Chief Medical Officer shall make the decision as to which case takes precedence.

C. FOREIGN BODIES

1. In all cases of radiopaque foreign body retained in the patient, an x-ray must be taken in the operating room unless, in the opinion of the radiologist, the object is too small to be seen on x-ray.

D. REQUIREMENTS FOR INPATIENT/OUTPATIENT SURGERY UNDER GENERAL ANESTHESIA/LOCAL ANESTHESIA

1. The Department of Surgery shall develop and regularly update policies related to anesthesia.

1025 GENERAL RULES REGARDING SURGICAL CARE

A. DEFFINITION OF 'SURGERY':

*Surgery is **an action** performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician **or suturing of simple dermal lacerations**). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.*

This definition is obtained from the American Medical Association (https://policysearch.amaassn.org/policyfinder/detail/surgery?uri=%2FAMADoc%2FHOD.xml-0-4317.xml). Words in **bold** are added to this definition by the SCHHC medical staff for purposes of clarity.

A history and physical examination should be recorded prior to the time stated for a surgical procedure requiring general anesthesia, except in emergencies. Emergency surgery is defined as life threatening or those procedures in which failure to initiate surgery as soon as possible will likely result in irreparable harm to the patient.

Written, signed, informed, informed surgical consent with the Informed Consent Rules and Regulations stated elsewhere in this document shall be obtained, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. It is advisable that another member of the Medical Staff, familiar with the patient's condition, be consulted for his/her concurrence in that situation.

Operative reports should be dictated or written in the medical record per medical records, rules, regulations, and policies.

1026 EMERGENCY SERVICES

A. QUALIFICATIONS OF THE EMERGENCY DEPARTMENT MEDICAL DIRECTOR

1. Must be a member in good standing of the SCHHC medical staff.

2. Must be board certified in Emergency Medicine or have equivalent training and experience in Emergency Medicine.

3. Must be actively engaged in the practice of Emergency Medicine and extensively familiar with current Emergency Medicine practice standards and guidelines.

B. ATTENDING CLINICIAN'S RESPONSIBILITY

1. Patients will be attended by the emergency department clinician on duty in the Emergency Department who shall be solely responsible for the patient's care unless arrangements are made for the patient to be seen by their own primary care provider in the emergency department. However, should any disagreement arise between the patient's primary care provider and the emergency department clinician on duty as to the course and method of treatment provided in the emergency department, the judgement of the emergency department clinician shall take precedence. It is expected that except in unusual circumstances, the ED provider will complete all notes in the Electronic Health Record related to patient care prior to the end of the shift in which those patients were seen.

C. MEDICAL SCREENING EXAMINATIONS

1. All patients in the Emergency Department will be triaged by qualified ED staff and evaluated in the order of severity of their problem, as determined by the Emergency Department staff. No exceptions shall be made.

2. All patients who present to the hospital and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition, or where applicable, active labor by the Emergency Department clinician on duty.

3. Upon the determination that an emergency medical condition or active labor exists, all available medical treatment within the

capability of the Hospital will be provided to the patient to alleviate the emergency, deliver the child or transfer the patient to another hospital in accordance with state, federal and the hospital's emergency treatment and transfer policies and regulations.

1027 PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY SERVICES

Physical, Occupational, and Speech Therapy providers may be contracted to provide services to Southern Coos Health District facilities.

A clinician must refer patients in writing, preferably using the Electronic Health Record, to be treated by physical, occupational and/or speech therapists. The referring physician must prescribe the treatment to be given either by specifying a specific treatment, frequency, and duration, or by stating that therapy be provided per therapist's recommendation.

Progress notes are written on all inpatients and Swing Bed patients in the Electronic Health Record regarding physical, occupational, and speech therapy progress each time treatment is rendered. Progress notes are sent to the referring physicians on outpatients at intervals as indicated.

1028 INFORMED CONSENT

1. Informed consent is required before administration of anesthesia or performance of procedures that are invasive or potentially hazardous, including blood transfusions and certain tests as well as for participation in research studies, participation in training activities involving "sensitive" exams, or filming or other video recording. Prior to performance of any of the above procedures or activities, the responsible practitioner will obtain informed consent from the patient or his/her representative. There will be no abbreviations used in informed consents. Every effort should be made to describe procedures and the risks and benefits thereof in terms a non-clinician can understand.

2. It is the right of the patient to accept or refuse treatment offered to them. The patient is to be given all information necessary to explain the risks, benefits, potential complications, alternatives and options to any operative and/or invasive procedure, prior to performing the procedure. Written consent is required before any major treatments or procedures are initiated. The written consent is to verify that the patient has been clearly informed regarding the nature of the procedure or treatment to be undertaken, the risks and benefits of the treatment, alternatives and options to consider and the expected outcome if the treatment is declined.

3. The practitioner who has primary responsibility for the patient or who will be performing the procedure/treatment is responsible for informing the patient

and for obtaining the written consent when necessary.. Documentation of the Informed Consent and the Informed Consent discussion must be made in the patient's medical record. The patient record must indicate what was communicated, what risks/benefits were discussed with the patient and if the patient had difficulty understanding the discussion. All items on the Consent Form must be completed, signed, witnessed, timed and dated according to organizational policy.

4. Informed consent must be obtained from the patient's appointed surrogate, conservator or next-of-kin if the patient is unable to understand or give consent. If the patient does not have a surrogate or conservator, certification by the attending physician must be documented The reason why the patient is unable to provide consent must be documented. As described in paragraph 6 below, only life-saving emergency procedures or procedures emergently needed to prevent severe morbidity such as loss of limb may be performed without consent in a situation where informed consent cannot be obtained from the patient or a legally acceptable surrogate.

5. When it is necessary to obtain consent by telephone, the conversation should be witnessed and described in the progress notes, signed by the attending physician and witness, and the name and phone number of the person giving consent documented in the progress notes or on the Consent Form.

6. In instances where the patient is unable to give consent and/or the surrogate is not readily available, and treatment is necessary as an emergency life-saving measure or to prevent loss of limb or body part, informed consent may be waived. This instance is to be utilized only as an emergency measure, and requires that the treating physician document in the medical record: the nature of the emergency, the planned treatment and/or procedure, the potential harm to the patient if the emergency treatment and/or procedure is delayed, the inability of the patient to consent and unavailability of surrogates/guardian/family members to provide consent. The physician must be sure to document that the treatment and/or procedure are being performed as an emergent life-saving and/or limb/body part saving measure. It is advisable to have concurrence from another physician who is familiar with the patient’s condition and circumstances, and to have this concurrence documented in the medical record, although signatures of two (2) physicians to perform an emergency procedure without patient/family consent is not required.

7. Requirements for Consent:

    - No surgical procedure (as defined in section 1025), treatment involving unusual risk to the patient (including blood transfusion), participation in research studies involving human subjects, video recording or filming of clinical encounters, any procedure involving

anesthesia or sedation, or examination of the breasts or genitalia (Sensitive Exams) performed by or observed by students or trainees shall be performed without both of the following documented in the record:

8. Informed Consent:

- It shall be the responsibility of the clinician performing the procedure to obtain informed consent from the patient or the patient's legally authorized representative. Informed consent shall include at least the following:
- an explanation of the procedure, appropriate alternatives and respective benefits;
- an explanation of the significant risks, complications and alternative options.
- an explanation of the possible consequences of refusing the proposed treatment, research study or procedure;
- an explanation that the patient has the right to refuse the proposed treatment.
- The clinician performing the procedure shall document in the medical record that an informed consent has been obtained or that the patient has refused the procedure after the informed consent discussion.

9. Consent to Treatment or Research:

The patient's written consent to treatment or research (as applicable) must be documented on an approved hospital form and entered into the Electronic Health Record.

1037 RESTRAINTS

All members of the SCHHC Medical Staff will receive annual training regarding regulations and policies related to the use of restraints. Restraints may only be used in full compliance with appropriate regulations and SCHHC policy.

1038 INCIDENT AND SENTINEL EVENT REPORTING

All incidents and sentinel events will be according to SCHHC policies and Statutory requirements.

1039 HUMAN RESEARCH

Any patient considered for participation in human research studies shall be informed of the purpose of the study, the potential risks of the study, and the potential benefits of the study. Patients have the right to agree to participate or

decline to participate in research and, at the same time, they have the right to know that research requirements have been followed. Southern Coos Health District is responsible for the protection of subjects from undue risk and from deprivation of personal rights and dignity. This protection is best ensured by consideration of two issues which are the touchstone of ethical research: 1) voluntary participation by the subjects, indicated by free and documented informed consent; 2) an appropriate balance exists between potential benefits of the research to the subject or to society and the risks assumed by the subject.

1040 HARASSMENT PROHIBITED

Harassment by a Medical Staff member against any individual (i.e., against another Medical Staff member, hospital employees or patients) shall not be tolerated.

Sexual harassment is unwelcome conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoon drawings, or posters).

Sexual harassment also includes unwelcome advances, requests for sexual favors, and any other verbal, visual, physical conduct of a sexual nature when:

Submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, benefits or other aspects of employment, or

This conduct substantially interferes with the individual's employment or creates an intimidating, hostile or offensive work environment.

All allegations of harassment shall immediately be jointly investigated by the Medical Staff and Administration/Human Resources and, if confirmed, will result in appropriate corrective action, from reprimands up to, and including, summary suspension or forced leave of absence, termination of Medical Staff membership or clinical privileges as per the terms of the District’s Harassment Policy, if warranted by the facts.

1041 ORGAN/TISSUE DONATION

Patients or their legal medical decision maker have a right to donate organs/tissue if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donations according to the established criteria. All deaths will be reported to the hospital’s designated Organ/Tissue Donation Agency, with all organ and tissue donation performed in accordance with state and federal laws and other regulatory body requirements.

1042 PROTECTIVE SECURITY

Southern Coos Hospital does not have the clinical staff or physical environment to care for Acute Psychiatric patients requiring protective security. Such patients will be evaluated and transferred safely to a hospital with a Psychiatric Unit.

A. COMBATIVE/CONFUSED PATIENTS

1. It is the responsibility of the clinical staff to respond to any situation where a patient is in imminent danger of harming himself/herself or another person. This requires immediate clinical assessment and/or intervention, which may include transferring the patient to a hospital equipped to provide involuntary psychiatric treatment. This responsibility lies with licensed staff in the immediate vicinity of the incident.

B. EMERGENCY COMMITMENT (Inpatients Who Require a Change of Status Form, Voluntary to Involuntary Admission)

1. A patient who meets criteria for involuntary psychiatric care and seeks to leave the hospital may be transferred to a hospital that provides such care if he/she is considered, due to mental illness, to be:
   a. a danger to others,
   b. a danger to himself/herself, or
   c. gravely disabled (a condition in which a person is unable to provide for basic needs for food, clothing, or shelter).

2. All involuntary patient holds will be performed according to state and federal regulations, and will be initiated to maximize patient and/or visitor and/or staff safety and wellbeing.

ADOPTED by the Medical Staff on July 9. 2025.

Chief of Staff, Medical Staff

APPROVED by the Board of Directors July 24, 2025

Chair, Board of Directors

1044 - ACKNOWLEDGEMENT OF RULES AND REGULATIONS/CODE OF CONDUCT

A. POLICY

1. Each member of the Southern Coos Health District Medical staff shall sign an acknowledgement form attesting to the fact that he/she has read the Medical Staff Rules & Regulations and agrees to abide by them.

B. PROCEDURE

1. As part of the privileging process each member of the Southern Coos Health District Medical Staff shall:

   a. read the Rules & Regulations and sign a form attesting that the Rules & Regulations have been read and that the staff member agrees to adhere to them;

   b. read the Code of Conduct and sign a form attesting that the Code of Conduct has been read and that the staff member agrees to adhere to them.

   These forms will be retained in the Medical Staff member's file in the Administration Office.

I, _ , have read the attached Medical Staff Rules

and Regulations and I agree to abide by these Rules and Regulations, the Code of Conduct, and all other policies adopted by the Southern Coos Health District.

_____ _____

Medical Staff Member – Title Date

Appendix A: Reserved

Appendix B
Code of Conduct & Expectations of Practitioners

Southern Coos Hospital & Health Center
Medical Staff

As a practitioner, I will:

1. Practice medicine according to accepted and evolving technical standards of care for my specialty and abide by the Principles of Medical Ethics of the American Medical Association;

2. Regard responsibility to the patient as paramount, including respecting the rights of patients and safeguarding their confidences and privacy;

3. Communicate effectively with colleagues and encourage other physicians to become the best physicians they can be;

4. Act in an appropriate and professional manner at all times. I will not use threatening or abusive language directed at nurses, hospital personnel, or other physicians (e.g., belittling, berating, and/or threatening another individual), either verbally or in the medical record;

5. Not express publicly, derogatory comments about the quality of care provided by other physicians, nursing personnel, or the Hospital;

6. Refrain from “sexual harassment” which is defined in the Rules and Regulations of the Medical Staff.

7. Where necessary for the care and safety of patients, participate in a fair and equitable call schedule, if an active staff member;

8. Participate in and contribute to Medical Staff meetings and Peer Review Committee functions;

9. Complete Medical Records in a timely manner.

I agree to adhere to the Southern Coos Hospital Medical Staff’s Code of Conduct and Expectations for Practitioners. I understand that failure to comply with the above expectations may result in disciplinary action as outlined in the Bylaws and Policies of the Medical Staff and may result in restriction of privileges or termination of Medical Staff membership.

Received by_____ Date _____
Print Name

_____
Member Signature

Appendix C
Medical Student and Resident
Privileging Rule

Southern Coos Hospital & Health
Center Medical Staff

Medical Students:

1. Preceptorships and training of students in medically-related disciplines are meant to provide periods of time for students in medically-related careers to observe and participate in the total experience of practice within the limits of their intended licensure and scholastic requirements. This rule is applicable to those students who are required to spend time with physicians in learning and experiencing the basics of medical practice, including the care of hospital patients.

2. Objectives:
   - to provide students insight into the professional aspects of medical care within the hospital setting; and
   - to provide students with the opportunity to work closely with staff physicians in order to learn skills important to the practice of medicine and observe the following aspects of quality healthcare: histories and physicals; laboratory and imaging tests; hospital practice; discharge summaries.

3. During the period of training, the preceptor or supervising Medical Staff member shall assure that all of the following requirements are met:
   - The supervising Medical Staff member shall present credentials of the proposed student(s) to the Medical Staff for review and approval prior to participation. Proof of insurance for the student shall also be provided as part of the credentials check.
   - Students will be able to see patients without the supervising Medical Staff member being immediately present so long as an initial visit with the supervising member has been conducted with each individual patient. Documentation by the student will not take the place of any required exam and/documentation of the supervising physician and the student will be, at all times, under the direct supervision of a Medical Staff member.
   - Patients shall provide consent prior to being seen by the student and this shall be so noted in the patient's record by the attending Medical Staff member.
   - During the initial visit, nursing staff shall also be provided with an introduction to the student so that they are familiar with who will be seeing individual patients.
   - The attending Medical Staff members shall acknowledge and personally sign off on any documents or orders initiated by any student being supervised. No orders will be initiated by Nursing Services without prior authentication of the order by the supervising physician (such authentication may be by phone so long as the record is physically authenticated at a later time).

4. Both the supervising staff member and student will abide by the Medical Practice Act which prohibits students from practicing except under the supervision of a qualified

Medical Staff member.

Resident Physicians

1. Resident physicians may perform elective rotations at SCHHC facilities for the purpose of gaining knowledge and experience regarding features and challenges of the practice of medicine unique to rural areas. All rotations shall be supervised by an attending physician member of the SCHHC Medical Staff (Supervising Physician) who has been granted privileges in the same specialty as the training program in which the resident participates (Family Medicine, General Surgery, Internal Medicine, etc.). Notwithstanding this provision, individual episodes of training may be supervised by a member of the medical staff who is not in the same specialty as the resident's training program if such training will provide the resident with a broader scope of understanding pertinent to the challenges of rural medicine .

2. Responsibilities of the Supervising Physician:
   - Coordinate with the resident's residency training program to ensure that the training goals for the elective rotation are clearly stated and a plan is in place for them to be met.
   - Coordinate with various SCHHC departments including the Medical Staff Services Office, Human Resources, Information Services, departmental leadership of any department in which the resident may work, and nursing to ensure that these departments are aware of the start date and length of the resident's rotation and any required activities such as granting access to the Electronic Health Record, employee health screenings, and familiarization of the resident with required departmental policies are completed prior to the resident physician's first patient encounters
   - Ensure that the resident physician completes all required medical records and that those records are accurate and complete and attest to same prior to co-signing the record.
   - Submit "charges" in the Electronic Health Record appropriate to the service and level of service provided to each patient by the resident physician using the appropriate billing code with billing modifier "GC" added.
   - Be immediately available to the resident physician to assist with the care of patients seen by the resident physician, answer any questions the resident may have regarding the proper performance of or the significance of patient examinations, the significance of results of diagnostic studies, and the plan of treatment. The supervising physician should also be prepared to demonstrate and precept any procedures to be performed by the resident physician. This requirement for immediate availability may be delegated by the supervising physician to another qualified member of the SCHHC medical staff.

3. Specific activities resident physicians may and may not perform:
   - Resident physicians may see patients independently as long as the treatment plan is discussed with the supervising physician either in person or via the supervising physician's review of the resident's notes. All notes in the medical record created by the resident physician must be sent to the supervising physician for cosignature.
   - Resident physicians may place orders in the Electronic Health Record which shall have the same validity as orders placed by members of the medical staff

except where prohibited by statute, regulatory guidance, or hospital policy.

- Resident physicians may not place hospital admission or discharge orders without first verbally discussing the plan of care with the supervising physician. The supervising physician should perform their own independent review of the patient's condition prior to authorizing hospital admission or discharge.
- Resident physicians may only perform invasive procedures such as central line placement, endotracheal intubation, chest tube insertion, or surgical procedures under the direct in-person supervision of a member of the medical staff who has privileges at SCHHC to perform the procedure. Independent performance of invasive procedures by resident physicians is not allowed.

Appendix D
Impaired Professional Program

Southern Coos Hospital & Health Center
Medical Staff

Providers referred to the program, either by themselves or other method, shall have their care managed according to the principles outlined below and all efforts will be made to provide services and support with maintenance of confidentiality and standards of patient safety as outlined below.

A. ELEMENTS OF THE PROGRAM

1. Education of organizational leaders and the Medical Staff about illness and impairment recognition issues specific to licensed independent practitioners:
   a. The hospital will sponsor an annual educational program regarding illness and impairment issues.
   b. Licensed independent practitioners will be issued written information regarding illness and impairment issues at time of initial appointment and reappointment to the Medical Staff.

2. Referral to the Impaired Professional Program:
   a. Licensed independent practitioners will be allowed to self-refer to the program.
   b. Referrals of licensed independent practitioners will be allowed by any member of the organization.

3. The affected licensed independent practitioner will be referred to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.

4. The confidentiality of the individual referred to the Impaired Professional Program will be strictly maintained, with the following exceptions:
   a. State and federal regulatory limitations (if applicable)
   b. Ethical obligations
   c. When maintaining confidentiality threatens the safety of a patient or patients:
      (1) In all instances, every effort to protect the confidentiality of the individual referred for assistance will be made.
   d. All complaints, allegations or concerns regarding the potential impairment of a licensed independent practitioner will be thoroughly investigated and evaluated for validity by the Impaired Professional Program Committee.
   e. The affected licensed independent practitioner will be monitored until rehabilitation or any disciplinary process is complete, to be sure the safety of the patient population under his/her care.
      (1) Method of monitoring will be determined by the Impaired Professional Program Committee and the Physician Advisor.
      (2) Monitoring will continue until the Professional Program Physician Advisor is able to verify that the impairment for which the licensed

independent practitioner was referred to the program:
(a) No longer exists
(b) No longer impacts the quality of patient care provided by the licensed independent practitioner

f. Reporting to the Medical Staff leadership instances in which a licensed independent practitioner is providing unsafe treatment:
(1) Any individual within the organization has the responsibility to report concerns regarding unsafe treatment by licensed independent practitioners.
(2) Reports may also be made to the Chief of the Medical Staff, the Chief Medical officer, and/or the Hospital Chief Executive Officer.
(3) Reports of this nature are to be kept confidential and will follow the routine Medical Staff evaluation process.

B. IMPAIRED PROFESSIONAL PROGRAM STRUCTURE

1. The Impaired Professional Program consists of a committee of three licensed independent practitioners and the Hospital Chief Executive Officer.
   a. One of the three committee members will serve as the Program Advisor.
   b. Ideally at least one member of the committee shall be a member of the medical staff who's scope of practice specializes in mental health and substance use disorder treatment.

2. The committee members will keep a list current of all internal and external resource individuals and organizations that specialize in the diagnosis and treatment of impaired healthcare practitioners.
   a. Affected practitioners will be given a confidential referral to the appropriate resource by the Program Advisor.

3. The committee members will be responsible to provide education regarding healthcare professional impairments. Education will:
   a. be provided on an annual basis during one of the regularly scheduled General Staff meetings;
   b. be provided in written format at time of initial appointment and reappointment to the Medical Staff;
   c. include issues related to licensed independent practitioner health, prevention of physical, psychiatric and/or emotional illness and the general components of the Impaired Professional Program.

4. All allegations, concerns or complaints will be brought before the committee to be investigated and evaluated by the Impaired Professional Program Committee as a whole. Any licensed independent practitioner under investigation may provide information to the committee or to the Program Advisor that he/she feels may clarify any concerns or issues brought before the committee.

5. Affected practitioners will be monitored through the mechanism determined by the committee members and the Program Advisor.
   a. If at any time during the diagnosis, treatment or rehabilitation phase of the process it is determined that the affected licensed independent practitioner is unable to safely perform the privileges he/she has been

granted, the matter will be forwarded by the Impaired Professional Program Committee members to the Medical Staff Committee for appropriate action, pursuant to mandated state and federal reporting requirements.

6. While the goal of the Impaired Professional Program is to provide assistance to enable the affected practitioner to safely practice medicine rather than disciplinary action, in some instances the committee members may request discipline of the licensed independent practitioner as a necessary action to improve or resolve quality of patient care issues. Any requests for disciplinary action will be forwarded to the Medical Staff Committee for approval.

7. All Licensed Independent Practitioners are eligible to participate in the Impaired Professional Program.

Chief Nursing Officer Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Cori Valet, RN, BSN, Chief Nursing Officer
Re: CNO Report for SCHD Board of Directors Meeting – July 24, 2025

Clinical Department Staffing –

- Medical-Surgical department – One night shift registered nurse has requested to step-down to a per diem position from full-time, creating one new night shift vacancy. However, one new full-time registered nurse has accepted a position and will begin July 23, 2025. Total Full-time RN positions vacant = 5. Currently utilizing 5 contract nurses.
- Laboratory department – One full-time Medical Laboratory Technologist has been recruited from TRS contract staffing agency. First day of orientation was July 2, 2025. This addition leaves only two vacancies within the department for Medical Laboratory Assistants (I & II).
- Case Management – One registered nurse with 15+ years of care management experience accepted a full-time position which will enable expansion of case management/utilization review and discharge planning services 7 days a week. Orientation to begin in August.

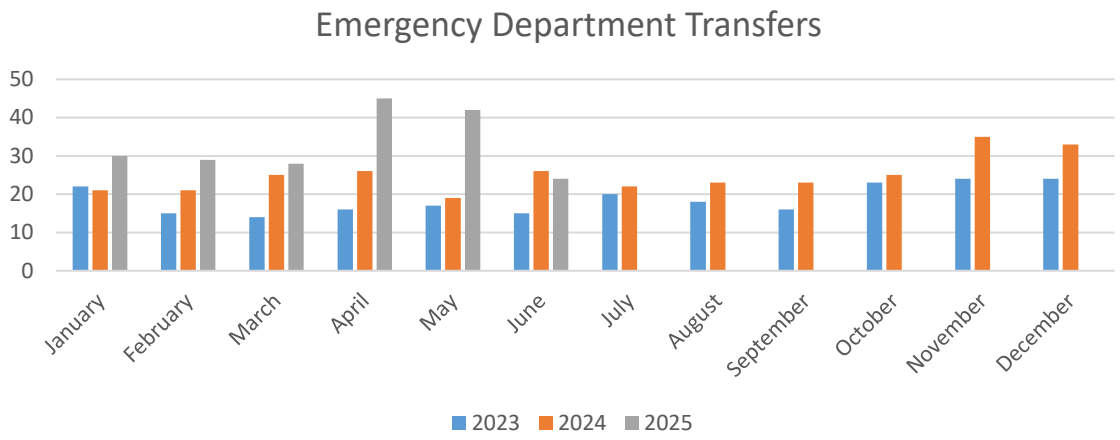
DAISY Award Program –

A DAISY award ceremony has been scheduled for September 4, 2025 at 1:30 pm in the SCHHC main conference room. At this ceremony, eight deserving nurses, who have been nominated for going above and beyond in providing exceptional care to their patients, will be recognized. The recipient of the DAISY award is kept confidential and will be announced and celebrated at the award ceremony. This event is open to all SCHHC staff, board members and family of those nominated.

SAINTS Study Participation –

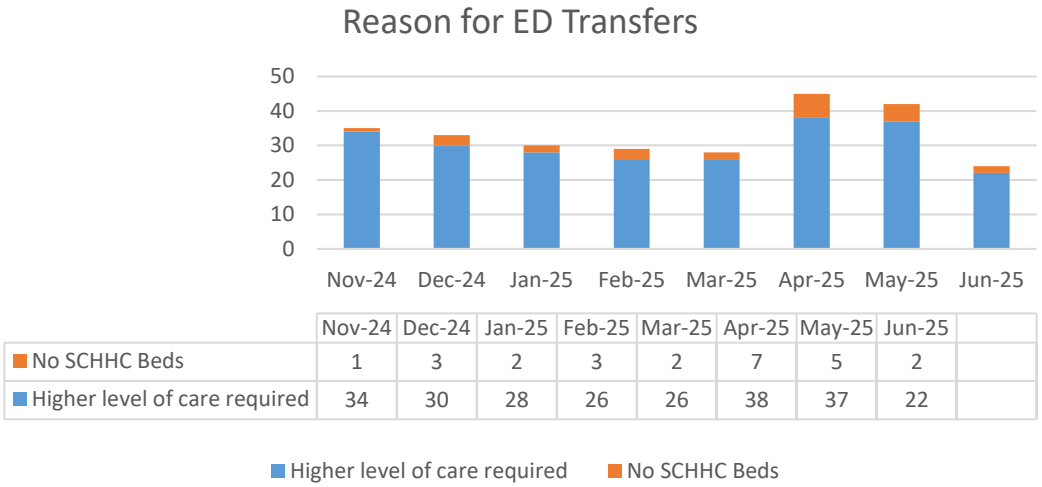
Southern Coos Hospital & Health Center is actively taking part in the Safety Integration Stewards (SAINTS) study with Oregon Health & Sciences University. The SAINTS program aims to minimize patient fall risk and reduce patient-assist injuries among hospital staff. At this time we have completed the key leader interviews and staff surveys. Other the next month we should learn if we are going to participate as a control group or an active participant. Control hospitals will engage in standard operating procedures and gain access to SAINTS trainings after the 2-year study period. The program hospitals will receive trainings and quality improvement cycles during the 2-year study period. Either method of participation will support our goals for reduced patient falls and employee injury related to falls.

Transfer Statistics –



- June 2025 Transfers – Total Transfers = 24.
  - Twenty-two (22) transfers required higher levels of care and/or services not offered at SCHHC.
    - Neurology – 4
    - Cardiology – 4
    - Surgical – 6
    - Obstetrical – 2
    - Intensive care – 3
    - Urology – 1
    - Pediatric – 1
    - Ultrasound – 1 Pt refusing CT due to pregnancy, ultrasound next option for workup, unavailable as pt presented after hours (night shift).

  - Two (2) transfers due to no bed availability at SCHHC related to last minute nurse vacancy and inability to find coverage (both transfers were in a single 12 hour night shift).



	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	
No SCHHC Beds	1	3	2	3	2	7	5	2	
Higher level of care required	34	30	28	26	26	38	37	22	

Chief Financial Officer Report

To: **Board of Directors and Southern Coos Management**
From: **Antone Eek, CFO**
Re: **CFO Report for Board of Directors Meeting – July 2025**

June 2025 Department Achievements/Activities

Accounting and Finance Update:

With the imminent departure of Katelin, SCHHC's Financial Planning & Analysis Manager, and given the depth of her reporting expertise and over nine years of institutional knowledge, the Finance team will prioritize the Medicare cost report and audit deliverables almost to the exclusion of all other projects. Over the next three weeks, our focus will be on these time-sensitive items while maintaining only the most essential day-to-day operations. Katelin is working closely with the team to support a smooth and effective transition.

Engineering / EVS Update:

- Business Office Conversion – Subcontractor meetings
- Department moves to 2nd Street Building

Materials Management / Supply Chain Update:

- Big news! Sage Intact Go Live 2.0 was a huge success.
- Physical Inventory on June 30 achieved getting quantities on hand corrected.
- We corrected incorrectly calculated costs by adjusting back to value of most recent. We did not change costing method of average cost.
- Final items purchased for Retail Pharmacy are in place.
- Desks, chairs, and IT items for 2nd Street were procured and in place.
- Developing costs for Admin building conversion including modular wall quotes.
- Begun assembling supplies for Dr Forester's medical support of golf tournament.
- Collaborated to get logos applied to pick up, emergency trailer and landscape trailer.

Revenue Cycle Update:

Key Highlights

- Stable Accounts Receivable (AR) Days: AR Days remained consistent at 50.1 days in June, indicating a stable approach to managing receivables, despite slight fluctuations in other metrics.
- Improvements in Discharged Not Final Billed (DNFB): DNFB decreased to 10.7 days in June, showing positive movement from previous months. However, further improvements are still necessary to reach the benchmark of 9.4 days.
- Ongoing Challenges with Coding Efficiency: Coding Days increased to 3.31 in June, highlighting challenges in completing coding efficiently due to incomplete or delayed documentation.
- Increased Payments: Payments rose to $3,576,611 in June, reflecting improvements in collections despite adjustments in the billing process.

- Preventable Denials: Focus is being placed on addressing preventable denials, particularly those related to patient demographics, insurance issues, and medical necessity for scheduled services.
- Patient Estimates: New regulations have introduced a requirement for providing patient estimates for out-of-pocket costs over $400. This initiative will help increase point-of-service collections and also necessitate financial assistance screening for eligible patients.

Areas of Focus

1. Reducing Initial Claim Billing Delays:

Delays in billing impact Aged AR over 90 Days. To reduce these delays, we are focusing on improving the efficiency of coding, which is often delayed due to incomplete or missing documentation.

Medical Records is working with departments to ensure proper documentation is provided for timely billing.

2. Preventable Denials:

We are working to reduce preventable denials, including those caused by incorrect patient demographics, insurance issues, coding errors, or missing authorizations.

Scheduled services not passing medical necessity or lacking proper authorization are also major contributors to these denials.

3. Patient Estimates:

New regulations require us to provide patient estimates for patients with out-of-pocket costs of $400 or more or those receiving out-of-network services.

This will help increase point-of-service collections, but it may also increase financial assistance needs as we are required to screen patients for eligibility.

Other Items:

- **Retail Pharmacy Update**
  - **Personnel**
    - Director of Pharmacy: Hired
    - Pharmacists: One hired, Still waiting on 2nd
    - Pharmacy Techs: Hired
  - **Insurance Contracting:** In Process – 80% Completed and In-Network
  - **Regulatory Inspections**
    - Board of Pharmacy – Expected

Retail Pharmacy was only open a few days in June. However, as reported at the end of last month, in 9 days of being open we were at an average of just over 42 prescriptions per day. We will have a full month to report for July, at the August 2025 Board Meeting.

Chief Information Officer Report

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: Scott McEachern, Chief Information Officer
Re: CIO Report for SCHD Board of Directors, July 24, 2025

The **Information Systems** team is working on the following items:

1. We selected a new Help Desk solution. We have configured the application in June 2025. In July, IS has deployed the program to selected Super Users. The system will be released enterprise wide on August 1.
2. The build of the new contract management system, Cobblestone, continues. The system will go live by August 1, 2025.
3. Our new phone agent has been live for two months and the system has stabilized.

Clinical Informatics Projects by Department

Complete
In Progress
🟡 *Education/Monitoring*
🔍 *Reviewing*

Clinical Informatics

- EMR Workflow Videos – *In Progress*
- Data Extraction – Archive Setup/Validation – *In Progress*
- Ticketing System – Clinical Informatics Ticket Revisions – *In Progress*

HC Primary Care

- 🟡 Result Scanning Workflow for External Results – *EducationMonitoring*
- 🔄 Ambulatory EKG Workflow for Interpretation Documentation – *In Progress*
- 🟡 Internal and External Referral Order Entry Process – *Education/Monitoring*
- 🔄 Telehealth Video Visit Workflow – *In Progress*
- 🔄 Care Gaps Documentation – *In Progress*
- 🔍 New Provider Onboarding Epic Onboarding 7/7 – *Reviewing*

Pain Management

- 🔍 Medication Administration Workflow – *Reviewing*
- 🔄 Ketamine Flowsheet Documentation – *In Progress*

Laboratory / Ambulatory Clinic

- 🔍 Ambulatory Preappointment Lab Testing Scheduling – *Reviewing*
- 🔍 Lab Pathology Ordering Workflow – *Reviewing*

Med Surg

- 🟡 Patient Status Transition Process (IP to Swing, DCRA One Way) – *Monitoring*
- 🔍 Returning Provider Epic Onboarding 7/1
- 🔍 New Provider Onboarding Epic Onboarding 7/30 – *Reviewing*
- 🔍 New Provider Onboarding Epic Onboarding 7/31 - *Reveiwing*

OP Nursing

- 🟡 Internal and External Therapy Plan Workflow – *Education/Monitoring*
- 🟡 Wound Care Acute/Ambulatory Workflow – *Education/Monitoring*
- 🔍 Blood Transfusion Type and Screen OP Nursing Workflow - *Reviewing*

Quality

- 🔄 Clinical Documentation Review – *In Progress*
- 🔄 Medici AUR reporting – *In Progress*
- 🔄 Quality Measures Clinical Documentation – *In Progress*
- 🔍 Promoting Interoperability - *Reviewing*

Respiratory Therapy

- 🔄 Internal Order Routing to Workqueue for RT Orders – *In Progress*

Surgical Services

- Anesthesia Workflow Review – Personalization Setup – *In Progress*
- Surgical Case Referral/Scheduling Workflow – *In Progress*

Multi-Specialty Clinic Report
June 2025

To: Southern Coos Health District Board of Directors and Southern Coos Management
From: David M Serle – Director Medical Group Operations
Re: Multi-Specialty Clinic Report for SCHD Board of Directors Meeting – July 24, 2025

Provider Recruiting/Onboarding: As of 7/18/25

Hiring/Onboarding Status: FNP's

- Kim Bagby – Traveling FNP.
  - First day seeing patients July 14, 2025
- Felisha Miller, FNP
  - Anticipated start date mid-September
- Full time Physician.
  - Recruiting is ongoing

Year: 2025 Month: June Provider	Clinic Days	PT's Sched	Cancel	No Show	Total Seen	AVG Seen	No Show Rate	Cancel Rate	Tele HLTH	New PT's	Jan	Feb	Mar	Apr	May	June	July Proj
Bonnie Wong, DO	9	113	8	3	102	11	3%	7%	4	10	83	118	109	48	127	102	
Paul Preslar, DO	12	149	11	4	134	11	3%	7%	0	9	160	143	133	129	115	134	134
Shane Matsui, LCSW	21	88	5	5	78	4	6%	6%	7	3	84	66	40	85	84	78	52
Victoria Schmelzer, CRNA	9.5	78	3	1	74	8	1%	4%	0	4	63	60	60	60	60	74	78
Tami Marriott, MD	8	96	5	4	87	11	4%	5%	1	0	25	32	35	23	57	87	85
Jennifer Webster, MD	15	193	9	3	180	12	2%	5%	6	29	24	152	133	149	147	180	74
Henry Holmes, MD											0	0	60	85	51	0	42
Veronica Simmonds, MD	12	85	7	3	75	6	4%	8%	0	45	0	0	0	34	71	75	39
Kim Bagby FNP																	63
Outpatient Services	21	223	11	6	206	10	3%	5%	0	0	190	183	201	243	189	206	194
Totals	**107.5**	**1025**	**59**	**29**	**936**	**8.7**	**2.8%**	**5.8%**	**18**	**100**	**716**	**754**	**771**	**856**	**901**	**936**	**761**
Totals Visits Minus OP	86.5	802	48	23	730	8.4	2.9%	6.0%	18	100	526	571	570	613	712	730	567

Clinic Visits:

- **Total clinic visits are up 3.8% from the previous month (+35)**
- **Provider visits minus OP services are up 2.5% (+18)**
- **Total clinic visits for July are projected to drop 23% compared to June (-175)**
- **Provider visits minus OP services, are projected to drop by 29% (-163)**
- **Dr. Simmonds:**
  - **75 visits included for June**
  - **39 visits projected for July**
- **Kim Bagby FNP:**
  - **63 visits projected for July**

Last 6 Months of Fiscal Year 2025 (Jan – June)

Clinic Provider Income Summary

All Providers

For The Budget Year 2025

	ACT JAN	BUD JAN	ACT FEB	BUD FEB	ACT MAR	BUD MAR	ACT APR	BUD APR	ACT MAY	BUD MAY	ACT JUN	BUD JUN	ACT YTD	Current Budget YTD FY25 Budget	Variance
Provider Productivity Metrics															
Clinic Days	73	120	67	115	59	115	74	119	85	108	87	111	876	1279	(403)
Total Visits	526	1,251	581	1,357	570	1,527	613	1,648	712	1,472	730	1,637	7,328	13,837	(6,509)
Visits/Day	7.3	10.4	8.7	11.9	9.7	13.3	8.3	13.8	8.4	13.7	8.4	14.7	8.4	10.8	(2.5)
Total RVU	1,189	2,616	1,327	2,727	1,224	2,991	1,461	3,245	1,764	3,025	1,789	4,348	17,034	30,110	(13,076)
RVU/Visit	2.26	2.09	2.28	2.01	2.15	1.96	2.38	1.97	2.48	2.05	2.45	2.66	2.32	2.18	0.15
RVU/Clinic Day	16.40	21.80	19.80	23.81	20.75	26.01	19.75	27.27	20.75	28.14	20.68	39.17	19.44	23.55	(4.11)
Gross Revenue/Visit	693	380	629	370	692	358	617	365	625	376	709	372	555	382	173
Gross Revenue/RVU	307	182	276	184	322	183	259	186	252	183	289	140	239	175	63
Net Rev/RVU	130	79	116	79	136	78	110	79	107	78	130	60	102	76	26
Expense/RVU	106	81	96	71	139	70	153	63	116	67	113	46	120.42	86	35
Diff	24	(2)	20	8	(3)	8	(43)	16	(9)	11	17	14	(18)	(10)	(9)
Net Rev/Day	2,135	1,713	2,305	1,886	2,827	2,039	2,174	2,160	2,216	2,208	2,690	2,343	1,984	1,791	193
Expense/Day	1,737	1,758	1,899	1,691	2,882	1,833	3,028	1,727	2,412	1,895	2,344	1,785	2,342	2,020	321
Diff	398	(45)	406	195	(55)	206	(854)	433	(196)	312	346	558	(358)	(229)	(128)
Patient Revenue															
Outpatient															
Total Patient Revenue	364,678	475,000	365,686	502,517	394,363	546,731	377,962	602,298	444,952	553,491	517,390	609,498	4,065,655	5,284,047	(1,218,392)
Deductions From Revenue															
Total Deductions From Revenue (Note A	209,923	269,404	211,239	286,569	227,551	312,190	217,069	345,208	256,592	316,179	284,693	349,456	2,327,610	2,994,415	(666,805)
Net Patient Revenue	**154,755**	**205,596**	**154,447**	**215,947**	**166,812**	**234,540**	**160,893**	**257,090**	**188,360**	**237,312**	**232,697**	**260,042**	**1,738,045**	**2,289,632**	**(551,588)**
Total Operating Revenue	**154,755**	**205,596**	**154,447**	**215,947**	**166,812**	**234,540**	**160,893**	**257,090**	**188,360**	**237,312**	**232,697**	**260,042**	**1,738,045**	**2,289,632**	**(551,588)**
Operating Expenses															
Salaries & Wages	72,413	106,550	75,807	98,454	98,153	106,550	143,756	103,852	131,089	106,550	128,963	103,852	1,235,506	1,401,842	(166,336)
Benefits	3,654	14,847	4,645	13,410	5,301	14,847	7,250	14,368	9,448	14,847	8,571	14,241	94,052	159,632	(65,581)
Medical Supplies	(163)	875	0	875	(202)	875	8,327	875	8,904	875	992	875	20,679	10,179	10,500
Other Supplies	317	610	0	610	0	610	0	610	2,842	610	2,079	610	5,867	7,317	(1,450)
Maintenance and Repairs	0	21	0	21	0	21	0	21	0	21	0	21	0	255	(255)
Other Expenses	70	3,292	0	3,292	0	3,292	0	3,292	0	3,292	67	3,292	10,974	39,500	(28,526)
Allocation Expense	49,615	84,801	46,805	76,984	66,789	84,603	64,751	82,504	52,772	77,566	62,105	75,214	684,189	964,250	(280,061)
Total Operating Expenses	125,906	210,996	127,257	193,646	170,041	210,799	224,084	205,521	205,055	203,761	202,777	198,104	2,051,267	2,582,975	(531,708)
Excess of Operating Rev Over Exp	**28,849**	**(5,400)**	**27,190**	**22,301**	**(3,229)**	**23,742**	**(63,191)**	**51,569**	**(16,695)**	**33,551**	**29,920**	**61,938**	**(313,222)**	**(293,343)**	**(19,880)**
Total Non-Operating Income	**150**	**394**	**(450)**	**394**	**(2,854)**	**394**	**0**	**394**	**0**	**394**	**0**	**394**	**(300)**	**4,725**	**(5,025)**
Excess of Revenue Over Expenses	**28,999**	**(5,006)**	**26,740**	**22,694**	**(6,083)**	**24,135**	**(63,191)**	**51,963**	**(16,695)**	**33,945**	**29,920**	**62,332**	**(313,522)**	**(288,618)**	**(24,904)**

Note A - Average Collection Rate =41% of Gross Charges, therefore the Deduction Rate is 59% of Gross Charges 0 0

Human Resources Report

To: Southern Coos Health District Board of Directors
From: Stacy Nelson II, Director, Human Resources
Re: Report for SCHD Board of Directors, July 2025

Metrics

Employee Engagement:

- The Gallup Organization - July 2025
- Engaged / Not Engaged / Actively Disengaged
- Global = 23%, U.S. = 31%, HC = 32%, Gallup Workplace = 72%, SCHHC = TBD

Compensation Surveys:

- Critical Access Hospitals - July 2025
- Milliman/Salary.com - August 2025

Turnover:

- FY 2024 = 12.21% (20.01% less PD Staff and Involuntary Terminations)
- FY 2025 = 9.31% (13.59% less PD Staff and Involuntary Terminations)
- FY 2026 = TBD
- FY 2026 New Employee Turnover = TBD

Open Positions as of 7/18/2025:

POSITION TITLE	DEPARTMENT	FT / PT / PD
1218 - CERTIFIED MEDICAL ASSISTANT	CLINIC	FT
1203 - COOK	DIETARY	PD
1106 - RN	EMERGENCY	PD
1125 - LPN	EMERGENCY	PD
1162 - LPN	EMERGENCY	FT
1163 - LPN	EMERGENCY	FT
1177 - RN	EMERGENCY	FT
1208 - RN	EMERGENCY	PT
1050 - RN	MED/SURG	PD
1108 - CNA II	MED/SURG	PD
1109 - CNA II	MED/SURG	PD
1119 - RN	MED/SURG	FT
1131 - CNA II	MED/SURG	FT
1205 - RN	MED/SURG	PT
1206 - LPN	MED/SURG	PT
1202 - CT/RAD TECH	MEDICAL IMAGING	FT

1183 - PHARMACIST	PHARMACY	FT
1201 - PHARMACY TECHNICIAN	PHARMACY	FT
1104 - RESP THERAPIST REG	RESPIRATORY	PD
1167 - RESP THERAPIST REG	RESPIRATORY	FT

Regulatory

- Continuing with DNV Readiness
- Wage & Hour Laws - Meal & Rest Periods Attestations
- SCHHC Employee Handbook Update

Events

- Celebration of Life Service & BBQ
    - Jim Morgan
    - Coquille Community Center
    - 8/9/2025 at 11:30

- Employee Picnic
    - Dr. Crane's Home
    - 90475 North Bank Lane, Bandon, OR
    - 8/16/2025 at 11:00 - 4:00

Training & Development

- Relias / HealthStream – August 2025
- Legal 101 for Leaders – 2025
- Others TBD

People:

Employees of the Month - June 2025:

- Clinical – Deena Buchanan

This employee is an outstanding team member whose versatility, dedication, and commitment to patient care make a significant impact across the entire hospital. Working across multiple modalities, they consistently delivers high-quality imaging services while maintaining a calm, professional, and compassionate presence. She is a true team player who is always willing to adjust her schedule to meet the department's needs and ensure that patients receive their exams in a timely and efficient manner. Her flexibility and reliability are unmatched, and she routinely steps up to fill gaps without hesitation—often going above and beyond what is expected. Despite the challenges of working in various imaging areas, Deena maintains an exceptional standard of quality in her work. Her broad skill set, combined with her attention to detail and patient-first mindset, allows her to provide excellent care no matter the setting or modality. She is deeply respected by her peers and consistently demonstrates a commitment to both clinical excellence and teamwork. Deena's adaptability, strong work ethic, and dedication to both patients and colleagues make her a truly invaluable asset to our department. I strongly recommend her for Employee of the Month recognition. (Deena Buchanan, nominated by Christy Dressell)

- Non-Clinical – Michelle Juergenson

This employee has unwavering dedication to patient care & consistently goes above & beyond for both patients and our team. They are not only highly knowledgeable & skilled, but they also approach each patient interaction with compassion, urgency, and a deep sense of responsibility. Whether it's ensuring follow-up care is arranged, coordinating with other departments, or simply taking the time to reassure a worried patient or family member, this employee consistently goes the extra mile to make sure every patient receives timely, high-quality care. They often take initiative without being asked, anticipate needs before they arise, & are always willing to step in to support a colleague or help solve a problem. Their positive attitude & commitment to excellence contribute greatly to the success of our department. (Michelle Jurgenson, nominated by Christy Dressell).

Southern Coos Health Foundation Report

To: Southern Coos Health District Board of Directors and Southern Coos Health Foundation
From: Alix McGinley, Executive Director, SCHF
Re: SCH Foundation Report for SCHD/SCHF Board of Directors, July 11, 2025

Golf for Health Classic (GFHC)- The 18th anniversary 2025 Golf for Health Classic is September 19th and 20th. Our goal for this year's signature event is $125,000.00. To date we have received or have promises for $80,250 for this year's tournament, under $50k to go! We have a host of new sponsors and the majority of returning Sponsors are upping their game. Our Bandon Dunes reception is going to be the best yet.
If you have a personal connection with any community partners, please encourage them to support our biggest fundraiser of the year. This event helps fund most of the SCHF expenses throughout the year.

Meet & Greet-SCHHC & SCHF Lecture Series
SCHHC/SCHF is slotted in for the second Tuesday of each month Meet & Greet at Bandon Fisheries Warehouse. Our July 2025 presenter was our very own CEO Ray Hino. Presentation was an overview of FY25, what is to come and the Federal Budget Reconciliation Bill. As always, his presentation was very informative, well attended and audience was very engaged.

**Session added on July 22nd for our MFP community engagement session.

SCHF Quarterly Art Show & Gift Shop
Art from our local art community is a value add for our Hospital. Next show is Sunday (July 13th) entitled Goodies from the Garden. The hospital looks alive with garden views.

Gift Shop Karen Reber's finished out her last shift as Gift Shop Coordinator and began training our new Development Coordinator Tina Gulseth. Karen will return as a volunteer, and I am looking forward to seeing Tina grow in this role.

New/continuation of fundraising programs-
*Grateful Patient is nearly ready for roll-out in September. Employee Giving, Annual Giving programs and Capital Campaign initiatives to follow.

Grant Submissions- Two additional grants are getting ready for submission this month for OCF and CHIP (Advanced Health). If granted, could be worth up to $50k towards our business office remodel to additional clinic space.

I will be in Madison, WI for the week of July 20th- 25th as such will miss the District Board meeting this month. Please reach out if you need additional information on any afore mentioned SCHF business.

Monthly Financial Report

To: Board of Directors and Southern Coos Management
From: Antone Eek, CFO
RE: June 2025 Month End Financial Results - Presented July 24. 2025

Revenue Performance:

- Gross Revenue: Achieved $4,451,000, falling short of the budget of $4,823,000.

Revenue Deductions:

- **Deductions from Revenue**:
  - June amounted to $1,855,000 or 41.7%, down from May of 46.3%. YTD Deductions stand at 40.0% compared to a budget of 36.0%.
  - Accounts receivable decreased by $782,000 to $8,575,000 in June, however, AR over 120 days increased by $238k.
  - Actual Contractuals came in at 33.71% for the month of June. Included in that amount is $53,000 in Charity Care (1% compared to gross charges) and a recovery of $18,000 in bad debt payments.
  - Discounts were $66,000 or 1.5% compared to gross charges. Included in that amount is $24,000 in Medical Necessity Discounts and less than $1,000 in Non-Authorized Discounts.
  - Estimated Contractuals increase by $366k. This was primarily due to an increase in AR above 120 days. There is the possibility that these accounts can be collected on in the future, but to be conservative, our practice is to fully reserve these balances.
- **Medicare Cost Report Settlement for FY25**: The anticipated receivable was raised slightly in June to $341,000 up from May by $91,000. The final receivable will be determined once the FY25 cost report is filed in November. Payment would be expected in the January / February time frame.

Operating Revenues:

- **Total Operating Revenues**: Totaling $2,598,000 were less than the budget of $3,227,000 but marked an increase of $237,000 from the same period last year.
- **Total Operating Revenues YTD FY25** stand at $33,940,000, which is a significant increase of $2,408,000 over YTD FY24.

Operating Expenses:

- **Labor Expenses** totaled $2,292,000, coming in just above the budgeted $2,266,000
  - Increased overtime and double time related to unfilled positions drove this variance.
- **Other Operating Expenses** reached $756,000, coming in below the budget of $841,000.
  - Reduction in estimated expenses for purchased services in patient financial services and HIM contributed to this favorability.
  - YTD operating expenses of $36,953,000 remain well under the budget of $38,583,000.

Operating Income/Loss:

- Operating Loss of $(450,000) compared to a budgeted gain of $120,000.
    - Driven by higher revenue deductions and unrealized other operating revenue.

Change in Net Position:

- A loss of $(306,000) compared to the budgeted gain of $231,000

Financial Health Indicators:

- Days Cash on Hand: June increased to 80.1 from 72.8 in May.
- Accounts Receivable (A/R) Days Outstanding: Decreased to 52.3 days, down from 56.7 days in May.

Financial Ratio Benchmark Chart (as of June 2025)
For Organization Type: Critical Access Hospital / Public Healthcare District

Metric	Value	Target Range / Benchmark	What It Means
Cash to Debt Ratio	**0.88**	0.20 – 1.00+	SCHHC has **88¢ in cash** for every $1 of debt — strong liquidity for a small/rural hospital.
Debt Ratio	**0.51**	0.30 – 0.60 (nonprofit healthcare sector)	About **51% of our assets** are financed with liabilities — a **balanced use of debt**.
Days Cash on Hand	**80.1 days**	60 – 180 days (CAH benchmark: 75+ recommended)	We can cover **80 days of operations** with cash on hand — a **solid buffer** for stability and planning.
A/R Days Outstanding	**52.3 days**	40 – 55 days (typical nonprofit hospital range)	SCHHC **revenue cycle is performing well**. A/R collection is on track and reflects **efficient billing follow-up**.

- **Liquidity (Cash to Debt Ratio & Days Cash on Hand)**:
  SCHHC liquidity profile is strong. With 80.1 days cash on hand and a cash-to-debt ratio of 0.88, we are well-positioned to absorb operational volatility or delays in reimbursement without relying on credit.
- **Debt Management (Debt Ratio)**:
  Our 51% debt ratio places SCHHC in a moderate and stable financial leverage zone, suggesting a balanced approach to borrowing without overextending the organization.
- **Revenue Cycle (A/R Days Outstanding)**:
  At 52.3 days, our A/R is performing within industry norms. This indicates SCHHC billing and collections are functioning efficiently, which supports cash flow.

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses, and Changes in Net Position
As of June 30, 2025

	Month Ending 06/30/2025				Month Ending 06/30/2024	Year To Date 06/30/2025				Prior Year To Date 06/30/2024
	Actual	Operating Budget	Actual minus budget	Budget variance	Actual	Actual	Operating Budget	Actual minus budget	Budget variance	Actual
Total Patient Revenue										
Inpatient Revenue	571,670	878,097	(306,427)	(34.9) %	750,752	9,957,735	12,070,659	(2,112,924)	(17.5) %	9,543,062
Outpatient Revenue	3,639,510	3,837,627	(198,117)	(5.2) %	3,300,650	42,344,071	44,490,343	(2,146,272)	(4.8) %	37,201,665
Swingbed Revenue	240,263	107,660	132,603	123.2 %	247,666	4,163,141	1,341,608	2,821,533	210.3 %	3,353,358
Total Patient Revenue	**4,451,443**	**4,823,384**	**(371,941)**	**(7.7) %**	**4,299,068**	**56,464,947**	**57,902,610**	**(1,437,663)**	**(2.5) %**	**50,098,085**
Total Deductions	**1,854,817**	**1,697,676**	**157,141**	**9.3 %**	**1,980,634**	**22,561,980**	**20,821,727**	**1,740,253**	**8.4 %**	**18,668,011**
Revenue Deductions %	**41.7 %**	**35.2 %**	**6.5 %**	**18.5 %**	**46.1 %**	**40.0 %**	**36.0 %**	**4.1 %**	**11.3 %**	**37.3 %**
Net Patient Revenue	**2,596,627**	**3,125,709**	**(529,082)**	**(16.9) %**	**2,318,434**	**33,902,967**	**37,080,883**	**(3,177,916)**	**(8.6) %**	**31,430,074**
Other Operating Revenue	**1,790**	**101,543**	**(99,753)**	**(98.2) %**	**42,897**	**36,780**	**1,218,517**	**(1,181,736)**	**(97.0) %**	**101,980**
Total Operating Revenue	**2,598,416**	**3,227,252**	**(628,835)**	**(19.5) %**	**2,361,331**	**33,939,747**	**38,299,400**	**(4,359,652)**	**(11.4) %**	**31,532,054**
Total Operating Expenses										
Total Labor Operating Expenses	2,291,725	2,265,956	25,769	1.1 %	1,970,826	26,113,127	28,219,180	(2,106,053)	(7.5) %	23,726,934
Total Other Operating Expenses	756,307	841,053	(84,746)	(10.1) %	937,942	10,840,247	10,364,003	476,244	4.6 %	9,255,811
Total Operating Expenses	**3,048,032**	**3,107,009**	**(58,977)**	**(1.9) %**	**2,908,768**	**36,953,374**	**38,583,183**	**(1,629,809)**	**(4.2) %**	**32,982,745**
Operating Income / (Loss)	**(449,616)**	**120,243**	**(569,859)**	**(473.9) %**	**(547,438)**	**(3,013,626)**	**(283,783)**	**(2,729,843)**	**961.9 %**	**(1,450,691)**
Net Non Operating Revenue	**143,628**	**110,923**	**32,705**	**29.5 %**	**195,808**	**1,410,726**	**1,311,226**	**99,501**	**7.6 %**	**1,609,216**
Change In Net Position	**(305,988)**	**231,166**	**(537,154)**	**(232.4) %**	**(351,630)**	**(1,602,900)**	**1,027,443**	**(2,630,343)**	**(256.0) %**	**158,525**
Collection Rate %	58.3%	64.8%	(10.0%)	(10.0%)	53.9%	60.0%	64.0%	(6.2%)	(6.2%)	62.7%
Compensation Ratio %	79.0%	63.1%	25.1%	25.1%	75.1%	68.5%	66.5%	3.0%	3.0%	65.5%
Operating Margin	(17.3%)	3.7%	(564.5%)	(564.5%)	(22.9%)	(8.9%)	(1.0%)	818.8%	818.8%	(4.4%)
OP EBIDA Margin $	(321,321)	287,518	(608,839)	(211.8%)	(436,517)	(1,244,084)	1,637,484	(2,881,568)	(176.0%)	(142,378)
OP EBIDA Margin %	(12.4%)	8.9%	(21.3%)	(238.8%)	(18.5%)	(3.7%)	4.3%	(7.9%)	(185.7%)	(0.5%)
Total Margin (%)	(11.8%)	7.2%	(18.9%)	(264.4%)	(14.6%)	(4.7%)	2.5%	(7.2%)	(292.2%)	0.7%

* Other Operating Income YTD:
  - $14k - Levy Payment from CMS
  - $13k – Advanced Health CCO (Coordinated Care Organization) Risk Share
  - $1k – SWOREIPA Quality Incentives
  - $9k – GPO Rebates

	CPSI					EPIC								
Income Statement	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Average	YTD
Average Daily Revenues	145,120	138,377	134,786	152,532	138,032	157,797	171,571	157,340	158,461	174,331	169,007	148,381	153,811	155,123
Average Daily Actual Contractuals	50,383	52,345	59,447	41,629	55,338	46,284	46,783	68,655	60,582	57,301	65,027	50,022	54,483	54,504
% of Actual Contractuals of Total Payment	39.31%	38.84%	47.31%	29.78%	37.55%	35.06%	41.54%	40.02%	33.89%	39.09%	37.88%	28.95%	37.43%	37.08%
Revenues	4,498,717	4,289,700	4,043,588	4,728,499	4,140,953	4,891,719	5,318,712	4,720,191	4,912,288	5,229,933	5,239,205	4,451,443	4,705,412	56,464,947
Actual Contractual Adjustments	1,561,868	1,622,685	1,783,421	1,290,510	1,660,139	1,434,799	1,450,264	1,922,339	1,878,034	1,719,027	2,015,851	1,500,658	1,653,300	19,839,595
Actual Discount Adjustments	61,901	100,556	127,981	355,013	205,662	134,449	60,943	65,516	42,386	83,045	113,782	65,897	118,094	1,417,133
Estimated Contractuals	7,407	11,154	5,913	1,819	(241,398)	656,754	417,723	128,939	(169,861)	282,444	26,417	366,342	124,471	1,493,654
Medicare Tool Adjustment	(73,500)	(138,500)	(277,500)	126,451	12,500	(272,637)	(68,931)	68,552	221,337	22,483	269,423	(78,080)	(15,700)	(188,402)
Total Deductions	1,557,676	1,595,895	1,639,815	1,773,793	1,636,903	1,953,365	1,860,000	2,185,347	1,971,896	2,106,999	2,425,473	1,854,817	1,775,349	22,561,980
Actual Contractuals % of Revenues	34.72%	37.83%	44.10%	27.29%	40.09%	29.33%	27.27%	40.73%	38.23%	32.87%	38.48%	33.71%	35.39%	35.14%
Discount Adjustments % of Revenues	1.38%	2.34%	3.17%	7.51%	4.97%	2.75%	1.15%	1.39%	0.86%	1.59%	2.17%	1.48%	2.56%	2.51%
Estimated Contractuals % of Revenues	0.16%	0.26%	0.15%	0.04%	-5.83%	13.43%	7.85%	2.73%	-3.46%	5.40%	0.50%	8.23%	2.46%	2.65%
Medicare Tool Adjustment % of Revenues	-1.63%	-3.23%	-6.86%	2.67%	0.30%	-5.57%	-1.30%	1.45%	4.51%	0.43%	5.14%	-1.75%	-0.49%	-0.33%
Total Deductions % of Revenues	34.62%	37.20%	40.55%	37.51%	39.53%	39.93%	34.97%	46.30%	40.14%	40.29%	46.29%	41.67%	39.92%	39.96%

Balance Sheet	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25		
CPSI Patient Cash Posted	2,411,100	2,555,332	1,986,226	3,043,539	2,760,601	2,655,082	1,424,662	438,957	239,439	76,659	63,212	106,549	*1,480,113*	17,761,357
EPIC Patient Cash Posted	-	-	-	-	-	2,919	616,615	2,442,366	3,423,668	2,602,439	3,243,053	3,576,611	*1,325,639*	15,907,671
Total Cash Posted	2,411,100	2,555,332	1,986,226	3,043,539	2,760,601	2,658,001	2,041,277	2,881,323	3,663,107	2,679,098	3,306,265	3,683,159	*2,805,752*	33,669,028
Average Daily Cash	77,777	82,430	66,208	98,179	92,020	85,742	65,848	102,904	118,165	89,303	106,654	122,772	92,333.45	92,497
Total Patient AR Over 120 Days	*791,940*	*872,105*	*1,121,137*	*736,322*	*724,374*	*911,366*	*1,097,046*	*1,140,638*	*1,006,758*	*1,192,889*	*1,684,147*	*1,922,522*	*1,100,104*	*1,922,522*
Total Patient AR	7,412,906	7,492,493	8,485,631	7,670,231	7,121,141	7,761,771	9,505,725	9,372,293	8,762,600	9,509,727	9,356,665	8,574,636	8,418,818	8,574,636
AR Allowance for Uncollectables	3,294,540	3,374,560	4,128,486	3,270,150	2,973,070	3,589,909	3,933,049	4,068,297	3,904,790	4,184,857	4,211,528	4,580,214	3,792,788	4,580,214
Net Patient AR	4,118,366	4,117,933	4,357,145	4,400,081	4,148,071	4,171,862	5,572,676	5,303,996	4,857,810	5,324,870	5,145,137	3,994,422	4,626,031	3,994,422
% Allowance for Oustanding AR	44.44%	45.04%	48.65%	42.63%	41.75%	46.25%	41.38%	43.41%	44.56%	44.01%	45.01%	53.42%	45.05%	53.42%
% Change in Allowance from Prior Month				-6.02%	-0.88%	4.50%	-4.88%	2.03%	1.15%	-0.56%	1.00%	8.40%	0.53%	
Increase of AR Over 120 from Prior Month	100,798	80,165	249,032	(384,814)	(11,948)	186,992	185,680	43,592	(133,879)	186,131	491,258	238,375	102,615	
Increase of Total AR from Prior Month	184,407	79,587	993,138	(815,400)	(549,090)	640,630	1,743,954	(133,432)	(609,693)	747,127	(153,062)	(782,029)	112,178	

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses & Changes in Net Position
As of June 30, 2025

Current Month

	Month Ending 06/30/2025				Month Ending 06/30/2024
	Actual	Operating Budget	Actual minus budget	Budget variance	Actual
Total Patient Revenue					
Inpatient Revenue	571,670	878,097	(306,427)	(34.9) %	750,752
Outpatient Revenue	3,639,510	3,837,627	(198,117)	(5.2) %	3,300,650
Swingbed Revenue	240,263	107,660	132,603	123.2 %	247,666
Total Patient Revenue	**4,451,443**	**4,823,384**	**(371,941)**	**(7.7) %**	**4,299,068**
Total Deductions	**1,854,817**	**1,697,676**	**157,141**	**9.3 %**	**1,980,634**
Net Patient Revenue	**2,596,627**	**3,125,709**	**(529,082)**	**(16.9) %**	**2,318,434**
Other Operating Revenue	**1,790**	**101,543**	**(99,753)**	**(98.2) %**	**42,897**
Total Operating Revenue	**2,598,416**	**3,227,252**	**(628,835)**	**(19.5) %**	**2,361,331**
Total Operating Expenses					
Total Labor Expenses					
Salaries & Wages	1,569,329	1,520,647	48,682	3.2 %	1,296,458
Contract Labor	435,275	341,842	93,433	27.3 %	431,523
Benefits	287,121	403,467	(116,346)	(28.8) %	242,845
Total Labor Expenses	2,291,725	2,265,956	25,769	1.1 %	1,970,826
Purchased Services	133,680	296,652	(162,972)	(54.9) %	405,323
Drugs & Pharmaceuticals	111,626	75,324	36,302	48.2 %	64,080
Medical Supplies	101,426	113,121	(11,695)	(10.3) %	95,411
Other Supplies					
4300 - OTHER NON-MEDICAL SUPPLIES	67	-	67	100.0 %	6,245
4301 - OFFICE SUPPLIES	8,949	3,997	4,952	123.9 %	6,813
4304 - LAUNDRY & LINENS / NONFOOD SUPPLIES	16,280	2,641	13,640	516.6 %	(269
4398 - MINOR EQUIPMENT	13,061	28,625	(15,565)	(54.4) %	5,203
4399 - INVENTORY ADJUSTMENT	(20,688)	(5,071)	(15,617)	308.0 %	7,644
4505 - CATERING & FOOD	7,354	8,352	(998)	(11.9) %	8,838
Other Supplies	25,023	38,544	(13,521)	(35.1) %	34,474
Lease & Rental Expense	-	558	(558)	(100.0) %	5,954
Repairs & Maintenance	10,543	27,748	(17,204)	(62.0) %	29,185
Other Expenses					
4302 - POSTAGE & FREIGHT	5,809	3,204	2,604	81.3 %	7,454
4303 - COMPUTER & IT EQUIPMENT	2,867	-	2,868	100.0 %	-
4501 - MARKETING - ALLOWABLE (MCR)	15,663	15,529	133	0.9 %	18,203
4502 - MARKETING - NON ALLOWABLE	1,614	-	1,613	100.0 %	1,916
4504 - PRINTING & COPYING	3,088	-	3,088	100.0 %	-
4700 - OTHER EXPENSES	-	(544)	544	(100.0) %	-
4701 - OREGON PROVIDER TAX	1,149	-	1,149	100.0 %	-
4702 - LICENSING & GOVERNMENT FEES	29,830	5,734	24,098	420.3 %	11,426
4703 - DUES & SUBSCRIPTIONS	70,144	39,372	30,771	78.2 %	48,806
4704 - EMPLOYEE RELATIONS ACTIVITIES - MEETINGS	3,873	4,779	(906)	(19.0) %	567
4705 - TRAINING / CONFERENCE FEES	4,302	25,579	(21,278)	(83.2) %	5,567
4706 - TRAVEL & LODGING	9,487	6,295	3,193	50.7 %	10,248
4710 - OCCUPANCY / RENT EXPENSE	-	-	-	0.0 %	-
4711 - EQUIPMENT RENTAL	-	412	(412)	(100.0) %	-
4720 - DONATIONS / GRANTED FUNDS	1,000	-	1,000	100.0 %	-
4797 - MISC TAX (A/P)	1	-	1	100.0 %	-
4798 - BANK & COLLECTION FEES	25,202	10,446	14,757	141.3 %	5,731
4799 - MISCELLANEOUS EXPENSE	102	(39,196)	39,297	(100.3) %	(1,494
Other Expenses	174,131	71,610	102,520	143.2 %	108,424
Utilities	26,660	29,578	(2,917)	(9.9) %	27,148
Insurance	44,923	20,617	24,305	117.9 %	63,590
Depreciation & Amortization	128,295	167,301	(39,006)	(23.3) %	104,353
Total Operating Expenses	**3,048,032**	**3,107,009**	**(58,977)**	**(1.9) %**	**2,908,768**
Operating Income / (Loss)	**(449,616)**	**120,243**	**(569,859)**	**(473.9) %**	**(547,438**
Net Non Operating Revenue					
Property Taxes	96,792	96,045	747	0.8 %	135,558
Non-Operating Revenue	42,457	19,203	23,254	121.1 %	49,027
Interest Expense	(18,935)	(47,125)	28,190	(59.8) %	(23,005
Investment Income	23,314	42,800	(19,486)	(45.5) %	33,475
Gain / Loss on Asset Disposal	-	-	-	0.0 %	753
Net Non Operating Revenue	**143,628**	**110,923**	**32,705**	**29.5 %**	**195,808**
Change In Net Position	**(305,988)**	**231,166**	**(537,154)**	**(232.4) %**	**(351,630**

Southern Coos Hospital & Health Center
Statements of Revenues, Expenses & Changes in Net Position
As of June 30, 2025

	Year To Date 06/30/2025				Prior Year To Date 06/30/2024
	Actual	Operating Budget	Actual minus budget	Budget variance	Actual
ıl Patient Revenue					
atient Revenue	9,957,735	12,070,659	(2,112,924)	17.5 %	9,543,062
tpatient Revenue	42,344,071	44,490,343	(2,146,272)	4.8 %	37,201,665
ringbed Revenue	4,163,141	1,341,608	2,821,533	210.3 %	3,353,358
ıl Patient Revenue	**56,464,947**	**57,902,610**	**(1,437,663)**	**(2.5) %**	**50,098,085**
ıl Deductions	**22,561,980**	**20,821,727**	**1,740,253**	**8.4 %**	**18,668,011**
Patient Revenue	**33,902,967**	**37,080,883**	**(3,177,916)**	**(8.6) %**	**31,430,074**
er Operating Revenue	**36,780**	**1,218,517**	**(1,181,736)**	**(97.0) %**	**101,980**
ıl Operating Revenue	**33,939,747**	**38,299,400**	**(4,359,652)**	**(11.4) %**	**31,532,054**
ıl Operating Expenses					
al Labor Expenses					
alaries & Wages	17,765,952	18,374,441	(608,489)	(3.3) %	15,344,188
ontract Labor	5,364,540	5,003,687	360,853	7.2 %	5,797,031
enefits	2,982,635	4,841,052	(1,858,417)	(38.4) %	2,585,715
al Labor Expenses	26,113,127	28,219,180	(2,106,053)	(7.5) %	23,726,934
rchased Services	3,603,361	3,559,802	43,558	1.2 %	3,465,931
ugs & Pharmaceuticals	1,228,444	916,443	312,003	34.0 %	1,197,243
dical Supplies	1,177,693	1,328,732	(151,040)	(11.4) %	1,017,280
her Supplies					
00 - OTHER NON-MEDICAL SUPPLIES	36,185	-	36,185	100.0 %	62,351
01 - OFFICE SUPPLIES	53,388	47,965	5,424	11.3 %	53,874
04 - LAUNDRY & LINENS / NONFOOD SUPPLIES	135,004	31,685	103,317	326.1 %	24,940
08 - MINOR EQUIPMENT	134,441	343,509	(209,067)	(60.9) %	147,934
09 - INVENTORY ADJUSTMENT	(74,705)	(60,853)	(13,852)	22.8 %	(56,174)
05 - CATERING & FOOD	107,910	100,216	7,694	7.7 %	94,333
her Supplies	392,223	462,522	(70,299)	(15.2) %	327,258
ase & Rental Expense	(1,913)	6,699	(8,612)	(128.5) %	(5,815)
pairs & Maintenance	212,523	332,975	(120,453)	(36.2) %	231,817
her Expenses					
02 - POSTAGE & FREIGHT	69,379	38,446	30,934	80.5 %	51,588
03 - COMPUTER & IT EQUIPMENT	76,876	-	76,876	100.0 %	-
01 - MARKETING - ALLOWABLE (MCR)	111,041	186,357	(75,316)	(40.4) %	175,354
02 - MARKETING - NON ALLOWABLE	80,570	-	80,570	100.0 %	66,608
04 - PRINTING & COPYING	25,862	-	25,863	100.0 %	-
00 - OTHER EXPENSES	-	12	(13)	(100.0) %	-
01 - OREGON PROVIDER TAX	(43,909)	-	(43,909)	100.0 %	-
02 - LICENSING & GOVERNMENT FEES	282,389	68,798	213,590	310.5 %	73,043
03 - DUES & SUBSCRIPTIONS	883,874	472,469	411,406	87.1 %	437,583
04 - EMPLOYEE RELATIONS ACTIVITIES - MEETINGS	60,437	57,346	3,091	5.4 %	36,669
05 - TRAINING / CONFERENCE FEES	55,501	306,953	(251,452)	(81.9) %	166,242
06 - TRAVEL & LODGING	82,041	75,532	6,508	8.6 %	89,054
10 - OCCUPANCY / RENT EXPENSE	3,892	-	3,892	100.0 %	-
11 - EQUIPMENT RENTAL	-	4,950	(4,950)	(100.0) %	3,300
20 - DONATIONS / GRANTED FUNDS	2,967	-	2,968	100.0 %	-
97 - MISC TAX (A/P)	3,656	-	3,656	100.0 %	-
98 - BANK & COLLECTION FEES	126,316	125,348	968	0.8 %	133,295
99 - MISCELLANEOUS EXPENSE	2,125	(189,329)	191,454	(101.1) %	(63,462)
her Expenses	1,823,017	1,146,882	676,136	59.0 %	1,169,274
lities	344,920	354,929	(10,009)	(2.8) %	325,870
urance	290,436	247,411	43,025	17.4 %	292,026
preciation & Amortization	1,769,543	2,007,608	(238,065)	(11.9) %	1,234,927
ıl Operating Expenses	**36,953,374**	**38,583,183**	**(1,629,809)**	**(4.2) %**	**32,982,745**
rating Income / (Loss)	**(3,013,626)**	**(283,783)**	**(2,729,843)**	**961.9 %**	**(1,450,691)**
Non Operating Revenue					
operty Taxes	1,147,164	1,132,685	14,479	1.3 %	1,174,124
n-Operating Revenue	216,754	230,433	(13,680)	(5.9) %	287,605
erest Expense	(440,188)	(565,497)	125,310	(22.2) %	(292,252)
estment Income	486,996	513,605	(26,608)	(5.2) %	492,090
in / Loss on Asset Disposal	-	-	-	0.0 %	(52,351)
Non Operating Revenue	**1,410,726**		**99,501**	**7.6 %**	**1,609,216**
nge In Net Position	**(1,602,900)**	**1,027,443**	**(2,630,343)**	**(256.0) %**	**158,525**

Southern Coos Hospital & Health Center
Balance Sheet Summary

	Year To Date 06/30/2025	Year Ending 06/30/2024		Year Ending 06/30/2023
	Current Year Balance	Prior Year	Current vs. Prior	Actual
Total Assets				
Total Current Assets				
Cash and Cash Equivalents	11,239,810	11,721,015	(481,205)	12,771,743
Net Patient Accounts Receivable	3,994,422	3,907,633	86,789	2,813,679
Other Assets	1,030,033	798,202	231,832	678,642
Total Current Assets	16,264,265	16,426,850	(162,584)	16,264,064
Net PP&E	8,708,314	6,423,952	2,284,361	6,677,893
Total Assets	**24,972,579**	**22,850,802**	**2,121,777**	**22,941,957**
Total Liabilities & Net Assets				
Total Liabilities				
Current Liabilities	8,391,023	4,490,006	3,901,018	4,057,278
Total Long Term Debt, Net	4,358,938	4,535,131	(176,194)	5,217,539
Total Liabilities	12,749,961	9,025,137	3,724,824	9,274,817
Total Net Assets	12,222,618	13,825,665	(1,602,900)	13,667,140
Total Liabilities & Net Assets	**24,972,579**	**22,850,802**	**2,121,924**	**22,941,957**

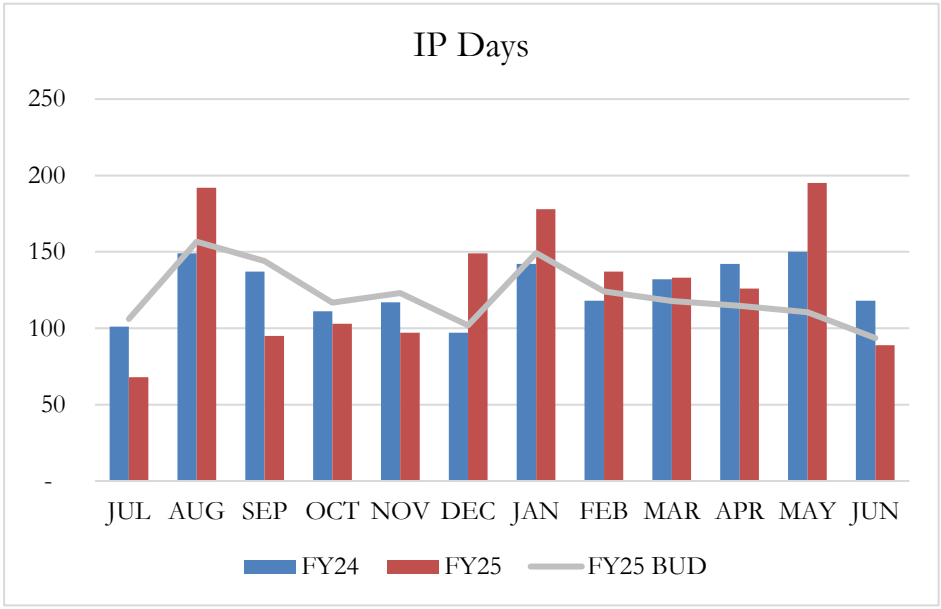
Cash to Debt Ratio	**0.88**	**1.30**	**(0.42)**	**1.38**
Debt Ratio	**0.51**	**0.39**	**0.12**	**0.40**
Current Ratio	**1.94**	**3.66**	**(1.72)**	**4.01**
Debt to Capitalization Ratio	**0.24**	**0.25**	**(0.01)**	**0.29**

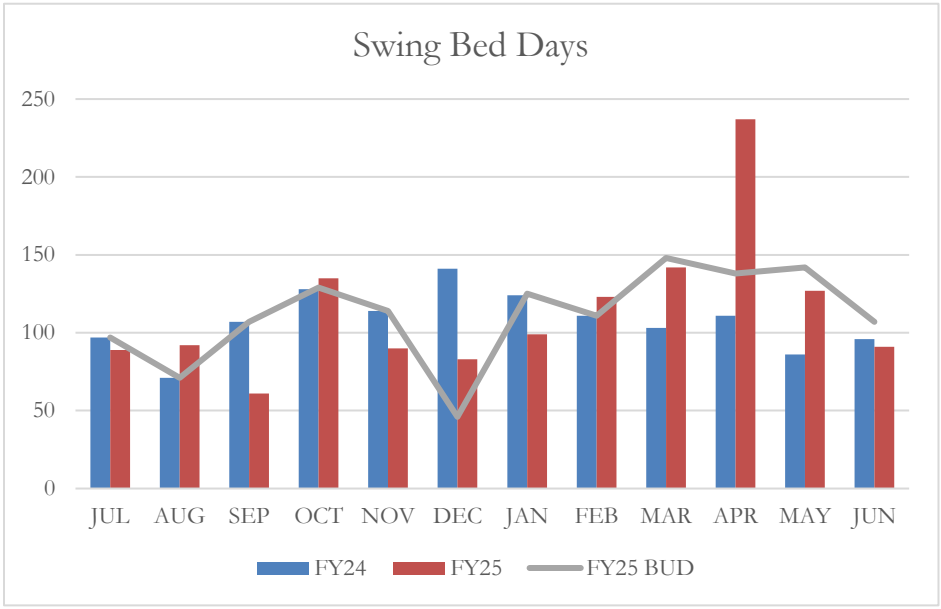
Southern Coos Hospital & Health Center
Balance Sheet

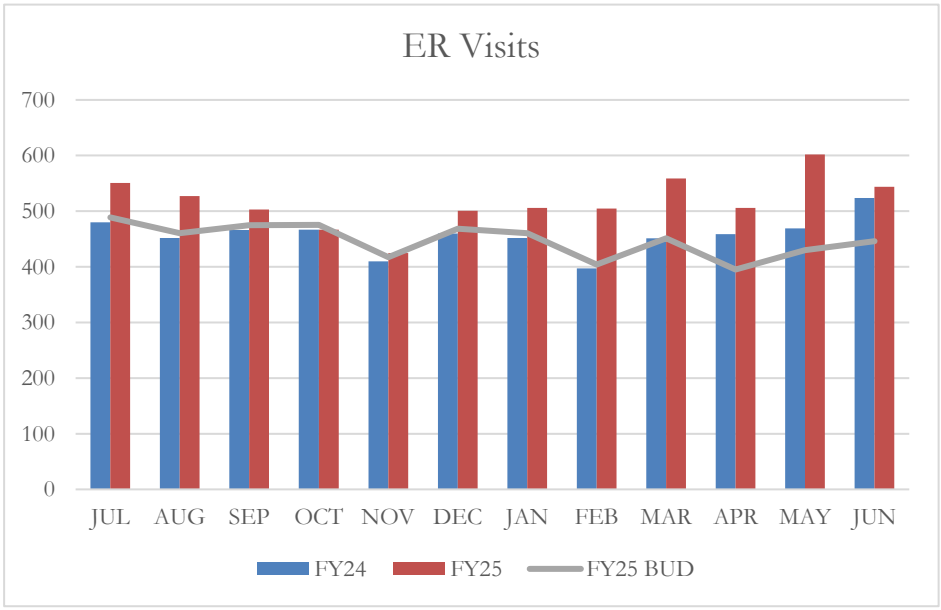
	Year To Date 06/30/2025	Year Ending 06/30/2024		Year Ending 06/30/2023
	Current Year Balance	Prior Year	Change	Actual
Total Assets				
Total Current Assets				
Cash and Cash Equivalents				
Cash Operating	**1,335,553**	**1,400,507**	**(64,954)**	**8,783,262**
Investments - Unrestricted	**3,984,314**	**4,076,428**	**(92,115)**	**829,546**
Investments - Reserved Certificate of Deposit	**3,186,238**	**3,510,375**	**(324,136)**	**-**
Investments - Restricted	**-**	**-**	**-**	**952,448**
Investment - USDA Restricted	**233,705**	**233,705**	**-**	**233,704**
Investment - Board Designated	**2,500,000**	**2,500,000**	**-**	**1,972,783**
Cash and Cash Equivalents	**11,239,810**	**11,721,015**	**(481,205)**	**12,771,743**
Net Patient Accounts Receivable				
Patient Accounts Receivable				
1101 - A/R PATIENT - EPIC	7,850,956	-	7,850,956	-
1102 - A/R PATIENT - CPSI / EVIDENT	723,680	7,228,690	(6,505,010)	5,634,804
2003 - REFUNDS - PATIENT / INSURANCE	-	(192)	191	(6,692)
Patient Accounts Receivable	**8,574,636**	**7,228,499**	**1,346,137**	**5,628,112**
Allowance for Uncollectibles				
1121 - ALLOW FOR UNCOLL - EPIC	(4,598,461)	-	(4,598,460)	-
1122 - ALLOW FOR UNCOLL - CPSI	(723,679)	(3,840,559)	3,116,878	(3,141,299)
1130 - WRITE OFF RECOVERY	(723,288)	(554,030)	(169,257)	(401,991)
1132 - BAD DEBT W/O - NON-MEDICARE	1,465,214	1,073,723	391,491	728,857
Allowance for Uncollectibles	**(4,580,214)**	**(3,320,866)**	**(1,259,348)**	**(2,814,433)**
Net Patient Accounts Receivable	**3,994,422**	**3,907,633**	**86,789**	**2,813,679**
Other Assets				
Other Receivables	**29,598**	**21,045**	**8,553**	**20,893**
Inventory	**369,514**	**230,930**	**138,584**	**262,233**
Prepaid Expense	**572,290**	**465,262**	**107,028**	**367,358**
Property Tax Receivable	**58,631**	**80,965**	**(22,333)**	**28,158**
Other Assets	**1,030,033**	**798,202**	**231,832**	**678,642**
Total Current Assets	**16,264,265**	**16,426,850**	**(162,584)**	**16,264,064**
Net PP&E				
Land	**461,528**	**461,527**	**-**	**461,527**
Property and Equipment	**24,224,122**	**20,435,404**	**3,788,718**	**20,092,235**
Accumulated Depreciation	**(16,235,298)**	**(15,194,163)**	**(1,041,135)**	**(13,904,245)**
Construction In Progress	**257,962**	**721,184**	**(463,222)**	**28,376**
Net PP&E	**8,708,314**	**6,423,952**	**2,284,361**	**6,677,893**
Total Assets	**24,972,579**	**22,850,802**	**2,121,777**	**22,941,957**

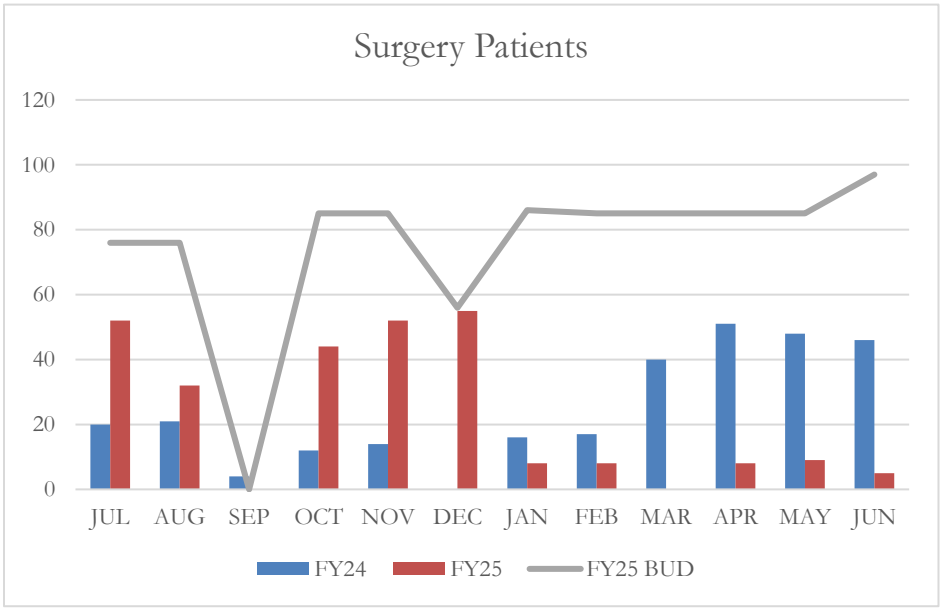
Southern Coos Hospital & Health Center
Balance Sheet

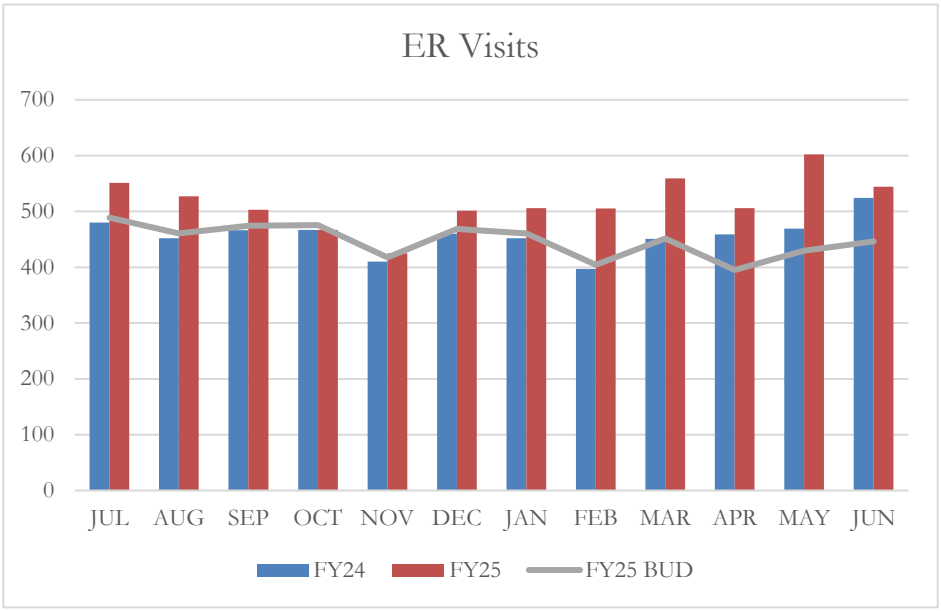
	Year To Date 06/30/2025	Year Ending 06/30/2024		Year Ending 06/30/2023
	Current Year Balance	Prior Year	Change	Actual
Total Liabilities & Net Assets				
Total Liabilities				
Current Liabilities				
Accounts Payable	1,517,014	1,344,652	172,362	842,313
Accrued Payroll and Benefits	1,748,456	1,411,152	337,304	1,145,491
Line of Credit Payable	3,139,376	-	3,139,376	-
Interest and Other Payable	278,968	100,992	177,975	100,328
Estimated Third Party Payor Settlements	1,050,372	997,650	52,723	800,004
Current Portion of Long Term Debt	656,837	635,560	21,278	1,169,142
Current Liabilities	8,391,023	4,490,006	3,901,018	4,057,278
Total Long Term Debt, Net				
Long Term Debt	4,358,938	4,535,131	(176,194)	5,217,539
Total Long Term Debt, Net	4,358,938	4,535,131	(176,194)	5,217,539
Total Liabilities	12,749,961	9,025,137	3,724,824	9,274,817
Total Net Assets	12,222,618	13,825,665	(1,602,900)	13,667,140
Total Liabilities & Net Assets	24,972,579	22,850,802	2,121,924	22,941,957

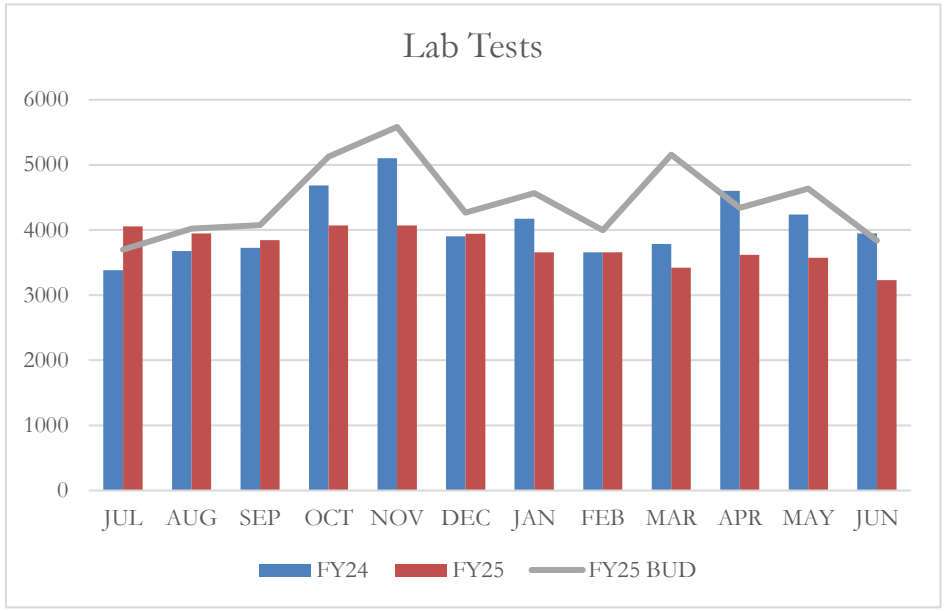

IP Days
250
200
150
100
50
-
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD

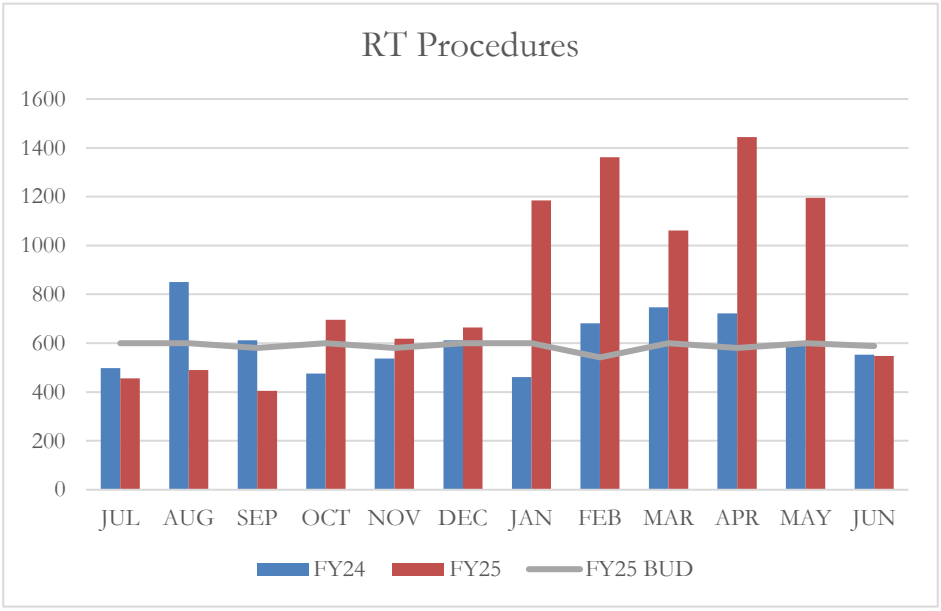

Swing Bed Days
250
200
150
100
50
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD

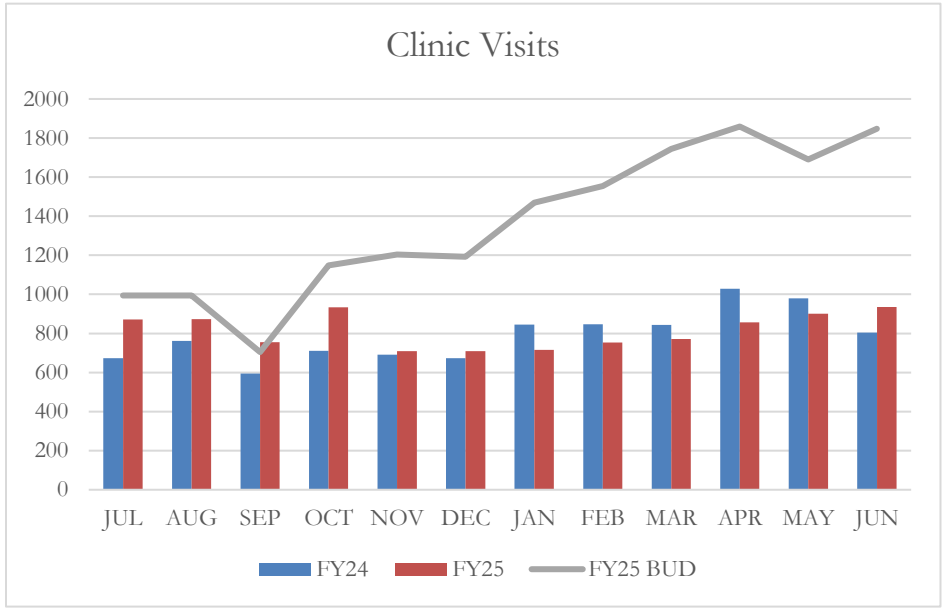

ER Visits
700
600
500
400
300
200
100
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD


Surgery Patients
120
100
80
60
40
20
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD


ER Visits
700
600
500
400
300
200
100
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD


Lab Tests
6000
5000
4000
3000
2000
1000
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD


RT Procedures
1600
1400
1200
1000
800
600
400
200
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD


Clinic Visits
2000
1800
1600
1400
1200
1000
800
600
400
200
0
JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY JUN
FY24 FY25 FY25 BUD

EPIC Stabilization Graph Package
As of 7/11/25

Week #31

SO. COOS HB STABILIZATION

HB KEY METRICS										
Metric	Status	As of 7/11		As of 7/4		13wk	Baseline	Top	Median	Bottom
Total AR	◆	53.1 Days*	$8.5M	51.3 Days*	$8.3M		50 Days*	49.5 Days*	53.7 Days*	58.2 Days*
Epic AR	◆	48.5 Days*	$7.8M	46.7 Days*	$7.6M			43.8 Days*	48.7 Days*	51.9 Days*
Legacy AR	◆	4.6 Days*	$743.9K	4.6 Days*	$745K			4.5 Days*	6.1 Days*	8.7 Days*
Cumulative Charge Variance	◆	112.8%	$4M	112.9%	$3.9M		$1M/wk	$2.2M	$1.3M	$285.4K
Cumulative Payment Variance	◆	3.7 Weeks	$2.3M	3.8 Weeks	$2.4M		$620.2K/wk	$667.1K	$32.3K	-$507.2K
CFB	●	9.7 Days	$1.6M	8.4 Days	$1.4M			5.3 Days	6.6 Days	7.7 Days
Claim Edit	●	2.3 Days	$361.6K	3.5 Days	$562.6K			1 Days	1.5 Days	2.2 Days
Uncoded CFB	●	2.3 Days	$367.6K	2.2 Days	$363.7K			1 Days	1.4 Days	2 Days
Open Denial	◆	2.2 Days	$347K	3.7 Days	$596.8K			2 Days	3 Days	4.5 Days
Epic Payment Average	◆	147.3%	$913.7K	151.8%	$941.6K			108.9%	103.7%	99%
Primary Denial Rate	■	14.4%	11.5% (Curr)	16.1%	12% (Curr)			10.5%	13.3%	17.1%

**Total, Epic, and Legacy AR Days are calculated using combined Legacy+Epic ADR and not Epic-only ADR*

Status Key:

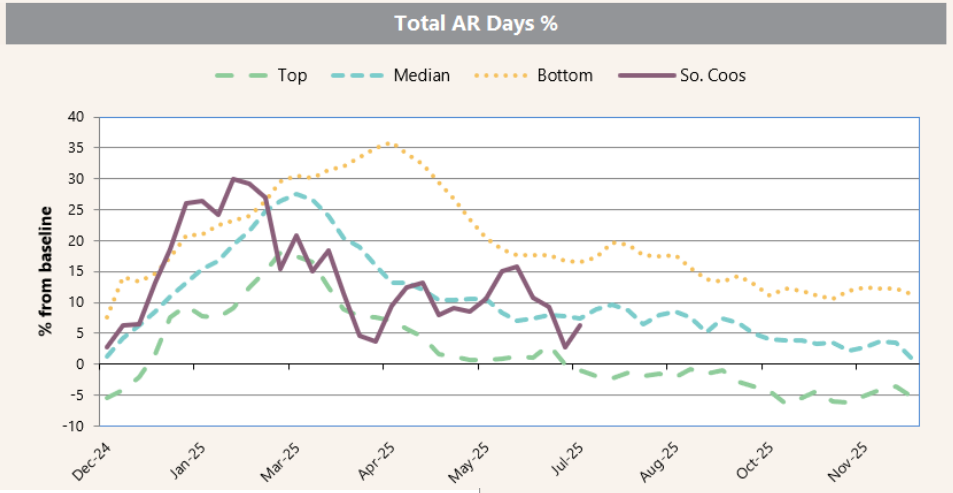
- ◆ Performing well/on track
- ■ Area to watch
- ● Off track
- ✱ Significant concern

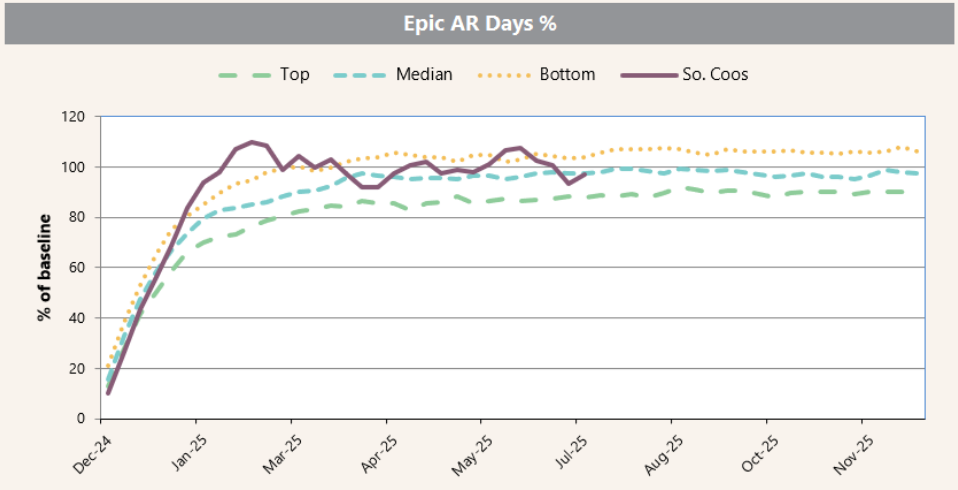
Top	Threshold for the 75th percentile for the metric at week 31
Median	Median (50th percentile) value for the metric at week 31
Bottom	Threshold for the 25th percentile for the metric at week 31

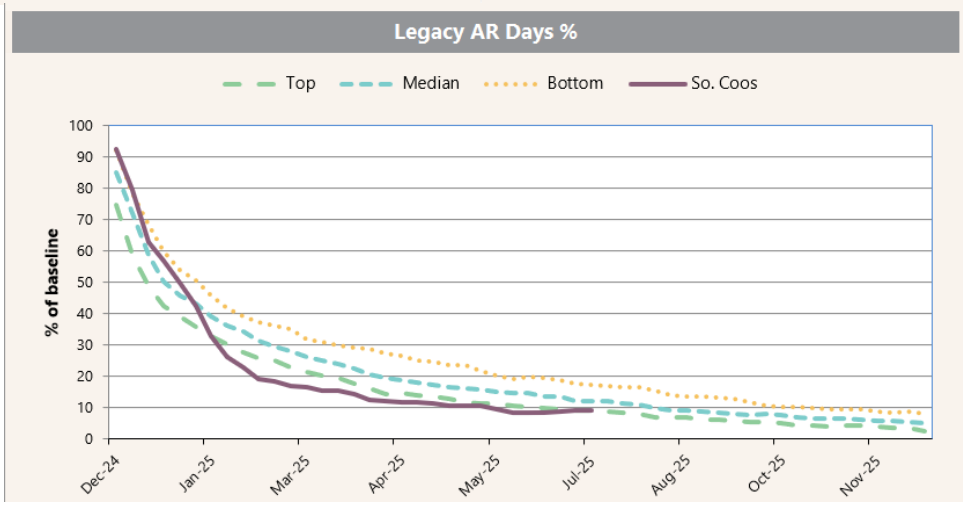
EPIC Stabilization Graph Package
As of 7/11/25

Definitions	
Total AR	Total outstanding Accounts Receivable (Epic + Legacy) / Days calc: AR divided by combined (Epic + Legacy) average daily revenue (13 weeks)
Epic AR	Epic outstanding Accounts Receivable / Days calc: AR divided by combined (Epic + Legacy) average daily revenue (13 weeks)
Legacy AR	Legacy outstanding Accounts Receivable / Days calc: AR divided by combined (Epic + Legacy) average daily revenue (13 weeks)
Cumulative Charge Variance	Total charges posted (Epic + Legacy) compared to the historical weekly charge average summed over the weeks live / Dollar difference between the two values and percent of total expected
Cumulative Payment Variance	Total payments posted (Epic + Legacy) compared to the historical weekly payment average summed over the weeks live / Dollar difference between the two values and difference divided by historical weekly payment average
CFB	Total of all discharged but not final billed balances, minus min hold balances / Days calc: amount divided by Epic average daily revenue (up to 13 weeks)
Claim Edit	Total of all billed account balances that are held for claim errors / Days calc: amount divided by Epic average daily revenue (up to 13 weeks)
Uncoded CFB	Total of all discharged but not final coded balances, minus min hold balances / Days calc: amount divided by Epic average daily revenue (up to 13 weeks)
Open Denial	Total of all account balances that have an open denial from insurance / Days calc: amount divided by Epic average daily revenue (up to 13 weeks)
Epic Payment Average	Average of Epic payments posted over the last 4 weeks / Percent of historical payment average
Primary Denial Rate	(4-Week Avg) Percent (by count) of payments received in the last 4 weeks that indicate a denial (Current Week) Percent (by count) of payments received this week that indicate a denial

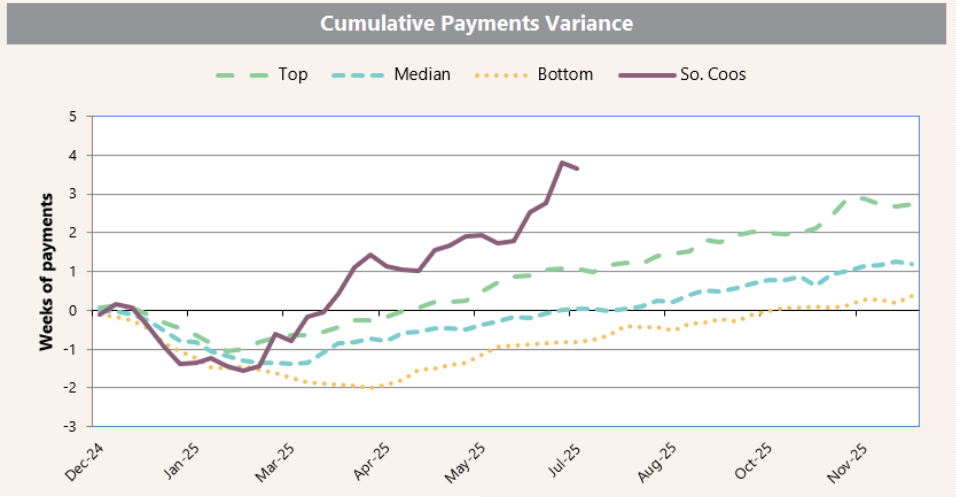
EPIC Stabilization Graph Package
As of 7/11/25

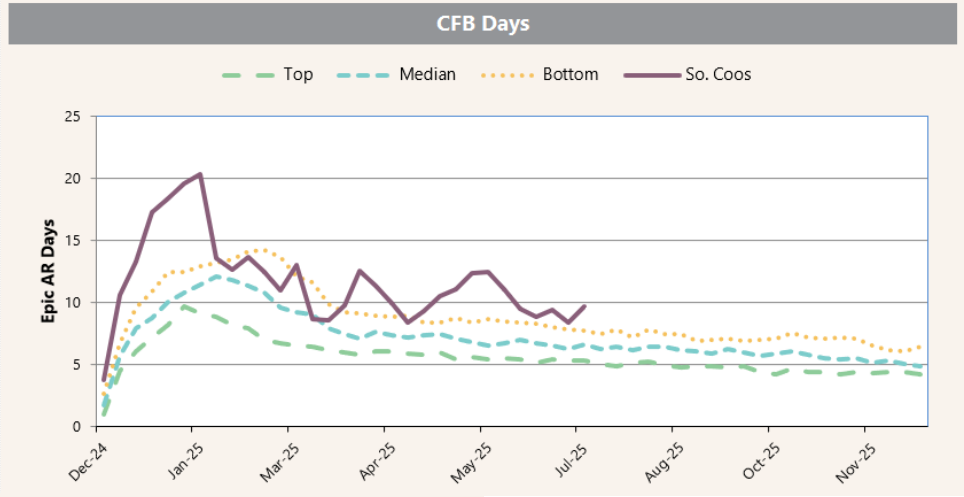


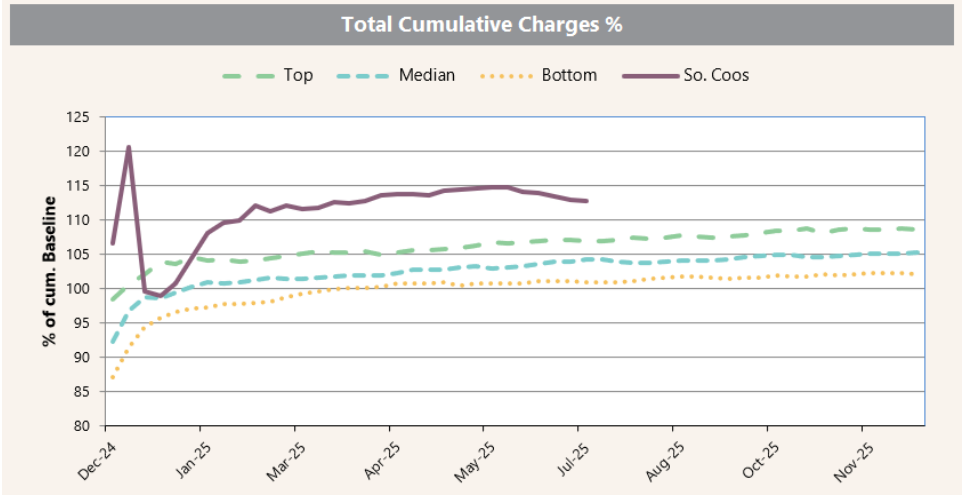




EPIC Stabilization Graph Package
As of 7/11/25



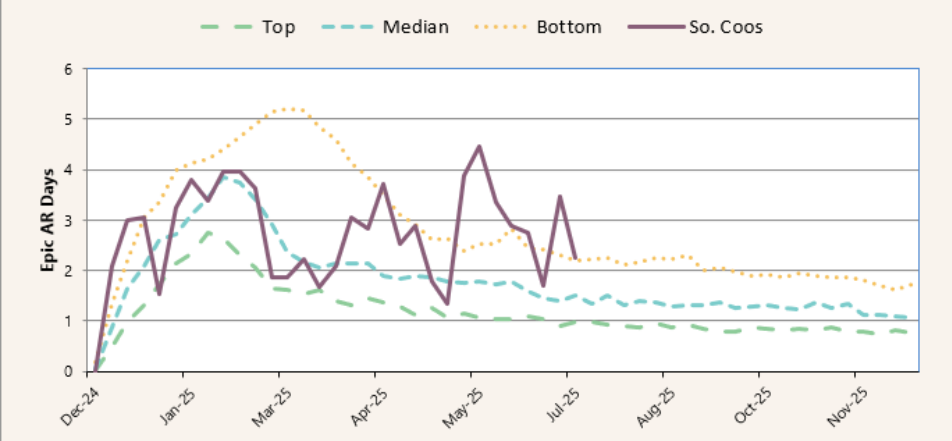




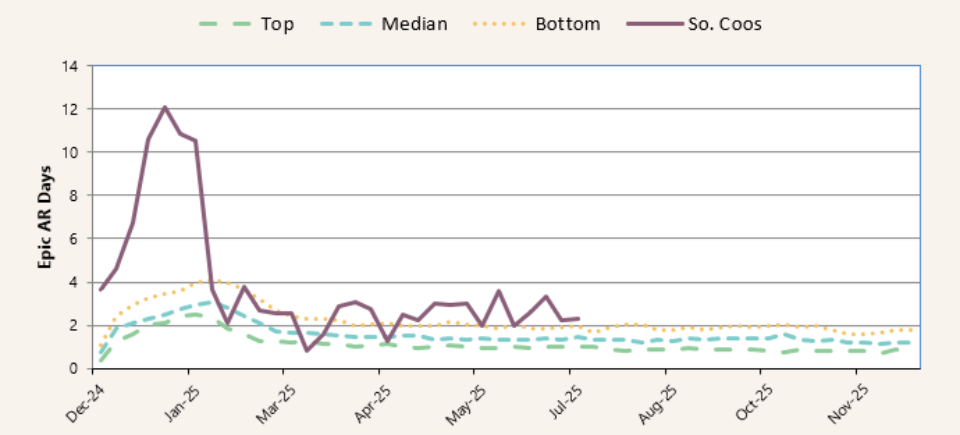
Note: The initial spike in charges was adding CPSI IP/SWB accounts into EPIC so they could be billed out of the new system, the dip was when the charges were removed from CPSI.

EPIC Stabilization Graph Package
As of 7/11/25

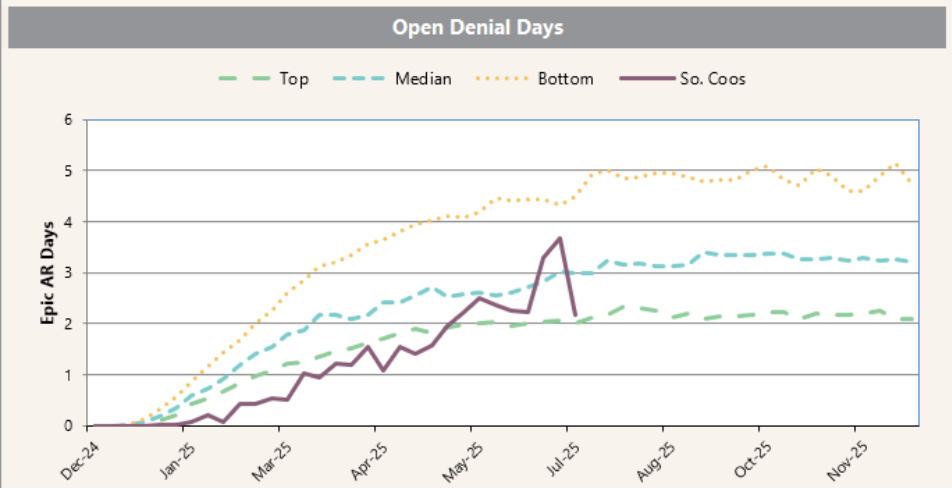
Claim Edit Days



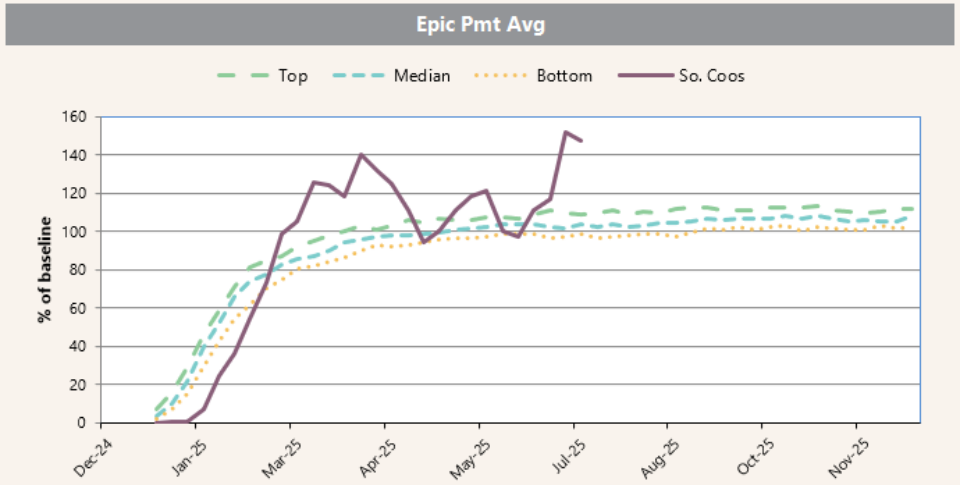
Coding Days



Open Denial Days



Epic Pmt Avg



EPIC Stabilization Graph Package
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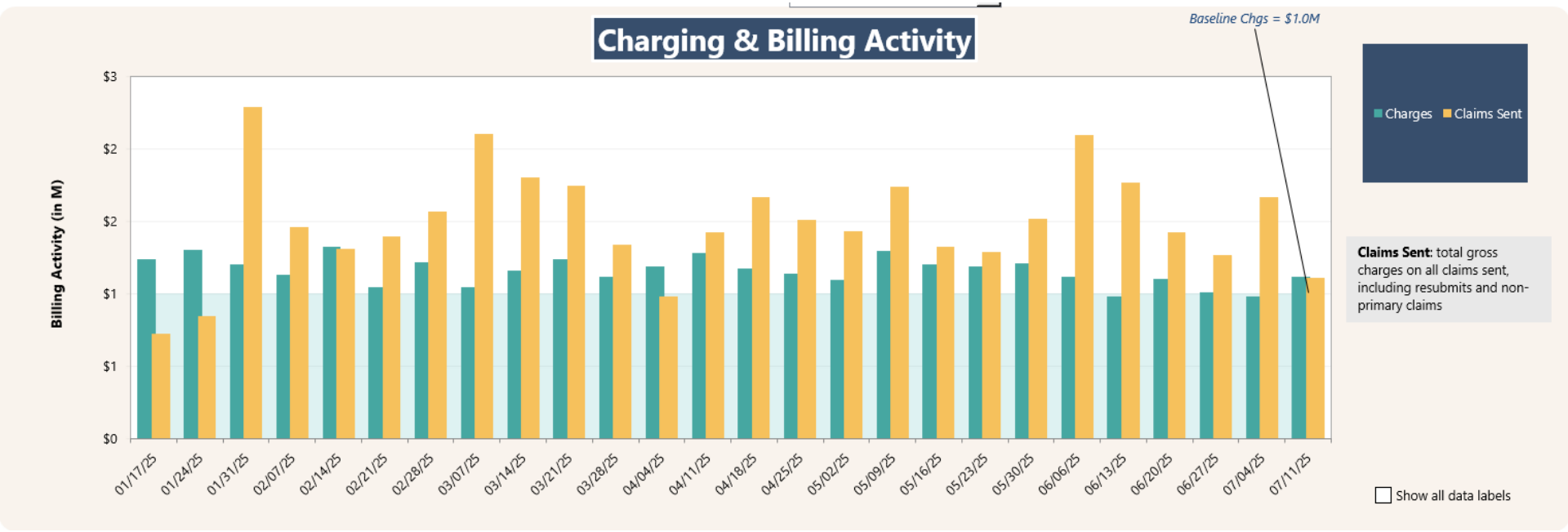
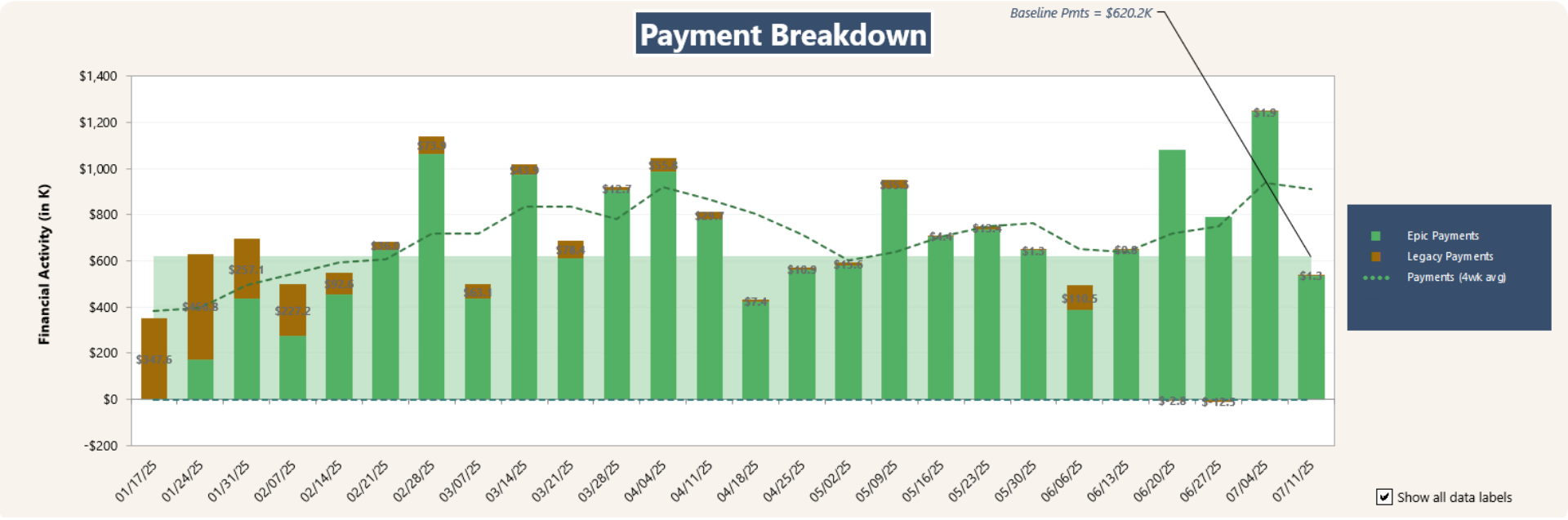


Note:

- Charges for the weeks of Christmas and New Year's were lower than average due to lower volumes. Overall, SCHHC has recognized an increase in charges
- Claims were temporarily held until the last week of January while staff worked through processes and workflow challenges, we continue to optimize processes.

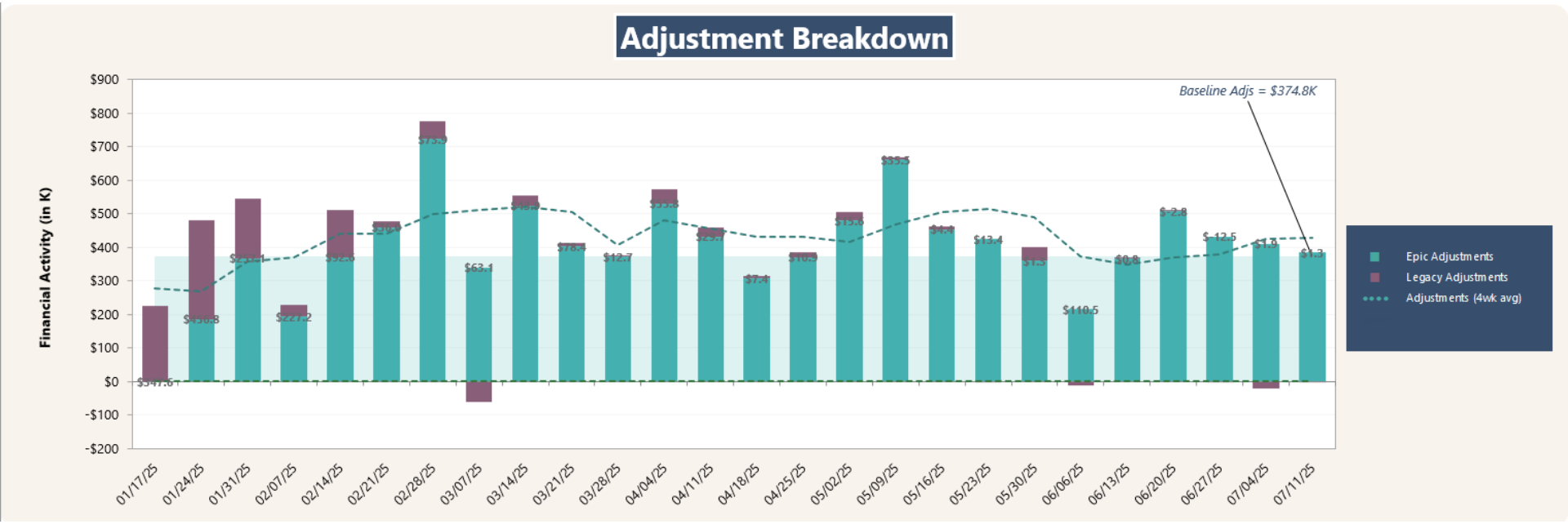
EPIC Stabilization Graph Package
As of 7/11/25



Note:

- A significant increase in payments (cash) was seen in February due to payments 30 days following the large push in claims at the end of January

EPIC Stabilization Graph Package
As of 7/11/25



Note:

- With a spike of cash payments in February, we also had a large number of contractuals posted, which was expected as payments catch back up
- The number of contractual adjustments out of CPSI is dropping as total AR is worked down

Southern Coos Hospital & Health Center

Volume and Key Performance Ratios

For The Period Ending June 2025

		Month						Year to Date				
		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior		Actual	Budget	Prior Year	Variance to Bud	Variance to Prior
Volume Summary	IP Days	89	94	118	-4.9%	-24.6%		1,562	1,458	1,514	7.1%	3.2%
	Swing Bed Days	91	107	96	-15.0%	-5.2%		1,369	1,335	1,289	2.5%	6.2%
	Total Inpatient Days	180	201	214	-10.2%	-15.9%		2,931	2,793	2,803	4.9%	4.6%
	Avg Daily Census	5.8	6.5	6.9	-10.2%	-15.9%		23.8	22.7	22.8	4.9%	4.6%
	Avg Length of Stay - IP	2.4	2.6	3.3	-7.4%	-26.6%		3.8	3.8	4.0	-1.7%	-5.3%
	Avg Length of Stay - SWB	9.1	15.3	13.7	-40.5%	-33.6%		11.3	12.7	12.3	-11.0%	-7.8%
	ED Registrations	544	446	524	22.0%	3.8%		6,196	5,372	5,487	15.3%	12.9%
	Clinic Registrations	936	457	528	104.8%	77.3%		8,343	5,588	6,320	49.3%	32.0%
	Ancillary Registrations	1,479	1,081	1,081	36.8%	36.8%		15,829	13,593	13,593	16.4%	16.4%
	Total OP Registrations	2,959	1,984	2,133	49.1%	38.7%		30,368	24,553	25,400	23.7%	19.6%
Key Income Statement Ratios	Gross IP Rev/IP Day	6,423	9,386	7,629	-31.6%	-15.8%		6,862	8,279	7,673	-17.1%	-10.6%
	Gross SWB Rev/SWB Day	2,640	1,006	976	162.4%	170.4%		2,484	1,005	989	147.2%	151.2%
	Gross OP Rev/Total OP Registrations	1,230	1,934	1,550	-36.4%	-20.6%		1,394	1,812	1,465	-23.0%	-4.8%
	Collection Rate	58.3%	64.8%	53.9%	-10.0%	8.2%		60.0%	64.0%	62.7%	-6.2%	-4.3%
	Compensation Ratio	79.0%	63.1%	75.1%	25.1%	5.2%		68.5%	66.5%	65.5%	3.0%	4.6%
	OP EBIDA Margin $	(320,581)	247,301	(436,517)	-229.6%	-26.6%		(1,240,862)	1,492,638	(215,764)	-183.1%	475.1%
	OP EBIDA Margin %	-12.3%	7.7%	-18.5%	-261.0%	-33.3%		-3.7%	3.9%	-0.7%	-193.8%	434.4%
	Total Margin	-11.7%	5.9%	-14.6%	-298.6%	-19.6%		-4.7%	2.1%	0.5%	-326.9%	-1038.1%
Key Liquidity Ratios	Days Cash on Hand	80.1	80.0	131.6	-0.1%	-39.1%						
	AR Days Outstanding	52.3	50	47.4	4.6%	10.3%						

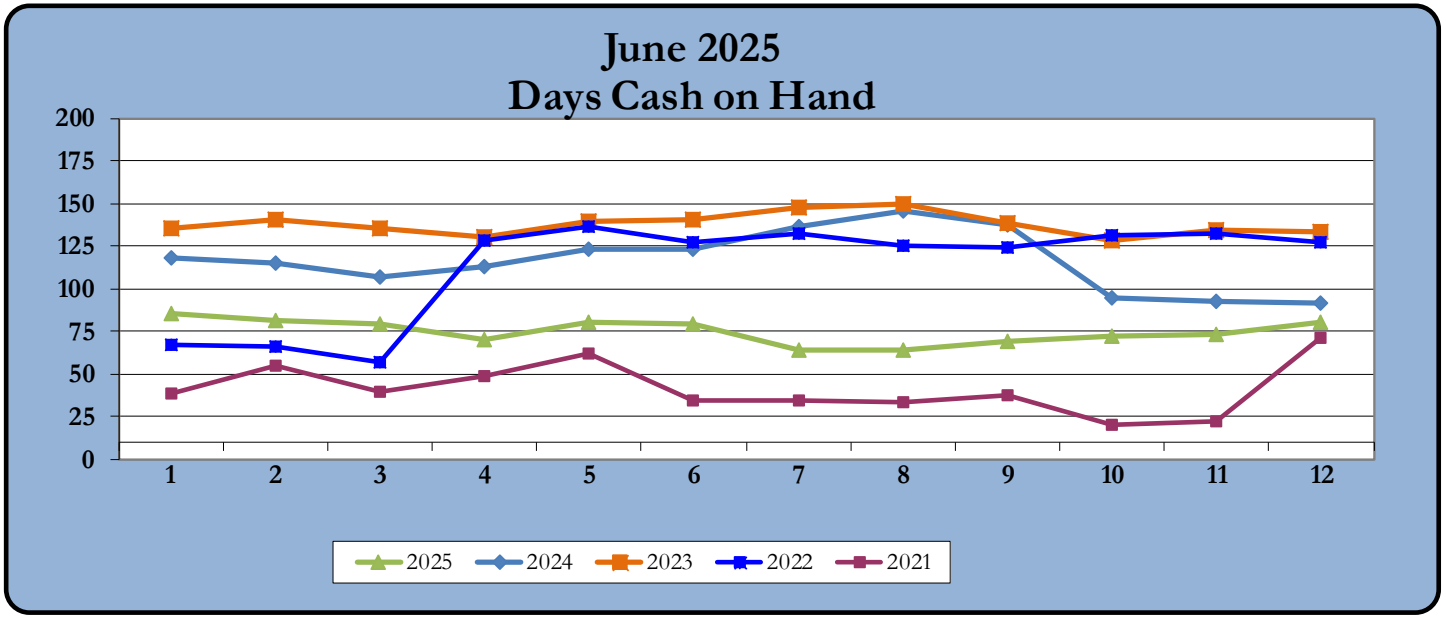
Southern Coos Hospital & Health Center

Data Dictionary

Volume Summary	IP Days	Total Inpatient Days Per Midnight Census
	Swing Bed Days	Total Swing Bed Days per Midnight Census
	Total Bed Days	Total Days per Midnight Census
	Avg Daily Census	Total Bed Days / # of Days in period (Mo or YTD)
	Avg Length of Stay - IP	Total Inpatient Days / # of IP Discharges
	Avg Length of Stay - SWB	Total Swing Bed Days / # of SWB Discharges
	ED Registrations	Number of ED patient visits
	Clinic Registrations	Number of Clinic patient visits
	Ancillary Registrations	Total number of all other OP patient visits
	Total OP Registrations	Total number of OP patient visits

Key Income Statement Ratios	Gross IP Rev/IP Day	Avg. gross patient charges per IP patient day
	Gross SWB Rev/SWB Day	Avg. gross patient charges per SWB patient day
	Gross OP Rev/Total OP Registrations	Avg. gross patient charges per OP visit
	Collection Rate	Net patient revenue / total patient charges
	Compensation Ratio	Total Labor Expenses / Total Operating Revenues
	OP EBIDA Margin $	Operating Margin + Depreciation + Amortization
	OP EBIDA Margin %	Operating EBIDA / Total Operating Revenues
	Total Margin (%)	Total Margin / Total Operating Revenues

Key Liquidity Ratios	Days Cash on Hand	Total unrestricted cash / Daily OP Cash requirements
	AR Days Outstanding	Gross AR / Avg. Daily Revenues



Calculation: Total Unrestricted Cash on Hand / Daily Operating Cash Needs

Definition: This ratio quantifies the amount of cash on hand in terms of how many "days" an organization can survive with existing cash reserves.

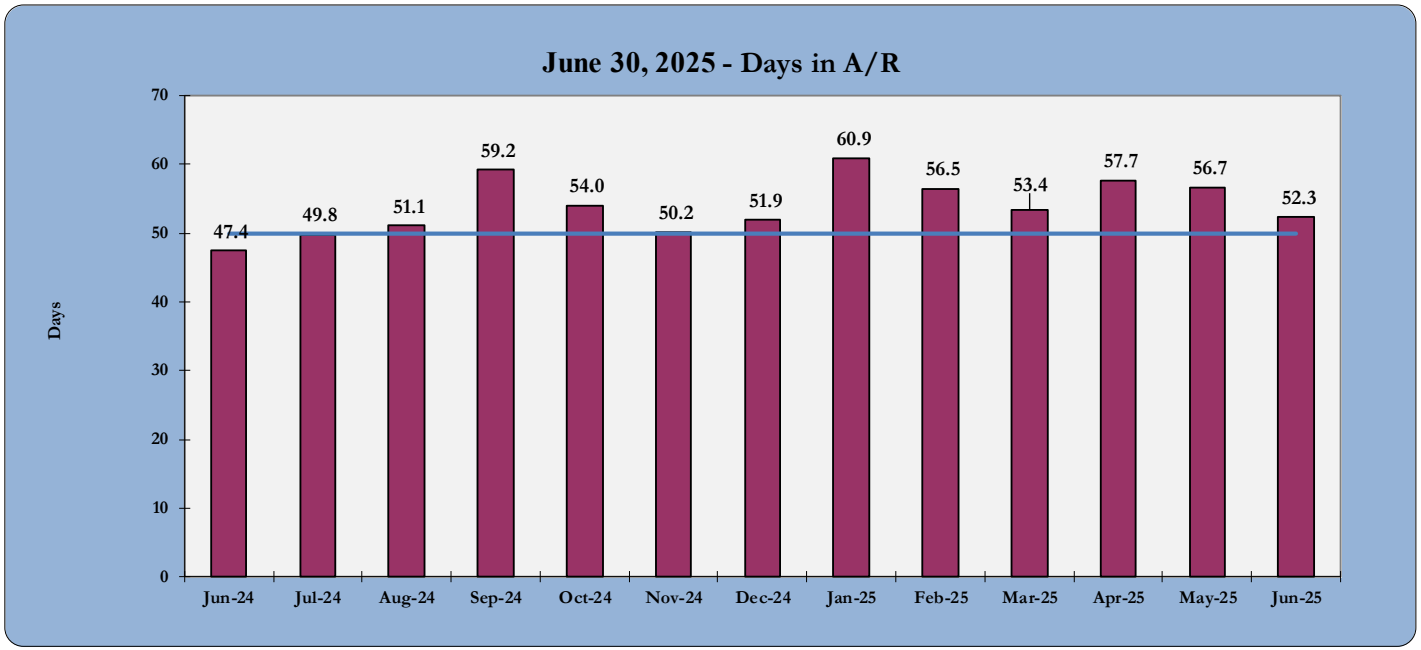
Desired Position: Upward trend, above the median

Year	Average
2025	74.8
2024	116.3
2023	137.8
2022	143.0
2021	41.2

Benchmark **80 Days**

How ratio is used: This ratio is frequently used by bankers, bondholders and analysts to gauge an organization's liquidity--and ability to meet short term obligations as they mature.

Fiscal	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2025	85.4	81.4	79.0	70.5	79.9	79.7	64.2	63.7	68.6	71.9	72.8	80.1
2024	117.7	114.5	106.8	113.1	123.1	123.3	136.1	145.3	137.0	94.5	92.8	91.4
2023	135.9	140.8	135.2	130.5	139.4	140.7	147.8	149.7	138.9	127.8	134.2	133.3
2022	67.2	66.2	56.6	128.6	136.1	127.4	132.1	125.1	124.6	131.5	132.8	127.5
2021	38.7	54.6	39.1	48.2	61.6	34.4	34.6	33.0	37.2	19.9	21.9	70.8



Calculation: Gross Accounts Receivable / Average Daily Revenue

Definition: Considered a key "liquidity ratio" that calculates how quickly accounts are being paid.

Desired Position: Downward trend below the median, and below average.

Benchmark ***50***

How ratio is used: Used to determine timing required to collect accounts. Usually, organizations below the average Days in AR are likely to have higher levels of Days Cash on Hand.

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
A/R (Gross)	7,005,894	7,194,350	7,269,865	8,263,819	7,671,394	7,122,984	7,761,771	9,505,725	9,372,293	8,762,600	9,509,727	9,356,665	8,574,636
Days in AR	**47.4**	**49.8**	**51.1**	**59.2**	**54.0**	**50.2**	**51.9**	**60.9**	**56.5**	**53.4**	**57.7**	**56.7**	**52.3**

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	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
A/R (Gross)	7,005,894	7,194,350	7,269,865	8,263,819	7,671,394	7,122,984	7,761,771	9,505,725	9,372,293	8,762,600	9,509,727	9,356,665	8,574,636
Days in Month	30	31	31	30	31	30	31	31	28	31	30	31	30
Monthly Revenue	4,299,068	4,498,717	4,289,700	4,043,588	4,728,499	4,140,953	4,891,719	5,318,712	4,720,191	4,720,191	5,229,933	5,239,205	4,451,443
3 Mo Avg Daily Revenue	147,763	144,429	142,255	139,478	141,976	141,902	149,578	155,993	165,896	163,990	164,835	165,101	163,962
Days in AR	**47.4**	**49.8**	**51.1**	**59.2**	**54.0**	**50.2**	**51.9**	**60.9**	**56.5**	**53.4**	**57.7**	**56.7**	**52.3**

SOUTHERN COOS HOSPITAL & HEALTH CENTER
CAPITAL PURCHASES SUMMARY FY2025

Approved Projects:

Budgeted Non-Threshold Capital Purchases (<$15,000)

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Status	Notes
Abbott ID Now Analyzer	Clinic	10,000		10,000		
60' Refrigerated Chef Base / Gas Griddle / Convection Oven	Dietary	18,000	16,576	1,424	Completed	Capitalized 03.31.25
OBGN Gurney	ER	6,500	7,787	(1,287)	Completed	Capitalized 04.30.25
New Desk/Workspace	ER	10,000		10,000		
Cast Cart	ER	5,500	5,163	337	Completed	Capitalized 08.31.24
Mindray Monitor Upgrade	ER	6,000		6,000	Completed	Included in EPIC project
Exam Lights	ER	13,000	1,806	11,194	In Progress	
Phone System VOIP upgrade	Information Systems	5,000	-	5,000	Expensed - Under $5k	Project came in under $5k - expensed per policy
Ortho MTS Workstation (Blood Bank)	Lab	8,000		8,000		
ID TipMaster	Lab	5,000		5,000		
Freezer	Lab	10,000		10,000		
Centrifuges (x4)	Lab	8,000		8,000		
Reclining Chairs	Med Surg	12,000	10,808	1,192	Completed	Capitalized 01.31.25
Suction Flow Meters	Med Surg	6,000		6,000		
Instrument Sets	Surgery	13,000	10,162	2,838	Completed	Capitalized 04.30.25

Un-Budgeted Non-Threshold Capital Purchases (<$15,000)

Copier Replacement	Information Systems		12,600	(12,600)	Completed	Capitalzied 02.28.25
RT - Ventiliation System	RT		7,590	(7,590)	Completed	Capitalized 01.31.25
Radiology Scanner	Radiology		9,000	(9,000)	Completed	Capitalized 04.30.25
Colposcope	OBGYN		6,295	(6,295)	Completed	Capitalized 04.30.25
Maintenance Trailer	Plant Operations		5,075	(5,075)	Completed	Capitalized 04.30.25
Clinic Exam Carts (2)	Clinic		8,278	(8,278)	Completed	Capitalized 05.31.25
Totals - Non Threshold Projects		**136,000**	**101,140**	**34,860**		

SOUTHERN COOS HOSPITAL & HEALTH CENTER
CAPITAL PURCHASES SUMMARY FY2025

Approved Projects:

Budgeted Threshold Projects (>$15,000)

Project Name	Department	Budgeted Amount	Total Spending	Amount Remaining	Status	Notes
Meal Carts	Dietary	18,000		18,000		
Floor Replacement for Various Departments	Engineering	36,000		36,000		
Vital Sign Machines (10 EA)	Engineering	45,000		45,000		
Building Automation (HVAC)	Engineering	95,000		95,000		
ER Signage	Engineering	25,000	14,194	10,806	Completed	Capitalized 04.30.25
Parking Lot Resurface	Engineering	30,000	53,115	(23,115)	Completed	Capitalized 04.30.25
Air Handler	Engineering	150,000		150,000		
Gurney (x3)	ER	45,000		45,000		
Storage Server Replacement	Information Systems	15,000		15,000		
DataCenter Battery Backup Replacement	Information Systems	19,000		19,000		
Blood Culture Incubator w/ Synapsys (BD FX 40)	Lab	20,500		20,500		
Bacterioscan	Lab	23,500		23,500		
Biosafety Cabinet Type II Class 2B (Hood)	Lab	25,000		25,000		
BACT Alert Combination System	Lab	35,000		35,000		
Bariatric Bed	Med Surg	31,000		31,000		
Cardiac Monitors	Med Surg	29,000		29,000		
Second Ultrasound Machine	Radiology	170,000		170,000		
Ultrasound Echo Bed	Radiology	20,000		20,000		
Vyntus PFT	Respiratory	75,000		75,000		
Liposuction Equipment	Surgery	50,000		50,000		
Sonosite Ultrasound	Surgery	25,000		25,000		
Medication Management System	Surgery	25,000		25,000		
Glide Scope	Surgery	25,000	15,544	9,456	Completed	Capitalized 08.31.24
Arthroscopy Tower Light Source	Surgery	20,000		20,000		

Un-Budgeted Threshold Projects (>$15,000)

OP Pharmacy	Pharmacy		255,038	(255,038)	Completed	Capitalized 06.30.25
2nd Street Building Office Space	Administration		34,882	(34,882)	In Progress	
Business Building Remodel to Clinic Space	Administration		19,555	(19,555)	In Progress	
Master Facilities Plan	Administration		4,113	(4,113)	In Progress	
Clinic Exam Tables	Clinic		18,713	(18,713)	Completed	Capitalized 04.30.25
		-		-		
Totals - Threshold Projects		**1,052,000**	**415,155**	**636,845**		
Grand Total		**1,188,000**	**516,295**	**671,705**		