Northern Inyo Hospital

May 19 2021 Regular Meeting

May 19 2021 Regular Meeting - May 19 2021 Regular Meeting

Agenda, May 19 2021 Regular Meeting

Agenda, May 19 2021 Regular Board meeting 2

Billing Services Agreement with OutSource Inc.

Billing Services Agreement with OutSource Inc. 5

Policy and Procedure, Sanctions for Breach of Patient Privacy

Policy and Procedure, Sanctions for Breach of Patient Privacy 19

Policy and Procedure, Funding Requests of NIH Foundation

Policy and Procedure, Funding Requests of NIH Foundation 23

Policy and Procedure, Grant Program Activities

Policy and Procedure, Grant Program Activities 24

Chief of Staff Report

Medical Executive Committee Report, May 2021 30
MEC Policy and Procedure approvals 31

Consent Agenda

District Board Minutes, April 21 2021 regular meeting 89
Interim Chief Executive Officer report 95
Chief Medical Officer report 113
Chief Nursing Officer report 116
Pioneer Home Health quarterly report 117
Pioneer Home Health quarterly report (part 2) 121
Eastern Sierra Emergency Physicians quarterly report 129
Policy and Procedure annual approval 131
Financial and Statistical reports as of March 30 2021 134
District Board Minutes, April 28 2021 Special Meeting 141

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
May 19, 2021 at 5:30 p.m.

Northern Inyo Healthcare District invites you to attend this Zoom meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. NIHD and Inyo County Covid-19 update (*information item*).
   B. Moment of appreciation by Board members for District employees and providers (*information item*).
   C. NIHD Strategic Plan update, David Sandberg (*information item*).
   D. Cerner Implementation update (*information item*).
   E. Construction project updates, Colombo Construction (*information item*).
   F. Billing Services Agreement with OutSource Inc. (*action item*).

G. Policy and Procedure approval, *Sanctions for Breach of Patient Privacy Policies* (*action item*).

H. Policy and Procedure approval, *Funding Requests of NIH Foundation* (*action item*).

I. Policy and Procedure approval, *Grant Program Activities* (*action item*).

4. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Reappointment for Calendar Years 2021-2022 (*action item*):

1. John Daniel Cowan, MD (*anesthesiology*) – Active Staff

B. Policy and Procedure Approvals (*action items*):

1. *DI – Radiation Protection for the Patient*
2. *Nursing Bedside Swallow Screen*
3. *District-Wide Quality Assurance and Performance Improvement (QAPI) Plan FY 2021*
4. *MERP: Plan to Eliminate or Substantially reduce Medication-Related Errors*
5. *Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Remediation, or New Construction Projects*
6. *Cleaning and Care of Surgical Instruments*
7. *Packaging, Wrapping, and Dating Trays and Instruments*
8. *Precleaning and Returning Instruments to Sterile Processing*
9. *Medical Staff Department Policy – Outpatient Medicine*

C. Outpatient Medicine Critical Indicators (*action item*).

D. Emergency Department Privilege Form (*action item*).

E. Medical Executive Committee report (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the April 21 2021 regular meeting
6. Approval of minutes of the April 28 2021 special meeting
7. Interim Chief Executive Officer report
8. Chief Medical Officer report
9. Chief Nursing Officer report
10. Financial and Statistical reports as of March 31 2021
11. Policy and Procedure annual approvals

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12. NIHD Committee updates from Board members (*information items*).
13. Reports from Board members (*information items*).

14. Adjournment to Closed Session to/for:
    A. Conference with legal counsel, existing litigation (*pursuant to Gov. Code 54956.9(d)(1*)). One case: NIHD v. SMHD.
    B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (*pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9*) two cases.
    C. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957 (b*)) title: Interim Chief Executive Officer.
15. Return to Open Session and report of any action taken (*information item*).
16. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

BILLING SERVICES AGREEMENT

This Billing Services Agreement (the "Agreement") is made and entered into effective as of the 17th day of May 2021 (the "Effective Date") by and between OutSource, Inc. (D.B.A. OS inc.), a Wisconsin corporation, ("OutSource") and Northern Inyo Healthcare District, a California Hospital District organized and operating under the California Health Care District Law ("Client").

R E C I T A L S

A. Client operates hospital, in or through which provide a variety of healthcare services.

B. OutSource provides administrative, billing, and collection services on behalf of hospitals and health care providers.

C. Client desires to contract with OutSource to provide the billing and billing related services with respect to Client's healthcare services payable by various payers and OutSource is willing to provide such services on and subject to the terms hereof.

NOW, THEREFORE, in consideration of the mutual promises herein contained, and other good and valuable consideration, the adequacy and receipt of which are acknowledged, it is agreed as follows:

A G R E E M E N T

I. Services.

I.1 In General

(a) During the term of this Agreement, OutSource will provide reasonable and necessary billing and other services (the "Services") for healthcare services rendered by Client which are covered by various payers excluding Medicaid and Worker's Compensation payers (all these Payers are collectively referred to herein as "Payers") and secondary claims related to such services. OutSource shall bill as the agent for Client, in the name and under the provider numbers of the individual hospitals. OutSource hereunder shall include its delivery of services to Client as set forth in each Statement of Work (SOW) executed by the parties (a sample of such SOW is attached hereto as Exhibit B (the "Services")).

Without limiting the generality of the foregoing, Services include the following.

(i) Prepare and submit to Payers all initial claims and bills for Client within 1 business day after the receipt of accurate billing and coding data from Client.

(ii) Prepare and submit all secondary claims and bills within 1 day after receipt of payment or nonpayment determination from Payers.

(iii) Post and reconcile payments received by Client within 1 business day after receipt of payment batch information from Client.

(iv) Respond to and follow up with all Payers and insurance plans billed within 35 days from claim submission date.

(v) Report on claim submission and aging of claims submitted by OutSource.

(vi) Respond to any message or inquiry from a Payer within 5 days concerning a bill submitted by OutSource. If the Payer's inquiry requires a response from Client's medical records department, OutSource shall notify Client of the inquiry.

(vii) Provide or arrange for appropriate storage and data back-up for all records pertaining to Client's bills hereunder, accessible to Client at all reasonable times.

(viii) Conference regularly with representatives of Client to discuss results, problems, and recommendations.

(ix) Maintain auditable records of all Services performed for at least (7) years.

(x) Retain all billing records not tendered or returned to Client on any termination of this Agreement for at least seven (7) years. This undertaking will expressly survive the termination of this Agreement.

(xi) Perform follow-up efforts on submitted claims to secure payments from Payers (such follow-up shall not include commencing litigation).

(xii) Provide Client with the data necessary for collection services to be performed when an account has received all the payments payable by Payers and the balance of the account is the responsibility of the patient.

(xiii) Notify Client immediately in writing of any notices of audit, requests for medical records or other documentation or information out of the normal course of business from representatives of Payers.

(xiv) Notify client of payer and patient overpayments requiring refunds within 30 days of account credit balance.

(b) OutSource is appointed as the agent of Client under this Agreement solely for the express purposes of this Agreement to billing, receiving and storing documents related to the Payers. OutSource will have no authority to pledge credit, contract, or otherwise act on behalf of Client except as expressly set forth herein.

(c) In the performance of their obligations hereunder, the parties agree to abide by all applicable federal and state patient confidentiality laws and regulations including, but not limited to, the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the parties agree to comply with the HIPAA Compliance Requirements attached hereto as Exhibit A, the terms of which are incorporated herein by this reference.

I.2 Personnel. OutSource shall employ or otherwise provide staff to furnish the Services. OutSource agrees to confirm that as of the Effective Date and throughout the term of the Agreement, no OutSource personnel has ever been excluded or is subject to exclusion from any federal health care program or convicted of any offense related to fraud in the provision of health care services. Nothing in the foregoing shall be construed to restrict OutSource from engaging independent contractors ("Contracted Personnel") to provide Services under this Agreement, provided such individuals meet the requirements set forth in this Section I.2. In addition to and notwithstanding any termination provision set forth in Section VII (Term and

Termination) of the Agreement and Exhibit A, if either party is excluded from any federal health care program, the other party shall have the immediate right to terminate the Agreement. In the event a party has employed or contracted with an excluded person, that party shall immediately terminate its relationship with the excluded person, or the other party shall have the immediate right to terminate the Agreement. Both parties agree to continuously monitor the OIG List of Excluded Individuals/Entities and the government disbarment list and notify each other within a reasonable period of time of the exclusion of a person employed by, or contracted with, such party.

II. Obligations of Client.

II.1 Coding Information. Client shall provide to OutSource all necessary information relating to patient insurance coverage. Client shall provide OutSource with accurate information as to the health care services provided and the appropriate ICD-10 diagnosis codes or other billing code for each such service (collectively "Coding Data"). Client will provide OutSource with the HCPCS and CPT-4 codes for such services, with review of the accuracy of these codes by Client. Client shall also be solely responsible for ensuring that all billed services are properly documented, are medically necessary and are coded and supported in compliance with all applicable laws. The parties expressly agree that OutSource may rely on the completeness and accuracy of all Coding Data provided by Client in the preparation and submission of bills as well as that all services provided were medically necessary and have been accurately documented by qualified medical personnel.

II.2 Patient Information. Client shall provide to OutSource reasonable access to patient registration and demographic data, dictation, discharge summaries, medical record entries, charge documents, and other data reasonably necessary to perform OutSource's services. Client shall be responsible to ensure that all medical records and patient information is provided to OutSource in compliance with all confidentiality laws.

III. Obligations with Respect to Monitoring and Policies and Procedures.

III.1 Monitoring. OutSource acknowledges and agrees that, if requested by Client's compliance program, OutSource shall be subject to routine monitoring, review, and, potentially, external audit (limited to OutSource activities used in performance of this Agreement). OutSource agrees to cooperate fully in any such review conducted in connection with the administration of Client's compliance program.

III.2 Policies and Procedures. Client will provide OutSource with a copy of certain policies and procedures relating to business office operations. OutSource agrees to abide by all the terms and conditions of the Policies, as the same may be amended from time to time. Client shall notify OutSource in writing of any modifications or amendments to the Policies, which modifications or amendments shall be binding on OutSource upon receipt thereof.

IV. Compensation.

Client shall pay Outsource in accordance with the terms set forth in the applicable Statement of Work Addendum (Exhibit B). This Agreement allows for multiple Statement of Work Addendums between Client and Outsource.

V. Accounts Receivable.

OutSource acknowledges and agrees that OutSource has no ownership interest in the accounts receivable and that all collections derived from Client's services belong to Client. Payments on bills will be made directly to Client. If OutSource ever receives any payment on any such bill, it shall immediately remit the same to Client. OutSource shall not negotiate, and shall not have any authority to negotiate, any check payable to Client from Payers.

VI. OutSource's Reliance on Others; Limitation on Liability.

Client agrees and acknowledges that efficientC (or other vendors) software ("Software Programs") utilized by OutSource are not designed to be one hundred percent (100%) foolproof, and will not detect all possible errors made by Client or OutSource. Client further acknowledges that Payers' guidelines and regulations are subject to interpretation by the applicable governmental agency. OutSource does not represent or guarantee that a governmental agency will not interpret a guideline or regulation in a manner inconsistent with the Software Programs used by OutSource. OutSource's sole obligation is to maintain and to utilize the currently available updates of the Software Programs. Furthermore, Client hereby acknowledges and agrees that OutSource is not responsible and shall bear no liability for the nature or accuracy of the information provided by Client or used in conjunction with the Software Programs or the form and substance of the underlying transactions thereto. OutSource shall not be responsible for any Client provided information that is inaccurate or for any transaction to which such information related that violates or breaches any applicable federal, state, or local laws, rules or regulations. OutSource shall not be responsible and shall bear no liability for data entry errors or other actions or omissions made by Client's personnel. Client accepts and acknowledges: that use of the Software Programs may not detect all billing errors or irregularities; that not all errors or irregularities detected through the use of the Software Programs will prove on review to have been actual errors or irregularities; and that errors or irregularities which appear in submissions to Payers could lead to criminal or civil liability of Client for false, fraudulent or otherwise improper claims. Client is solely responsible for all submissions to Payers, including the accuracy and propriety of all such submissions, and for making all determinations of and taking any action to disclose any billing errors.

In no event will OutSource be liable for consequential, incidental, indirect, punitive or special damages (including loss of profits, data business or goodwill) regardless of the nature of the claim.

VII. Term and Termination.

VII.1 Term. This Agreement shall be effective as of May 17, 2021 and shall continue in effect until September 30, 2021. The term hereof shall automatically renew for successive one-year terms unless either party provides written notice of its election to terminate the Agreement, which notice must be given no later than sixty (60) days prior to the end of the then-effective term.

VII.2 Default. This Agreement may be terminated prior to the end of the term if either party breaches any of its material agreements herein and such breach continues for a period of thirty (30) days after written notice. Notwithstanding the foregoing, if a breach is not of a type that is curable or is not curable within such thirty (30) day period, the right to terminate or seek other remedies shall be delayed for the period necessary to cure the default provided the

defaulting party commences the cure within thirty (30) days and diligently pursues the cure to completion thereafter.

VII.3 Transfer of Accounts; Continued Services after Termination. Upon expiration or termination of this Agreement, the following shall occur: OutSource shall deliver and transfer to Client promptly upon request, all records, and other property of Client in its custody (collectively, "Documentation"), including without limitation, the following: paper and digital copies of information regarding open accounts in standard form and format and non-proprietary information concerning Payers and claims processing, all without additional charge. OutSource shall, in addition, otherwise furnish reasonable cooperation and assistance in any transition to Client, or its successor billing agent.

VIII. Books and Records.

VIII.1 Record Keeping. OutSource shall comply with all laws, regulations, and ordinances now in effect or hereafter adopted regarding the retention and availability of its books and records related to the performance of its obligations under this Agreement, including without limitation the following:

(a) Until the expiration of five (5) years after the furnishing of all Services pursuant to this Agreement, OutSource shall make available, upon written request to the Secretary, or upon request to the Comptroller General, of any of their duly authorized representatives, the Agreement, and books, documents and records of OutSource that are necessary to certify the nature and extent of such costs, and,

(b) If OutSource carries out any of the duties of the Agreement through a subcontract, with a value or cost of $10,000 or more over a twelve-month period, with a related organization (as that term is defined by regulation), such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary, or upon request to the Comptroller General, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

VIII.2 Access to Books and Records. OutSource shall maintain and retain complete and accurate source documents, billing information, and other books and records necessary or appropriate for the performance of the Services. Client shall be permitted access upon reasonable notice to all books and records relating to the performance of this Agreement in the possession and control of OutSource, including all billing files.

IX. Change of Law.

If there is a change in any statute or regulation, state or federal, which affects this Agreement or the activities of either party under this Agreement or any change in the judicial or administrative interpretation of any such statute, or regulation and either party reasonably believes that the change will have a substantial adverse effect on that party's business operations or its rights or obligations under this Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement concerning the modification of this Agreement within the earlier of thirty (30) days after the date of the notice seeking renegotiation

or the effective date of the change, or if the change is effective immediately then either party may immediately terminate this Agreement by written notice to the other party.

X. Independent Contractors.

In the performance of this Agreement, it is mutually understood and agreed that OutSource is at all times acting and performing as an independent contractor with, and not as an employee, joint venturer or lessee of, Client. OutSource shall not have any claim under this Agreement or otherwise against Client for workers' compensation, unemployment compensation, sick leave, vacation pay, pension or retirement benefits, Social Security benefits or any other employee benefits, all of which shall be the sole responsibility of OutSource. Client shall not withhold on behalf of OutSource or any OutSource Personnel any sums for income tax, unemployment insurance, Social Security or otherwise pursuant to any law or requirement of any government agency, and all such withholding, if any is required, shall be the sole responsibility of OutSource.

XI. Force Majeure.

Notwithstanding any provision contained herein to the contrary, OutSource shall not be deemed to be in default hereunder for failing to perform or provide any of the Services if such failure is the result of any labor dispute, act of God, inability to obtain labor or materials, unavailability for any reason (including malfunctioning) of information systems or Software Programs, governmental restrictions or any other event which is beyond the reasonable control of OutSource.

XII. Third-Party Beneficiaries.

None of the provisions contained in this Agreement shall be deemed to confer any benefit on any person not a party to this Agreement.

XIII. Governing Law.

This Agreement shall be governed by and interpreted under the laws of the State of California.

XIV. Entire Agreement.

This Agreement, together with all exhibits and appendices hereto, constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior documents, representations, and understandings of the parties which may relate to the subject matter of this Agreement. No other understanding, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind either party.

XV. Amendment.

No modification, amendment or addition to this Agreement, nor waiver of any of its provisions, shall be valid or enforceable unless in writing and signed by both parties.

XVI. Headings.

The headings set forth herein are for the purpose of convenient reference only and shall have no bearing whatsoever on the interpretation of this Agreement.

XVII. Notices.

Any notice, demand, request, consent, approval or other communication required or permitted hereunder to be served on or given to either party hereto by the other party shall be in writing and shall be deemed to have been served or given on the date of delivery if delivered in person to the party named below, or if delivered by certified or registered mail, postage prepaid, return receipt requested, or other reputable delivery service such as Federal Express, upon the date indicated on the return receipt if addressed as follows:

If to OutSource:
W237N2920 Woodgate Road, Suite 100
Pewaukee, WI 53072
Attn: Lori Zindl

If to Client:
150 Pioneer Lane
Bishop, CA 93514
Attn: Vinay Behl ,
Accounting Dept

or at such other address, and to the attention of such other person, as either party may designate in writing from time to time.

XVIII. Insurance

At all times during the term of this Agreement, OutSource shall procure and maintain comprehensive general liability insurance covering itself and its employees providing services pursuant to the Agreement on an occurrence basis in the minimum amounts of One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate of all claims. OutSource shall maintain worker's compensation coverage equal to statutory limits and shall obtain a waiver of subrogation with respect to the worker compensation coverage.

IN WITNESS WHEREOF, the parties hereto have entered into the Agreement as of the Effective Date.

By:_____

Name:Kelli Davis, MBA_____

Title:_Interim CEO_____

Date:_____

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop CA, 93514

By:_____

Name:LoriZindl_____

Title: President

Date:_____

OutSource, Inc

W237 N2920 Woodgate Road, St. 100

Pewaukee, WI 53072

EXHIBIT A

HIPAA COMPLIANCE REQUIREMENTS

I. **Definitions**. The following terms, when used in this Exhibit, shall have the meanings set forth below. Capitalized terms not defined herein shall have the meaning set forth in HIPAA. For purposes hereof "OutSource" means OutSource, Inc. and "Client" means Northern Inyo Healthcare District.

I.1 "Designated Record Set" has the meaning set forth in HIPAA.

I.2 "Disclose" and "Disclosure" mean, with respect to PHI, the release, transfer, provision of access to, or divulging in any other manner of PHI outside OutSource's internal operations or to other than its employees.

I.3 "HIPAA" means Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160, 162 and 164).

I.4 "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium, that: (i) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; (ii) identifies the individual (or for which there is a reasonable basis for believing that the information can be used to identify the individual); and (iii) is received by OutSource from or on behalf of Client, or is created by OutSource, or is made accessible to OutSource by Client.

I.5 "Required by Law" has the meaning set forth in HIPAA.

I.6 "Secretary" means the Secretary of the U.S. Department of Health and Human Services.

I.7 "Use" or "Uses" mean, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such PHI within OutSource's internal operations.

II. **Obligations of OutSource**. To the extent OutSource has been provided PHI, OutSource shall comply with HIPAA as follows:

II.1 Permitted Uses and Disclosures of PHI. OutSource may:

(a) Use and Disclose PHI solely as necessary to perform services for, or on behalf of, Client as described in the Agreement; provided that such Use or Disclosure would not violate HIPAA if done by Client;

(b) Use and Disclose PHI for the proper management and administration of OutSource and to carry out its legal responsibilities; provided that with respect to any such Disclosure either: (i) the Disclosure is Required by Law, or (ii) OutSource obtains reasonable assurances from the person to whom the PHI is to be Disclosed that such person will hold the PHI in confidence and will not Use and further Disclose such PHI except as Required by Law and for the purpose(s) for which it was Disclosed by OutSource to such person, and that such

person will notify OutSource of any instances of which it is aware in which the confidentiality of the PHI has been breached;

(c) Use PHI to create aggregated or de-identified information in accordance with HIPAA; and

(d) Use or Disclose PHI to report violations of law to appropriate federal and state authorities in accordance with HIPAA.

II.2 Adequate Safeguards for PHI. OutSource warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of PHI in any manner other than as permitted by this Exhibit.

II.3 Mitigation. OutSource agrees to mitigate, to the extent practicable, any harmful effect that is known to OutSource of a Use or Disclosure of PHI by OutSource in violation of the requirements of this Exhibit.

II.4 Reporting Non-Permitted Use or Disclosure and/or Security Incident. OutSource shall report to Client each Use or Disclosure that is made by OutSource, its employees, representatives, agents or subcontractors that is not specifically permitted by this Exhibit. In addition, OutSource shall report to Client each Security Incident that occurred to OutSource or its agents or subcontractors.

II.5 Availability of Internal Practices, Books and Records to Government Agencies. OutSource agrees to make its internal practices, books, and records relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining Client's compliance with HIPAA.

II.6 Access to and Amendment of Disclosures of PHI. OutSource shall, to the extent Client determines that any PHI constitutes a Designated Record Set and as required by HIPAA: (i) provide Client access to, and copies of, PHI specified by Client; and (ii) make any amendments to PHI that are requested by Client.

II.7 Accounting of Disclosures. Upon Client's request, OutSource shall provide to Client an accounting of each Disclosure of PHI made by OutSource or its employees, agents, representatives or subcontractors as required by HIPAA.

II.8 Use of Subcontractors and Agents. OutSource shall require each of its agents and subcontractors that receive PHI from OutSource to comply with all the terms of this Exhibit.

II.9 Security. OutSource shall maintain a privacy and security program protecting the confidentiality, integrity and availability of PHI that OutSource creates, receives, maintains or transmits on behalf of Client that includes administrative, technical and physical safeguards appropriate to the size and complexity of OutSource's operations and the nature and scope of its activities and as otherwise required by HIPAA.

III. **Obligations of Client**.

III.1 Notice of Privacy Practices. Upon OutSource's request, Client shall provide OutSource with a copy of its privacy practices, developed in accordance with HIPAA, and any changes thereto.

III.2 Changes/Revocation in Permission. Client shall provide OutSource with any changes in, or revocation of, permission of an individual to Use and/or Disclose PHI if such changes or revocation affect OutSource's permitted Uses or Disclosures;

III.3 Specific Arrangements. Client shall notify OutSource, in writing and in a timely manner, of any arrangements permitted or required of Client under HIPAA that may impact in any manner the Use and/or Disclosure of PHI by OutSource under this Agreement, including, but not limited to, restriction on the Use and/or Disclosure of PHI as provided for in HIPAA and agreed to by Client.

III.4 Other Business Associates. Client shall require that all of its business associates agree in writing to similar terms and conditions as are contained in this Exhibit in accordance with the HIPAA. Client may request OutSource to Disclose PHI to other business associates of Client. Such requests must be made in writing, specify the authorized recipient (i.e., name of other business associate), and the nature and duration of the Disclosure. Client represents and warrants that any requests made pursuant to this Section 3.4 (Other Business Associates) are permissible under the HIPAA, by virtue of a business associate relationship having been established between the Client and other business associate, and Client shall indemnify OutSource for any improper Uses and/or Disclosures of PHI made at the direction or request of Client.

III.5 Requests. Client shall not request OutSource to Use and/or Disclose PHI in any manner that would conflict with HIPAA, or that would not be permissible if done by Client.

IV. **Term and Termination**.

IV.1 Termination. In addition to and notwithstanding any termination provision set forth in the Agreement, this Exhibit and Agreement may be terminated by Client, as the sole remedy to Client, if OutSource has materially breached a provision of this Exhibit and OutSource fails to cure such breach within thirty (30) business days of receiving written notice from Client of such breach (or such longer time necessary to cure such breach if the breach cannot be cured in such thirty (30) business days).

IV.2 Disposition of PHI Upon Termination or Expiration. Upon termination or expiration of the Agreement, OutSource shall either return or destroy, in OutSource's sole discretion, all PHI in the possession or control of OutSource and its agents and subcontractors related to the Agreement. However, if OutSource determines that neither return nor destruction of PHI is feasible, OutSource may retain PHI provided that OutSource: (i) continues to comply with the provisions of this Exhibit for as long as it retains PHI, and (ii) further limits Uses and Disclosures of PHI to those purposes that make the return or destruction of PHI infeasible.

V. **Miscellaneous**

V.1 Interpretation. Any ambiguity in this Agreement shall be resolved to permit Client to comply with HIPAA.

V.2 No Third-Party Beneficiaries. There are no third-party beneficiaries to this Exhibit.

EXHIBIT B

STATEMENT OF WORK ADDENDUM

This Statement of Work (SOW) serves as an addendum to the Billing Services Agreement dated May 7, 2021 between OutSource Inc (OutSource) and Northern Inyo Healthcare District (Client).

Item 1.0 Hospital or other Facility being serviced DBA:

Northern Inyo Healthcare District

Item 2.0 Project Description:

OutSource shall manage and perform all billing and billing related activities in the Cerner patient accounting system. Services to include:

- Billing – Working claim edits in Cerner and Experian
- Coding related edits and denials
- Denials and follow up on open accounts receivable from third party payers
- Self pay A/R management
- Payment posting
- Credit balances
- A/R management and reporting

Services do not include:

- Initial claim coding
- Authorization requests
- Charge Entry
- Billing and follow up for Medicaid and Worker's Compensation payers

Item 3.0 Project Performance Metrics:

- On the first day of any month, the total hospital accounts receivable more than 90 days old shall not exceed twenty percent (20%) of the total accounts receivable outstanding.
- On the first day of any month, the Hospital Gross Days Revenue Outstanding (GDRO) calculation on billed A/R shall not exceed 43.

Item 4.0 Payment Terms

OutSource shall bill Client monthly for staff and management time devoted to the project based on the contingency fees below. Terms are net 30 days.

Billed GDRO 45 or less	1.15 percent of collections
Billed GDRO greater than 45	1.00 percent of collections
Billed GDRO greater than 45 for more than 60 days	.85% percent of collections

If Billed GDRO is greater than 45 for more than 90 days, Client can terminate without notice

Client will not be charged for collections received from California Medicaid/Managed Care and Worker's Compensation payers.

By:	By:
Name:_____	Name:LoriZindl_____
Title:_____	Title: President
Date:_____	Date:_____
Northern Inyo Healthcare District 150 Pioneer Lane Bishop CA, 93514	OutSource, Inc W237 N2920 Woodgate Road, St. 100 Pewaukee, WI 53072

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

PURPOSE:

To comply with 45 CFR 164.530(e)(1) which requires "a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity"

POLICY:

Definitions:

"Sanction" means training with documentation in the employee record, disciplinary action or termination.

"Workforce" means persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

"Inadvertent Violation" means an error that results in a breach of privacy made while following District policies and procedures.

"Negligent Violation" means a breach of privacy made while incorrectly following or not following District policies and procedures.

"Deliberate Violation" means a breach of privacy made while willfully not following District policy.

"Protected Health Information" or "PHI" means any individually identifiable health information regarding a patient's medical or physical condition or treatment in any form created or collected as a consequence of the provision of health care, in any format including verbal communication.

"Unauthorized" means the inappropriate acquisition, access of, use or disclosure of protected health information without a direct need to know for medical diagnosis, treatment, or lawful use as permitted the California Medical Information Act or any other statute or regulation governing the lawful access, use, or disclosure of medical information. (California Health and Safety Code Sec. 2 1280.15)

"Malicious" means with intent to harm or with intent to gain personally.

Breach Levels by Incident

1. **Minor breach**
   A Minor Breach is inadvertent and non-malicious in nature.
   Examples include but are not limited to: distributing, emailing or faxing protected health information to the wrong individual unintentionally.

2. **Moderate breach**
   A moderate breach is negligent in nature. The intent of the violation is unclear and the evidence cannot be clearly substantiated as to malicious intent.
   Examples include but are not limited to failing to log off computer systems, failing to check a guarantor or insurance provider when registering a patient, failing to check that the provider selected for an outpatient order matches the written order presented by the patient, faxing protected health information to an unverified fax number, or a pattern of minor violations.

3. **Major/severe breach**
   A major/severe breach is a deliberate violation that purposefully or maliciously violates a patient's privacy or disregards Northern Inyo Healthcare District policy.
   Examples include but are not limited to: releasing or using data for personal gain, destroying or altering data, purposefully accessing or attempting to gain access to patient information which the employee has no work related need to access, maliciously attacking or hacking District information systems, releasing patient data with the intent to harm an individual or the District, or a pattern of repeated moderate violations.

Whistleblower Protection

a. Neither the District nor any employee of the District may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who reports any conduct that is unlawful or otherwise violates professional or clinical standards including, but not limited to the reporting of conduct that results in the breach of privacy of any patient of Northern Inyo Healthcare District.
b. Proven violation of this section will result in Immediate Loss of Employment.

Disciplinary Action

Disciplinary action, up to and including termination, based on recommended corrective actions in **Attachment A "Sanctions for Breach of Patient Privacy – Incident Severity Scale**", will be taken for any workforce member for a violation of privacy and security policies and procedures. Northern Inyo Healthcare District prohibits the use of District property for illegal purposes and for purposes not in support of Civil Code 56.36/Health and Safety Code 130200 and 1280.15.

ATTACHMENT A

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Sanctions for Breach of Patient Privacy – Incident Severity Scale

Guidelines with recommended corrective actions, once an incident and individual are identified.

		Action Level		
Level	**Intention of the Individual** Responsible for the privacy breach	**Minor**	**Moderate**	**Major/Severe**
A	**Inadvertent** • Inadvertent mistake	1	1	2
B	**Negligent/Unintentional** • Carelessness or negligence • No known or believed intent	2	3	3-4
C	**Intentional** • Due to curiosity or concern	2	3	3-4
D	**Intentional** • Malicious intent, including accessing or use of information in a domestic dispute • Personal financial gain • Willful or reckless disregard of policies, procedures or law	4	4	4

Action Level:

1. Re-training and/or coaching memo

2. Documented verbal counseling or written warning, as determined by leadership in conjunction with Human Resources

3. Written warning, probation, or suspension, including notification that further violation of the privacy of patient health information will result in termination, as determined by leadership in conjunction with Human Resources.

4. Termination

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Action Level Modification:

Action level may be modified by the consensus of the Privacy Officer, Human Resources Director, and the employee's manager by considering the following:

1. Previous history or corrective action (level of action may increase based on repeat offenses)
2. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.

References

1. 45 CFR 164.530(e)(1)
2. California Health and Safety Code Sec. 2 1280.15
3. Civil Code 56.36
4. California Health and Safety Code 130200

Approval	**Date**
Compliance Committee	10/24/2017
Administration	11/10/2017
Non-Clinical Committee Oversight Committee	2/22/2021
Board of Directors	11/15/2017
Last Board of Directors Review	5/15/19

Developed:
Revised 12/2013 KH, 10/20/2017 PD, 2/11/2021
Reviewed 12/16/15, 4/29/2019
Supersedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Funding Requests of NIH Foundation	
Scope:	Manual:
Source:	Effective Date: TBD

PURPOSE:

1. This policy is adopted to define Northern Inyo Healthcare District (District) goals and objectives regarding the internal request of funds from the Northern Inyo Hospital Foundation (Foundation). The Foundation's sole purpose is to fund unmet needs for NIHD. Timely requests for funds to address critical needs is of the upmost importance to the Foundation and this policy will help expedite that process.

POLICY:

1. District staff at all levels and physicians can present needs for funding by the Foundation. This process for staff would initiate with you and your direct supervisor having an initial discussion to see if there are already District resources planned for this activity or it falls outside the current scope of District funding. If the request is coming from a physician, then that physician would have a discussion directly with the Chief Medical Officer (CMO).

2. If it is determined that there are no current District resources to fund this need, then the District's Project Request Form would be completed and used to present the idea up that area's chain of command until it reaches that area's Senior Leader or directly to the CMO. The Executive Director of the Foundation will also receive a copy of the request form and inform their Senior Leader on what is being reviewed at the departmental/physician level.

3. Once it reaches the Senior Leader position for that area, it will be evaluated in the larger scope of the District's needs and priorities. If found to qualify as an urgent, unmet need, that Senior will take it to the broader Senior Leadership group for discussion and approval to present to the Foundation.

4. If further information on the request is needed, then that staff person and their direct leader could be called upon to either update the Project Request Form with additional information or present in person to Senior Leadership or their designated committee.

5. Upon Senior Leadership approval, it will be presented to the Foundation's Executive Director (ED) with approval to bring before the board of the Foundation. Depending on the urgency, the ED will present to the Foundation Board at the next possible board meeting or solicit a vote through other means if the request is deemed too urgent to wait until an official board meeting can be held.

6. Notification of funding or rejection will be passed back to the Senior Leader in charge of that area by the ED. A detailed response will be provided by the ED if the proposal is rejected. That Senior Leader will in turn inform the leaders involved with the request the result of the Foundation's decision.

Committee Approval	**Date**
Non-CCOC	4/30/2021
Board of Directors	

Developed:

Reviewed:

Revised:

Supersedes:

Responsibility for review and maintenance:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Grant Program Activities	
Scope:	Manual: Grant Writing
Source: FOUNDATION ED GRANT WRITER	Effective Date: TBD

PURPOSE:

1. This policy is adopted to define Northern Inyo Healthcare District (NIHD) goals and objectives regarding grant activities. Alternative funding via grant programs from outside agencies is an excellent means to supplement the hospital's budget and fund worthwhile and innovative projects. External funding sources may include federal and state governments, corporations, private foundations, and service groups.

POLICY:

1. NIHD shall exercise "mission driven grantsmanship," that is, shall only institute grant funded programs that are consistent with and operate to further the hospital's vision, mission statement and strategic plans.

2. NIHD shall seek grant funding only from organizations whose missions and goals are consistent with those of NIHD.

3. To ensure compliance with this policy, all applications for grant funding and all grant administration shall be conducted in accordance with the Grant Administration Procedures established by NIHD.

4. The position of NIHD Grant Writer has been established to assist staff in performing grant related activities and serve as a central depository, clearinghouse and information source for grant activities and grant funded programs. However, proper grant administration is the responsibility of all staff involved in grant related activities including:
   a) Developing grant funded projects and programs;
   b) Identifying and applying for grants;
   c) Overseeing grant expenditures;
   d) Monitoring grant funded programs;
   e) Drafting periodic grant narrative and financial reports;
   f) Evaluating grant funded activities;
   g) Any other activities necessary to ensure compliance with grant requirements.

5. When a viable funding source is identified, hospital staff must assure that the proposed project complements current and planned programs. For this reason, grant requests shall be coordinated and approved.

6. Responsibility for the administration of current grant projects must be assigned to assure accountability to the grantor and compatibility with other hospital programs.

ROLES

NIHD Grant Writer:

NIHD Grant Writer shall be charged with coordinating and facilitating the grants- seeking process. Specific responsibilities include:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Grant Program Activities	
Scope:	Manual: Grant Writing
Source: FOUNDATION ED GRANT WRITER	Effective Date: TBD

1. Identifying and cultivating possible funding sources.
2. Gathering background information pertinent to possible programmatic activities.
3. Assisting with and coordinating proposal preparation.
4. Obtaining required approvals prior to submission.
5. Submitting grant application to appropriate grantor.
6. If funded, assisting Finance Division in monitoring project budgets and Expenditures.
7. Maintaining complete files on all grants from initial application through final Report.
8. Ensuring that project reports are submitted to grantor.
9. Serves as an information resource and technical advisor to staff desiring to pursue grant funding.
10. Maintains a listing of projects and programs for which grant funding is needed and actively searches for appropriate funding sources for these items.
11. Stays abreast of grant opportunities and forwards information regarding opportunities to staff that have expressed an interest in receiving such information.
12. Works closely with staff to clarify the history, needs, goals and objectives of programs and assists with drafting grant applications.
13. Monitors the filing of periodic narrative and financial reports and is available to assist Project/Program Manager with drafting narrative reports.
14. Responsible for final review of applications to ensure all requirements are addressed.
15. Once a grant is awarded, NIHD Grant Writer is responsible for ensuring that all necessary paperwork, e.g., funding agreements, Intergovernmental Agreements, etc., is complete and all related procurement and/or contracting needs are met.

Return on Investment (ROI) Committee shall be established to provide oversight of grant requests and funding availability. It is responsible for reviewing current and future funding requests. Its main charge is to ensure that the requests are aligned with the District's mission, vision and strategic plans.

The NIHD Grant Writer will request to be put on this committee's agenda as Grant Project Request Form are completed or as funding streams become available.

Once the ROI Committee reviews the prospective requests, it may be necessary to form subcommittees to help Project/Program Manager or NIHD Grant Writer form a more complete request.

The finalized requests are then ranked by the ROI committee and Senior Management has final approval on which funding requests are pursued.

The ROI Committee membership shall be composed of the following:
ROI Committee Team

Staff Support:
NIHD Grant Writer

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Grant Program Activities	
Scope:	Manual: Grant Writing
Source: FOUNDATION ED GRANT WRITER	Effective Date: TBD

Applicant and Applicable Division Director
Others as requested by ROI Committee

Responsible Department:
Due to the significant number of potential external funding sources, case-specific eligibility conditions, and detailed administrative requirements for each application, it is critical that the NIHD Grant Writer monitor all such funding opportunities.

Project/Program Manager: The person or persons requesting grant funding for a particular project or program is primarily responsible for developing the project or program and provides all the research and background information that is required to develop a detailed, well supported problem statement, proposed solution and program design. Project/Program Manager is responsible for the day-to-day operation of the project and also is responsible for assisting NIHD Grant Writer in drafting periodic narrative/progress reports as required and ensuring compliance with program goals and evaluation criteria.

NIHD Controller: NIHD Controller is responsible for reviewing all grant proposals to insure adequacy and accuracy of the proposed budget and other financial information and to ensure all financial requirements are addressed. NIHD Chief Fiscal Officer is also responsible for establishing grant center numbers, maintaining grant financial records and completing periodic grant financial reports.

Sanctions:
Violations of this policy may result in disciplinary measures for the involved employee.

Renewal / Review:

This policy and the referenced procedures shall be reviewed annually to determine if they comply with current regulations and are compatible with current NIHD operations. In the event that significant related regulatory changes occur or operations change, the policy and referenced procedures will be reviewed and updated as needed.

PROCEDURE:

PROJECT/PROGRAM DESIGN AND GRANT PLANNING:

1. When informed that grant funding is desired for a particular purpose, NIHD Grant Writer requests that staff complete a Grant Project Request Form located on the Intranet. NIHD Grant Writer assists Project/Program Manager, but is not primarily responsible for completing the Grant Project Request Form, conducting background research, designing the program or project, determining the goals and objectives, defining program success or identifying needed resources. This application contains all information generally required for most grant applications.

   By utilizing the Grant Project Request Form, the requestor
   - Succinctly describes the project idea

- Identifies categories of community needs or opportunities addressed by the project (Issue statement or needs)
- Pinpoints the specific need or issue the project addresses (Goal)
- Specifies changes/outcomes to be achieved (specific objectives)
- Lists major steps required
- Identifies needed resources
- Estimates project costs
- Names potential partners
- Describes evaluation methods

2. Upon completion of the Grant Project Request Form, NIHD Grant Writer will request the ROI Committee review the Grant Project Request Form at its earliest possible meeting, with the NIHD Grant Writer and Project/Program Manager in attendance. If there are no significant changes determined by this committee, then the application will be completed by the NIHD Grant Writer and Project/Program Manager.

3. If the project is to be a collaborative effort between NIHD and outside agency(ies), NIHD Grant Writer assists in the facilitation of potential partnership identification, discussions and execution of partnership agreements as appropriate.

4. NIHD Grant Writer maintains an inventory of projects and programs for which grant funding is desired and targets grant opportunity research to funders whose funding priorities and goals are compatible with NIHD's.

APPLYING FOR A GRANT

A. Preliminary Proposals

1. Initiation of Proposal
   a. Department Directors or Managers contact NIHD Grant Writer for assistance with locating funding sources for a particular program or project.

   or

   b. NIHD Grant Writer identifies project and funding source and contacts personnel listed above.

2. Preliminary proposal is prepared following the procedure for "PROJECT/PROGRAM DESIGN AND GRANT PLANNING"

3. Preliminary proposal is forwarded to NIHD Grant Writer by appropriate Director with an indication of his or her concurrence.

4. NIHD Grant Writer and Project/Program Manager takes the preliminary proposal to the

ROI Committee.

5. Following ROI Committee approval, NIHD Grant Writer and Project/Program Manager may file a preliminary proposal, letter of inquiry or letter of intent as required by funding agency.

6. If funding agency indicates interest, or if funding agency's guidelines preclude submitting a preliminary proposal, a formal proposal is prepared by the NIHD Grant Writer and Project/Program Manager.

B. Formal Proposals

1. Upon acceptance to formally apply, Project/Program Manager works closely with NIHD Grant Writer to draft an application/proposal. This includes reformatting the previously drafted Grant Project Request Form to meet funder's application requirements, obtaining additional information as required by funder, finalizing the proposed budget and obtaining the required authorization signatures.

2. If NIHD Grant Writer is not directly involved in writing the proposal, a draft must be sent to Grants Office 20 working days before the deadline for comment and advice on format, budget, prevailing fringe benefit and indirect cost rates, etc. Finance Division may be contacted on budget items.

3. Formal proposals, in final form, must be submitted to Grants Office by appropriate Director ten working days before the deadline for final review.

4. The final proposal is sent to funding agency by NIHD Grant Writer.

ADMINISTRATION AND MAINTENCE OF GRANT AWARD

1. When a grant is awarded, notice of grant/funding award is provided by NIHD Grant Writer to all relevant parties at the District.

2. NIHD Grant Writer oversees execution of applicable grant implementation contract, e.g., funding agreements, Intergovernmental Agreements, etc.

3. NIHD Grant Writer ensures that all required contractual arrangements are made and procurement requirements are met.

4. NIHD Grant Writer will instruct NIHD Controller to create a new General Ledger fund account if one does not already exist for the funded project.

5. Project/Program Manager assists NIHD Grant Writer in drafting all narrative/progress reports that are required by funder.

Title: Grant Program Activities	
Scope:	Manual: Grant Writing
Source: FOUNDATION ED GRANT WRITER	Effective Date: TBD

6. NIHD Grant Writer monitors to ensure required reports are filed in a timely manner with funder.

7. If changes to the program or budget are required, Project/Program Manager must work with NIHD Grant Writer to draft and submit a grant modification request to funder. Copies of all program or budget modifications are provided to NIHD Grant Writer and NIHD Controller.

8. NIHD Grant Writer ensures that grant expenditures do not exceed grant awards or available funding if balances are carried forward from a preceding year.

Committee Approval	**Date**
NCCOC	4/30/2021
Board of Directors	

Developed:
Reviewed:
Revised:
Supersedes:

Responsibility for review and maintenance:

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: May 11, 2021
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Medical Staff Reappointments for Calendar Years 2021-2022 *(action item)*
    1. John Daniel Cowan, MD (*anesthesiology*) – Active Staff

B. Policies and Procedures (*action items*)
    1. *DI – Radiation Protection for the Patient*
    2. *Nursing Bedside Swallow Screen*
    3. *District-Wide Quality Assurance and Performance Improvement (QAPI) Plan FY 2021*
    4. *MERP: Plan to Eliminate or Substantially Re duce Medication-Related Errors*
    5. *Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Remediation, or New Construction Projects*
    6. *Cleaning and Care of Surgical Instruments*
    7. *Packaging, Wrapping, and Dating Trays and Instruments*
    8. *Precleaning and Returning Instruments to Sterile Processing*
    9. *Medical Staff Department Policy – Outpatient Medicine*

C. Outpatient Medicine Critical Indicators (*action item*)

D. Emergency Department Privilege Form (*action item*)

E. Medical Executive Committee Meeting Report (*information item*)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Radiation Protection for the Patient	
Scope:	Manual: Administrative
Source: DIRECTOR OF DIAGNOSTIC SERVICES	Effective Date: 3/18/2021

PURPOSE:

1. To ensure that all personnel adhere to the American Association of Physicists in Medicine's recommendations of the discontinuation of patient gonadal and fetal shielding during x-ray based imaging.
2. Identify advances in medical imaging technology (automatic exposure control) has greatly reduced the amount of radiation required to create a quality image. These advances have made patient shielding a practice that introduces more risk than benefit.
3. To establish a consistent practice in all areas that utilize radiation at NIHD.

POLICY: ALARA (as low as reasonably achievable) principles shall be maintained to provide high quality imaging exams with the lowest radiation exposure to the patient.

PROCEDURE:

1. The x-ray beam shall be collimated to the area of interest. Excessive field size contributes directly to exposure of patients and scatter radiation degrades image quality.
2. Correct positioning and proper exposure techniques should be used to avoid "repeat" exposures.
3. Careful instruction shall be provided to the patient and positioning devices shall be used to avoid motion.
4. Correct side identification shall be used on all images, (specifically lead markers, and sporadic use of digital markers)
5. Fluoroscopic "beam on" time should be as little as possible to provide a high quality exam.
6. American Association of Physicists with the endorsement from American College of Radiology recommends that the use of Gonadal and fetal shielding no longer be utilized on a routine basis.
7. Lead shielding of the thyroid gland should be used in those cases where the thyroid is in line of, or very close to, the primary beam.

Reduction in patient exposure also reduces the personnel exposure from scatter radiation.

Approval	**Date**
Radiation Services Committee	**10/13/2020**
Radiology Services Committee	**03/17/2021**
Medical Executive Committee	**05/11/2021**
Board of Directors	**6/15/16**

Developed:
Reviewed: 5/5/2016
Revised: 1/18/2021, 10/13/2020, 4/8/2021
Last Board Approval:
Supersedes: *Radiation protection for the patient, 2008*
Index Listings:
https://www.aapm.org/org/policies/details.asp?id=468&type=PP&current=true
https://www.aapm.org/org/policies/documents/CARES_FAQs_Patient_Shielding.pdf
https://www.thyroid.org/wp-content/uploads/statements/ABS1223_policy_statement.pdf

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Nursing Bedside Swallow Screen	
Scope: Rehab. (Speech-language Pathologists), Nursing	Manual: Clinical Practice Manual-GNT
Source: Director of Rehab or Lead SLP	Effective Date:

PURPOSE: To establish a standard protocol for a safe and objective screen of swallowing disorders utilizing the Yale Swallow Protocol Bedside Screen prior to referral to Speech-Language Pathology Services and to establish guidelines for the use of oral care strategies in individuals with suspected aspiration or dysphagia. Swallowing screens are pass/fail and used to identify individuals who require a comprehensive assessment of swallowing by a Speech-Language Pathologist. A systematic formal dysphagia screening and aggressive oral care can decrease the risk of aspiration pneumonia in hospitals.

POLICY:

1. **Statement:** Northern Inyo Healthcare District (NIHD) is committed to providing safe quality care for its patients. This includes utilizing an appropriate and objective protocol when screening patients with suspected dysphagia.

2. **Application:** This policy applies to RNs and Speech-Language Pathologists (SLPs) working in the acute inpatient unit and Emergency Department.

3. **Training:** All RNs must demonstrate competency by completing training as outlined below:

    a. Review of Nursing Bedside Swallow Screen Policy
    b. Review of Yale Swallow Protocol listed in Appendix
    c. Completion of Yale Swallow Protocol training video listed in Policy Appendix

PROCEDURE:

1. **Patients who are appropriate for Yale Swallow Protocol include:**
    a. Individuals with suspected dysphagia
    b. Individuals who have had a stroke
    c. Individuals with suspected aspiration

2. **Exclusion criteria:**
    a. No concern for aspiration risk
    b. Unable to remain alert for testing
    c. Eating a modified diet (thickened liquids) due to pre-existing dysphagia
    d. Existing enteral tube feeding via stomach or nose
    e. Head-of-bed restrictions < 30°
    f. Tracheostomy tube present
    g. NPO by physician order
    h. If the patient's clinical status changes resulting in a new risk for aspiration, the protocol must be re-administered before oral alimentation or medications are ordered

Title: Nursing Bedside Swallow Screen	
Scope: Rehab. (Speech-language Pathologists), Nursing	Manual: Clinical Practice Manual-GNT
Source: Director of Rehab or Lead SLP	Effective Date:

3. **Administration:** If patient is deemed an aspiration risk and all exclusion criteria has been ruled out, proceed with Yale Swallow Protocol. "Yale Swallow Protocol" document available for reference at nursing station and in appendix of this policy.
    a. Brief Cognitive Screen:
        i. What is your name? Where are you right now? What year is it?
    b. Oral-Mechanism Examination:
        i. Labial closure, Lingual range of motion, Facial symmetry (smile/pucker)
    c. Perform 3-ounce water swallow challenge:
        i. Sit patient upright at 80-90° (or as high as tolerated >30°). Ask patient to drink the entire 3 ounces (90cc) of water from a cup or with a straw, in sequential swallows, and slow and steady but without stopping. (Note: Cup or straw can be held by clinician or patient.) Assess patient for interrupted drinking and coughing or choking during or immediately after completion of drinking.
4. **If patient fails Yale Swallow Protocol**
        i. Notify MD and generate Speech-Language Pathology Swallow Evaluation at MD's discretion.
        ii. Protocol may be re-administered after 24 hours or sooner if change in status has occurred.
        iii. Oral care must be implemented based on the oral care procedures outlined in Lippincott.
5. **Documentation**
    a. A ".yale_swallow_protocol" macro has been created and is available for use in any macro enabled field. Nursing can be easily incorporate documentation on the Yale Swallow protocol into an Admission or Shift Note by typing ".yale" into a text field and selecting the full phrase that pops up.

REFERENCES:

1. American Speech-Language-Hearing Association. (2004). Preferred Practice Patterns for the Profession of Speech-Language Pathology [Preferred Practice Patterns]. Available from www.asha.org/policy.
2. Ashford, J. (2015, March 28). Winter 2014 SASS Minute. Retrieved September 10, 2019, from https://www.sasspllc.com/wp-content/uploads/2014/12/Yale-Swallow-Protocol.pdf
3. Suiter, D.M., Sloggy, J., & Leder, S.B. (2014). Validation of the Yale Swallow Protocol: A prospective double-blinded videofluoroscopic study. Dysphagia, 29, 199-203.
4. "Yale Swallow Protocol." YouTube, St. Joseph's Medical Center – Education Department, 21 Mar. 2019, https://www.youtube.com/watch?v=mt4WS5IzKpw.

CROSS REFERENCE P&P:

1. Lippincott: Oral care

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Nursing Bedside Swallow Screen	
Scope: Rehab. (Speech-language Pathologists), Nursing	Manual: Clinical Practice Manual-GNT
Source: Director of Rehab or Lead SLP	Effective Date:

Approval	**Date**
CCOC	7/27/2020
Pharmacy/Therapeutics Committee	10/15/2020
Med. Services/ICU	08/06/2020
Infection Control	09/22/2020
Medical Executive Committee	05/11/2021
Board of Directors	
Last Board of Directors Review	

Developed: 2/1/2020 CLK, CJK
Reviewed:
Revised:
Supersedes:
Index Listings:

APPENDIX:

1. Yale Swallow Protocol instructional video: https://www.youtube.com/watch?v=mt4WS5IzKpw
2. Yale Swallow Protocol: https://www.sasspllc.com/wp-content/uploads/2014/12/Yale-Swallow-Protocol.pdf

District-Wide

QUALITY ASSURANCE &

PERFORMANCE IMPROVEMENT

(QAPI)

PLAN

FY 2021

SECTION 1: INTRODUCTION

MISSION, VISION AND VALUES

Northern Inyo Healthcare District (NIHD) adopted a new mission statement on 11/18/15, as follows:

"Improving Our Communities one life at a time. One Team. One Goal. Your Health."

Northern Inyo Healthcare District also adopted a new Vision in 2015, as follows:

"Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with our trusted partners."

In 2018, Northern Inyo Healthcare District adopted new Values, which are divided into three categories:

CORE VALUES: COMPASSION AND INTEGRITY

This set of values are the foundation that defines who will choose to dedicate themselves to the well-being of others.

ASPIRATIONAL VALUES: QUALITY/EXCELLENCE AND INNOVATION

This set of values drives the District to work towards making tomorrow's healthcare better than yesterday's healthcare.

PERMISSIVE VALUES: TEAM-BASED AND SAFETY

These are the values without which a patient would not allow the District to engage in her/his care.

Collectively, a focus on the Mission, Vision and Values is expected to drive the quality of patient care and services provided.

PURPOSE

The Quality Assurance and Performance Improvement (QAPI) Plan establishes a district-wide program and interdisciplinary approach to monitor, assess and improve patient care and services at Northern Inyo Healthcare District (NIHD). Although this QAPI plan will provide for the identification of existing issues or concerns and correcting them, the goal of this QAPI plan is to emphasize the identification of potential areas of concern to prevent quality of care issues from arising.

SCOPE OF SERVICE AND AUTHORITY

The scope of this plan will include all patient care and support services throughout the district and will encompass all ancillary care facilities.

The Northern Inyo Healthcare District Board of Directors is responsible for:

- Evaluating and approving this plan, which supports the Mission & Vision of Northern Inyo Healthcare District.
- Delegating the development, and implementation of the QAPI plan to the Medical Staff and the NIHD Executive Team.

The Northern Inyo Healthcare District Executive Team is responsible for:

- Guiding and monitoring quality management efforts throughout the district;
- Ensuring resources are available to allow for the implementation of quality improvement programs;
- Implementing strategies and processes that focus on achieving the agreed upon goals; and
- Coordinating quality improvement efforts with the Medical Staff.

The Northern Inyo Healthcare District Medical Staff is responsible for:

- Coordinating with the NIHD Executive Team in the development, implementation and evaluation of the district-wide QAPI Plan as it pertains to achieving quality patient care and compliance with regulatory/accreditation organizations.
- Participating in Medical Staff committees and project teams related to quality improvement.
- In accordance with the medical staff bylaws, assisting the district in fulfilling its responsibility to assure patients receive quality care.

DEFINITIONS AND PRINCIPLES

QUALITY

Quality services are services that are provided in a safe, effective, patient-centered, timely, efficient and equitable fashion.

- SAFE: Avoiding injuries to patients from the care that is intended to help them.
- EFFECTIVE: Providing services based on scientific knowledge to those who would benefit, and refraining from providing services from those not likely to benefit.
- PATIENT-CENTERED: Providing care that is respectful of, and responsive to, individual patient preferences, needs, and values.
- TIMELY: Reducing delays in providing and receiving healthcare.
- EFFICIENT: Avoiding waste, including waste of equipment, supplies, ideas and energy.
- EQUITABLE: Providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status.

PERFORMANCE IMPROVEMENT PRINCIPLES

Performance improvement is a systematic approach to assessing services and improving them on a priority basis. The NIHD approach to performance improvement is based on the following principles:

- ***Patient Focus***. Every level of service shall be viewed from the perspective of the patient. With this frame of mind NIHD will focus on the patient experience and how best to adopt changes that enhance the experience.
- ***Employee ~~Empowerment~~Engagement***. All employees shall participate in ongoing quality improvement at NIHD. Employees shall understand that along with ownership of how they engage those who contact or present to the District they also are empowered to identify issues, bring those issues to the attention of others and participate in processes intended to prevent the issue or improve the experience.
- ***Leadership Involvement***. District Leadership along with Medical Staff will serve as 'Champions' of initiatives. As Champions, they will support and encourage the goals and provide necessary intervention when needed to reach these goals. Additionally, District leadership will ensure that the employees engaged in any given quality initiative have the tools, support and resources needed to achieve the defined goals.
- ***Data Informed Practice***. The District utilizes data to identify opportunities, determine priorities and evaluate the effectiveness of quality projects with the appropriate resources ~~will support and recruit staff who have the skills to gather and analyze data in order to inform decision makers on the areas of greatest need and the impact of changes once implemented.~~
- ***Statistical Tools***. The District will apply standard statistical tools to the data collected in order to generate information that is both informative and actionable.
- ***Prevention over Correction.*** Although this QAPI plan will provide for the identification of existing issues/concerns and correcting them, the goal of this QAPI plan is to emphasize the identification of potential areas of concern to prevent quality of care issues from arising.
- ***Continuous Improvement.*** The District will commonly use Plan-Do-Study-Act method of continuous improvement. This however will not be the exclusive method used. Each endeavor undertaken will warrant an assessment of the best method available to achieve the desired goal.

SECTION 2: LEADERSHIP

The key to the success of the performance improvement process is leadership. Leaders foster teamwork and can be involved at every level of the district.

The NIHD Executive Team ensures that the district strategic plan is achieved in a manner that is focused on quality improvement and safety, maintaining organizational focus on identified goals and priorities. The NIHD Executive Team is responsible for monitoring outcomes of performance improvement and assisting with key processes when the need arises.

The Medical Staff Quality Improvement Committee is responsible for assisting the district in fulfilling its responsibility to assure patients receive quality medical care as defined in the medical staff bylaws. The Medical Staff participates in surgical case review; blood usage review; medical record review; infection control; pharmacy and therapeutics review; mortality review; utilization management; review of transfers to other facilities; credentialing and will serve, from time to time, as liaisons to quality and performance improvement activities. The ultimate goal is to improve the quality and safety of care provided to the patients of NIHD.

Every department within NIHD is responsible for implementing quality and performance improvement activities in alignment with the district-wide QAPI plan. All quality improvement initiatives are conducted as a part of district-wide and departmental quality and performance improvement. Each department manager is responsible for setting goals that give direction for process improvement. Managers and department staff identify quality indicators, collect and analyze data, develop and implement changes to improve service delivery. Ongoing monitoring assures that improvement is made and sustained. The ultimate goal is to improve the quality and safety of care that is routinely provided to the patients of NIHD.

SECTION 3: PROGRAM STRUCTURE

DISTRICT QAPI COUNCIL

The District QAPI Council is responsible for:

- The annual update of the district-wide QAPI Plan;
- Reviewing and assessing feasibility of requests for quality related projects;
- ~~Appointing subcommittees or teams to work on specific quality projects as necessary;~~
- High level trending of data, such as review of "Unusual Occurrence Reports", Pillars of Excellence Reports, and Medication Administration Improvement Committee data.
- Prioritizing QAPI projects and making recommendations to the Executive Team;
- Overseeing the progress of quality projects to assure timely implementation;
- Reporting to the Medical Staff Quality Improvement committee, the NIHD Board of Directors, and NIHD staff as appropriate;
- Oversight of education of staff and the community regarding the QAPI Plan and projects;
- ~~Appointing subcommittees or teams to work on specific quality projects as necessary;~~
- Reviewing results of project teams;
- Utilizing regulatory requirements to identify opportunities for improvement.
- ~~~~

The District QAPI Council consists of the following individuals:

- ~~Chief Nursing Officer~~Chief Medical Officer, Chair
- Board of Directors member
- Chair of the Medical Staff Quality Improvement committee, or designee
- Chief Nursing Officer ~~(e.g. CEO, COO or CMO, etc.)~~
- ~~Quality Nurse/Infection Control Preventionist~~ DON Quality & Infection Prevention
- ~~Informatics and/or Clinical Informatics representative~~ QAPI Analyst
- Project Management Specialist
- ~~~~

Additional QAPI Council Ad Hoc roles may be included:

- ~~Director of Diagnostic Services, as needed~~ Directors (DON ED & IP, DON Periop, Diagnostic Services

- Outpatient representative, as needed
- Fiscal representative, as needed
- A physician advisor for Utilization Review, or designee
- Other attendees as identified

DISTRICT COMMITTEES AND TEAMS

PROJECT TEAMS

On going project teams include:

- Alarm Fatigue
- Sharps Project
- Pain Management
- Fall Prevention
- Quality and Data

Ad hoc project teams ~~can~~ may be created, as needed, by leadership. Project teams are responsible for:

- Identifying or addressing quality and performance improvement opportunities.
- Carrying out specific quality initiative project(s).
- Monitoring progress until goals have been met and maintained.
- Standardizing processes to achieve quality improvement in patient care services.

Membership will consist of key stakeholders as identified by leadership. Project team leaders will report back to the District QAPI Council or Medical Staff committee(s), as appropriate.

SAFETY HUDDLE

NIHD values the safety of our patients, visitors, and staff and implements continuous quality improvement via safety concerns brought to the NIHD Safety Huddle. The Safety Huddle consists of representatives throughout the district, including safety coaches, who bring safety concerns and solutions forward. Information regarding identified safety concerns, suggestions, and initiatives is shared with the district staff.

~~COMMITTEES FOCUSED ON HEALTHCARE DELIVERY QUALITY~~

~~The following four district committees partner with the NIHD Executive Team to establish goals and develop action plans to achieve those goals:~~

- ~~The Quality and Data Committee~~
- ~~The Patient Experience Committee~~
- ~~The Workforce Experience Committee~~
- ~~The Finance and Market Share Committee~~

~~The responsibilities of these four committees are to:~~

- ~~Select two quality improvement goals for NIHD no less than every two years.~~
- ~~Determine benchmarks for each patient experience goal.~~
- ~~Develop and implement plans for achieving goals.~~
- ~~Monitor and report to NIHD Board of Directors on progress no less than three times per year.~~
- ~~Report their findings, actions and follow up on a rotating schedule to the NIHD Executive Team.~~

MEDICAL STAFF

All members of the medical staff are responsible for participating in district-wide quality improvement. Individual members of the medical staff can bring ideas for performance improvement to their department chairs or directly to the medical staff quality improvement committee. The department chairs are responsible for reporting to the medical staff quality improvement committee on quality improvement projects as per the medical staff bylaws.

Individual members of the medical staff can also participate as provider champions on project teams and can coordinate with district staff on matters relating to quality patient care.

Additionally, the medical staff body participates in peer review activities and ongoing and focused professional practice evaluations for the internal monitoring of privileged practitioners and the care they provide. Performance monitoring is ongoing and reviewed prior to the granting privileges. Data or information regarding individual physicians and independent licensed practitioners obtained by the district is transmitted to the Medical Staff for review by appropriate medical staff committees and for storage in the medical staff office peer review documents and credentialing folders.

SECTION 4: GOALS AND OBJECTIVES

The QAPI plan provides the framework for NIHD to achieve these long-term performance improvement goals:

- To evaluate and improve performance measurement systems to assess key processes or outcomes.
- To bring leaders, clinicians and staff together to review data and clinical adverse occurrences to identify problems.
- To carefully prioritize identified problems or desired projects and set goals for their resolution.
- To achieve measurable improvement in highest priority areas for the selected goals.
- To meet internal and external reporting requirements.
- To provide education and training to leaders, clinicians and staff
- To develop or adopt necessary tools, such as practice guidelines, patient experience surveys and quality indicators

SECTION 5: PERFORMANCE MEASUREMENT, INDICATORS AND ASSESSMENT

PERFORMANCE MEASUREMENT

Performance measurement is the process of regularly assessing the results produced by NIHD. It involves identifying processes, system and outcomes that are integral to the performance of the service delivery system,

selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis. Performance improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance they identify.

The purpose of the measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems of a process or outcome, on a priority basis.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involves:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators indicate that a process is not stable, is not performing at an expected level or represents an opportunity for improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

PERFORMANCE INDICATORS

A performance indicator is a quantitative tool that provides information about the performance of a department's process, services, functions or outcomes. Selection of a Performance Indicator is based on the following considerations:

- ~~Relevance~~ Alignment to the mission
- Regulatory/Accreditation requirement
- Clinical Importance
    - Problem prone
    - High Risk
    - High Volume
- Scientific Foundation: Relationship between the indicator and the process, system or clinical outcome.
- Validity: Whether the indicator assesses what it purports to assess
- Meaningfulness: Whether the results of the indicator can be understood, the indicator measures a variable over which NIHD has control, and the variable is possible to change by reasonable performance improvement efforts.
- Standardized definitions
- Availability of industry benchmarks

DATA INDICATORS

Data may be collected for use by external programs (such as federal and state programs) or for internal purposes. External programs (e.g. CMS, MERP) may have a prescribed structured format in which the data must be reported.

For internal purposes or those external purposes which do not have a prescribed format, the Data and Information (D&I) Committee is responsible for approving reports and structured data formats, which are amenable to assessment and analysis. The D&I committee has oversight of surveys and development of new reports to assure data collection is relevant and consistent across the district, as well as responsibility for the management of data, analysis and production of information.

The members of the D&I committee are the following (or their designees), and should serve for no less than 12 months:

- ~~Chief Information Officer~~ Chief Executive Officer
- Chief Financial Officer
- Director of ITS
- ~~Manager of Quality/Clinical Informatics – Infection Preventionist~~ DON Quality & Infection Prevention

Data, information and performance improvement activities will be shared at the Department Heads meeting, as appropriate.

ASSESSMENT

Assessment is accomplished by comparing actual performance on an indicator with:

- Self over time. (NIHD historical trend over time)
- Pre-established standards, goals, benchmarks, or expected levels of performance.
- Information concerning evidence-based practices.
- Other hospitals, clinics or similar service providers.

Data will be assessed for patterns, trends and/or variations that may identify opportunities for improvement. QAPI Analyst will provide support to district staff relative to data significance.

SECTION 6: PERFORMANCE IMPROVEMENT INITIATIVES

Performance improvement initiatives may be selected by either identifying a desired goal once a baseline has been established, or by other prospective means as described in this plan. In the case of evaluating current practices, once the performance of a selected process has been measured, assessed and analyzed, the information gathered is shared with appropriate departments, committees and medical staff leaders to identify opportunities for improvement (OFIs). OFIs are prioritized and quality initiatives can be selected based on the highest priority OFIs.

Opportunities for improvement may be triggered by activities including, but not limited to the following:

- Designated structural, process and outcome metrics
- Performance Improvement Projects
- Results and improvements of The Joint Commission (TJC) or NIHD adopted Tracer Activities
- Results and improvements operational/process audits
- Actions and improvements of Root Cause Analyses and/or Failure Modes Effects (and Criticality) Analyses (FMEAs/FMECAs)
- Significant findings from internal audits such as the TJC Focused Standards Assessment
- Results, response and status of all accreditation surveys
- Medical Staff Critical Indicator – chart review process

Data will be assessed when a significant undesirable performance or variation is noted. Analysis may also be necessary when performance levels or variation indicate a serious issues, such as the following:

1. A sentinel event has occurred, triggering a root cause analysis.
2. Performance varies significantly from that of other organizations or recognized standards.

The purpose of an initiative is to improve the performance of existing services or to design new services.

SECTION 7: EDUCATION

Education coordinated by the District QAPI Council may include, but are not limited to, the following methods:

- Storyboards and/or posters displayed in common areas
- Sharing of NIHD annual QAPI plan evaluation
- Newsletters and handouts
- Community development efforts, press releases
- Provision of education tools and resources

All staff ~~are given the~~ have responsibility ~~and authority~~ to participate in NIHD's QAPI plan. All staff will be provided education regarding the plan on an annual basis. This education will include a description of the plan and how they fit into the plan, based on their particular job responsibilities.

SECTION 7: QAPI PLAN EVALUATION

An evaluation will be completed on an annual basis. This evaluation will be conducted by the District Leadership along with Medical Staff Leadership and reported to the Board of Directors.

The evaluation summarizes the goals and objectives of NIHD's QAPI plan and the performance improvement activities conducted during the past year. QAPI annual reports will include:

- Summary of progress towards meeting the Annual Goals/Objectives.
- For each of the goals, include a brief summary of progress.

- Brief summary of the findings for each of the indicators used during the year, including both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
- Summary of progress for Performance Improvement Initiatives and projects including project activities, results, next steps and holding the gains; also include implications of performance improvement projects/initiatives on outcomes, systems or QAPI processes.
- Recommendations: Based upon the evaluation and Lessons Learned analyses, state the actions needed for improving QAPI plan effectiveness.

Committee Approval	**Date**
Quality Council	**6/5/2020**
Medical Executive Committee	~~**10/1/19**~~**05/11/2021**
Board of Directors	~~**10/16/19**~~
Last Board of Director Review	~~**10/16/19**~~

- Developed: 10/19ta
- Reviewed:
- Revised: 5/2020ta

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: MERP: Plan to Eliminate or Substantially Reduce Medication-Related Errors	
Scope: Pharmacy, Cardiopulmonary, Nursing & DI	Manual: Pharmacy
Source: PHARMACY DIRECTOR	Effective Date:

Introduction

Northern Inyo Healthcare District (NIHD) operates a Critical Access 25-bed general acute care hospital located in Bishop, California. Northern Inyo Healthcare District serves a rural population of approximately 18,000 residents of Inyo County, 10,000 square miles in area, located between the eastern slopes of the Sierra Nevada and the Nevada/California border.

For purposes of this plan, and in accordance with California Health and Safety Code 1339.63, a "medication-related error" means any preventable medication related event that adversely affects a patient at Northern Inyo Hospital, and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Multi-disciplinary Process

The Pharmacy and Therapeutics Committee (P&T) is responsible for implementation of the Northern Inyo Healthcare District Medication Error Reduction Plan (MERP). The Pharmacy & Therapeutics Committee is a multi-disciplinary Medical Staff committee.

The Medical Staff Bylaws of ~~2/15/2017~~ 1/20/2021 establish the following:
~~*The committee is composed of at least two active Medical Staff members, the Pharmacy Director, and the Director of Nursing (Chief Nursing Officer) or other nurse designee. Ex Officio members serving without vote include: Administrator, or the Administrator's designee and the Quality Improvement Coordinator.*~~
~~*The committee meets at least once each quarter. The committee is "responsible for development of all drug utilization policies and surveillance of all drug utilization practices within the Hospital, in a reasonable effort to assure optimum clinical results and minimal potential for hazard, subject to such approval by the District Board, the Administrator, and the Executive Committee [of the Medical Staff]."*~~
~~*The committee is accountable to the Executive Committee of the Medical Staff.*~~

"The pharmacy and therapeutics committee shall be composed of at least three (3) active staff members, the pharmacy director (with vote), and the chief nursing officer or other nurse designated by the chief nursing officer (with vote). Ex-officio members serving without vote shall include the administrator, or the administrator's designee, and a representative from clinical informatics. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity. The duties of the pharmacy and therapeutics committee shall include:

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assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage… The pharmacy and therapeutics committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee and the quality improvement committee on a regular basis.

The Medication Administration Improvement Committee (MAIC), consisting of members of Nursing Administration, Pharmacy, Medical Staff, and Ancillary services was established in 2002 and revised in its composition in 2013. MAIC is a subcommittee of the P&T Committee. MAIC reviews all medication errors or near misses to determine cause and develop strategies for future prevention when needed. Policies and Procedures related to medication administration are reviewed in P&T Committee with input from MAIC team. MAIC findings are reported to P&T along with the indicators and any patterns found. MAIC meets monthly to complete concurrent and retrospective evaluations of medication errors and occurrences.

The Pharmacy and Therapeutics Committee with the help of the MAIC will evaluate, assess, and address each of the following:

Prescribing
Prescription order communications
Product labeling
Packaging and nomenclature
Compounding
Dispensing
Distribution
Administration
Education
Monitoring
Use

External Medication related error alerts will be made accessible to NIHD Staff:

1. ISMP Safety Alert newsletters will be distributed to Nurses and Pharmacists at NIHD via email.
2. Quarterly Action Agenda relative to ISMP alerts are reviewed at P&T committee. Actions are taken at the direction of the committee.

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Annual Review of MERP:
The effectiveness of each of the systems within the MERP will be evaluated and reviewed at the P&T committee annually. The plan will be modified as warranted when weaknesses or deficiencies are identified. At NIHD the MERP will be approved annually by the P&T Committee.

Technology used at NIHD in the reduction or elimination of medication errors includes:
Our Electronic Health Record (EHR) provides for automated allergy checking, automated dose checking, automated interaction checking, barcode medication administration and computerized physician order entry. The EHR provides a medication administration record that highlights due and overdue medications. The EHR has medication reconciliation modules for admission, transfer and discharge.

NIHD purchased, built the drug library and deployed the BBraun SPACE Pump over the summer of 2020. These new pumps have smart technology, which includes a drug library that contains safe upper and lower limits, and concentrations of the IV medications on our formulary. This drug library will be owned by pharmacy and reviewed annually in P&T. The entire drug library is available for review in the pharmacy and nursing shortcuts as with most other guidelines and dosing calculators.

The specific planned areas of assessment and improvement for 2021 are:

Prescribing:

1. Medication order sets will be re- evaluated annually by the director of pharmacy or their designee.
2. A review of the practice of deviating from CPOE via the use of verbal orders will be visited with appropriate guidance to providers once Cerner has gone live.
3. The Joint Commission standards for safe nomenclature and labeling in surgery will be reviewed and incorporated in the ~~Cerner~~EHR and automated dispensing cabinet ~~, Omnicel and Codonics~~ installs and upgrades.

Product Labeling:
The present ~~E H R~~EHR has limitations related to barcode scanning. Our informatics and IT departments diligently made the effort to overcome this shortfall by the EHR vendor. The Healthcare District will be transitioning to a new ~~E H R~~ EHRin May 2021. The new ~~E H R~~EHR is anticipated to fully support barcode scanning.

Packaging and Nomenclature:
Secondary to the pharmacy departments inability to manufacture sterile products in accordance to USP 797 NIHD is outsourcing compounded medications with greater shelf

life than 12 hours from credentialed manufacturers while our pharmacy relocation project is in progress.

Pre-made medications are being acquired from a 503b compounding facility for medications that are unable to be compounded with extended expiration dates. Examples include premixed Oxytocin, Vancomycin 2 gram loading doses, and Narcotic PCA's.

Compounding:
The pharmacy department reviews minimally semi-annually, the competency of pharmacy personnel in compounding in accordance with the Board of Pharmacy Sterile Compounding Licensure requirements.
The department trains all new hires sterile compounding procedures in adherence to USP 797, 800 and 825. Semi-annually the department carries out review for all employees.

Dispensing:
Automated dispensing cabinets (ADC) will be upgraded in 2021.Windows 10 technology will be operating in the new units which will have a 10 year life. Controlled substance adjudication to 0.00 mg is performed each day by staff. The Omnicell units are essential for this function. The Pharmacy department stocks these ADC twice a day. This has removed the requirement for medications to have to be requisitioned from pharmacy (potential source of error) and time sensitive operation.

Distribution:
A barcode scanning process has been implemented for the medication dispensing cabinet restocking process. The process is used to verify and validate the correct medication and earliest expiration date during restocking. This is an additional layer of safety beyond the pharmacist checking the ADC fills prior to distribution.
Process for (pharmacist-RN) confirmation of high-risk intravenous infusions prior to use in the emergency department has been established. This is an additional layer of safety prior to administration.
Pharmacy staff, to ensure full and complete reconciliation of all controlled substances, perform daily controlled substance adjudication.

Administration:
Pasero Opioid Sedation Scale (POSS) and Richmond Agitation Sedation Scales (RASS) have been added to routine narcotic/sedative administration monitoring practices. Hold parameters will add a layer of safety to patient medication management.
Drug library will be implemented with established dose regimens providing guardrails for safe and effective medication administration. (SMART Pumps)

Tracers Activity:
As part of medication safety Tracer activity, a medication pass and safe injection practice

observation will be done across the continuum of care quarterly.
The results will be reported to nursing administration and P&T committee. The observations will be used to educate clinical staff as to best practices. Training and changes in practice will be initiated as needed from the observations.

Education:
Education is provided during orientation and annually on safe injection practice for all staff who prepare and administer injectable medications.

The pharmacy will continue to provide an hour of education during nursing orientation to include ADC training, medication security, High Risk-High Alert medications, Look Alike-Sound Alike Medications, multi-dose vials, infection control, drug information, and basic pharmacy information.

The pharmacist will identify and educate patients who will benefit from additional information regarding the proper use of, and rationale for their medications prior to discharge.

Monitoring:

Adverse medication events are documented via the unusual occurrence reporting system (UOR) and then reviewed at the Medication Administration Improvement Committee (MAIC).

Baseline and routine INR's will be reviewed by pharmacy for all inpatients taking warfarin.

REFERENCES:

1. ISMP "CDPH Medication Error Reduction Plan" December 2016

CROSS REFERENCES:

1. High Alert Medications Policy NIHD
2. Medication Reconciliation Policy NIHD
3. Omnicel (ADU) Dispensing Cabinets Policy NIHD
4. Antibiotic Stewardship Program Policy NIHD

Approval	**Date**
CCOC	3/30/2021
Pharmacy & Therapeutics	04/14/2021

NORTHERN INYO HEALTHCARE DISTRICT
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Source: PHARMACY DIRECTOR	Effective Date:

Medical Executive Committee	05/11/2021
Board of Directors	
Last Board of Director review	

Developed: 11/2019fl
Reviewed:
Revised: 11/2020fl
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Remediation, or New Construction Projects	
Scope: NIHD	Manual: CPM - Infection Control-Environmental (ICE)
Source: Director of Quality and Infection Prevention	Effective Date: 1/31/2017

PURPOSE:
To provide parameters for safe design, construction, maintenance, and sustainability in the healthcare environment. The intent is to control airborne and waterborne biological contaminants in occupied patient care and staff areas during periods of demolition and renovation and new construction projects.

POLICY:
1. Infection risks, interventions, and control strategies must be considered in planning for new construction and/or renovation of healthcare facilities.
2. ~~interventions, and control strategies must be considered in planning for new construction and/or renovation of healthcare facilities.~~
3. ~~3.~~2. An Infection Control Risk Assessment (ICRA) is developed for all projects that may affect the health of patients and employees.
4. ~~4.~~3. When NIHD undergoes construction, renovation, remediation, repair or demolition, a multidisciplinary team that includes Infection Prevention and Control staff shall be established to coordinate demolition, construction and renovation projects, consider proactive preventive measures at the inception, and document and maintain summary statements of the team's activities.
5. ~~5.~~4. The multidisciplinary team will document the assessment process intended to proactively identify and mitigate risks from infection that could occur during construction activities.
6. ~~6.~~5. The ICRA process must take into account the patient population at risk, the nature and scope of the project, and the functional program of the healthcare facility.
7. ~~7.~~6. The ICRA determines the potential risk of transmission of various air- and waterborne biological contaminants in the facility.
8. ~~8.~~7. The ICRA shall be a part of integrated facility planning, design, construction, and commissioning activities and will be conducted during the early planning phase of a project, before construction begins, and continue throughout project construction and commissioning.
8. ICRAs will focus on prevention, but will also address monitoring, testing, and intervention when problems are identified.
9. During normal routine maintenance, an ICRA will not be completed.

DEFINITIONS:
Infection Control Risk Assessment (ICRA) - tool used to stratify infection control risks associated with construction or renovation

Infection Control Risk Mitigation Recommendation (ICRMR) - Written plans that describe the specific methods by which transmission of air- and waterborne biological contaminants will be avoided during construction as well as during commissioning, when HVAC and plumbing systems and equipment are started/restarted.

Project Manager - assigned person(s) responsible to the project, may be corporate or entity assigned

Design phase - Components include conceptual phase, schematic and structural considerations, programming needs, financial aspects

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Source: Director of Quality and Infection Prevention	Effective Date: 1/31/2017

Project Team - a multidisciplinary planning group that at a minimum should include representation from infection prevention, administration, facility operations, architect, engineer, project manager, and the contractor

PROCEDURE:

I. Northern Inyo Healthcare District (NIHD) Infection Prevention Process Elements:

a. The infection prevention department will be notified prior to onset of construction/ renovation projects that meet project notification criteria.
b. The multidisciplinary team will ensure that architects and project planners follow the Facility Guidelines Institute (FGI) when designing and planning for construction activities.
c. The infection prevention department reserves the right to seek outside consultant services as appropriate to the project.
d. Contracted workers will receive training and/or information on infection prevention and control practices and risks for the NIHD facility identified in the ICRA. This can be performed by the Maintenance Department, Biomed, Safety Officer, Infection Preventionist or designee prior to the start of any project.
e. Infection Prevention and multidisciplinary team will determine whether construction poses sufficient increased risk to require/recommend that patients be moved to an area of the facility that is not affected by construction.
f. Educating the construction team and hospital staff in immunocompromised patient care areas regarding the airborne infection risks associated with construction projects, dispersal of fungal spores during such activities, and methods to control the dissemination of fungal spores.
g. Breaches in infection control practices will be reported to the assigned project manager(s)/infection prevention services.
h. Routinely monitor construction for contractor and hospital staff compliance with the ICRA.
i. If a nosocomial infection occurs during construction, intensify surveillance to identify additional cases, searching both prospectively and retrospectively. If no evidence of ongoing transmission is discovered, continue with routine infection control measures. In the event more than one case is found, conduct environmental and epidemiological investigations to identify and eliminate the source of infection.
j. The project manager arranges for final construction cleaning, followed by a terminal/deep clean by environmental services prior to occupancy.
k. The infection prevention or designee will conduct a walk-through upon completion of the project and prior to occupancy.
l. Environmental Services (EVS) will work with multidisciplinary team to identify areas that need to be damp mopped/cleaned and clean these areas as scheduled. EVS will thoroughly clean new and renovated areas before admitting or readmitting patients or opening of new areas for staff members. EVS will coordinate inspection of final cleaning with Infection Control, or designee, prior to opening/reopening the area.
m. Facility services/plant operations will develop a system that communicates all respective projects.
n. The infection prevention department in collaboration with multidisciplinary team will determine which projects require the completion and documentation of an Infection Control Risk Assessment (ICRA).
o. The infection prevention department will communicate the findings and recommendations of the ICRA to the project manager(s) for review and distribution.

p. The ICRA will be posted at the construction, renovation or repair site to allow contractors and construction personnel to review project risk matrix and infection prevention measures.

II. The ICRA is based on Facility Guidelines Institute FGI Guidelines

a. ICRA Timing: Will be conducted during the early planning phase of the project, before construction begins, and continue throughout project construction.
b. ICRA Team: Will be conducted by a multidisciplinary team with knowledge in infection prevention, direct patient care, facility design, construction, and HVAC and plumbing systems when these systems are involved. The scope of the project will dictate others who may be involved.
c. ICRA Recommendations: Based on preconstruction ICRA, the Infection Preventionist or designee shall provide the following recommendations to incorporate into the program:
    i. Design recommendations generated by the ICRA.
    ii. Infection control risk mitigation recommendations (ICRMRs).
d. ICRA Design Elements if applicable:
    i. Number, location, and type of airborne isolation and protective environment rooms.
    ii. Number, location, and type of plumbed hand-washing stations, hand sanitation dispensers, and emergency first-aid equipment (eyewash stations and deluge showers).
        i. The number and location of hand-washing stations and hand-sanitation dispensers shall be determined by the functional program and the ICRA.
        ii. Hand-washing stations will be convenient and accessible for healthcare personnel and all other users.
    iii. Special HVAC needs to meet the functional program and accommodate the services included in or affected by the project (e.g., surgical services, airborne isolation rooms, laboratories, pharmacies, and other special areas).
    iv. Water systems to limit Legionella and other waterborne opportunistic pathogens.
e. Surfaces and Furnishings:
    i. Existing code requirements are to be met.
    ii. Easy to maintain, repair, and clean.
    iii. Does not support microbial growth.
    iv. Nonporous and smooth.
f. Construction Elements: When conducting the ICRA and developing the mitigation requirements for building and site areas anticipated to be affected by construction, the following shall be addressed:
    i. The impact of disrupting essential services to patients and employees.
    ii. Determination of the specific hazards and protection levels for each designated area.
    iii. Construction type is identified based on type of construction and dust producing activity (A, B, C, and D).**(Step 1)**
    iv. Identify and categorize risk groups by location according to their susceptibility to infection and the definition of risks to each. (low, medium, medium-high, high) **(Step 2)**
    v. Risk Assessment Matrix is determined by combining construction type and risk group, this will help determine the Prevention and Control Measures. **(Step 3)**
    vi. Assessment of external as well as internal construction activities.
    vii. Location of known hazards.
g. Compliance Elements:

i. ICRA Documentation: The ~~written~~ record shall remain an active part of the project documents for the duration of the construction project and through commissioning. The ICRA is filed into the master file for the specific project and sent to Safety Officer.
ii. ICRMRs (infection control risk mitigation recommendations). ~~Written~~ Documented plans that describe the specific methods by which transmission of air- and waterborne biological contaminants will be avoided during construction as well as during commissioning, when HVAC and plumbing systems and equipment are started/restarted.

h. Risk Mitigation (ICRMR) is prepared by the team to address the following prevention and control measures
   i. Standards for patient placement and barriers
   ii. Decrease d~~D~~ust
   iii. Temporary provisions or phasing
   iv. Protection from demolition
   v. Measures taken to train (see Other Risk-Reduction Strategies)
   vi. Impact of utility outages, planned and unplanned
   vii. Movement of debris, traffic flow, cleanup, egress plans for construction debris and supplies, and worker routes
   viii. Provision for use of bathroom and food facilities by construction workers
   ix. Storage and installation of materials (clean, dry, no water damage)

i. Monitoring Plan and Procedures
   i. The Infection Preventionist or designee shall provide monitoring plans for effective application of ICRMRs during the course of the project.
   ii. If identified as high risk the NIHD construction rounds compliance form will be done daily while construction is being done. Rounding timeframe will be determined in the risk mitigation section "Other Risk Reduction Strategies" ~~After~~ After project completed the forms will be scanned and sent to Safety Officer with final ICRA.
   iii. Provisions for monitoring shall include written procedures for emergency change of scope of work which may include suspension of work and/or protective measures indicating the responsibilities and limitations of each party if issues are identified. ~~(Infection Preventionist or designee, Safety Officer, Maintenance, and contractor)~~

j. Communication
   i. Updates on ICRA compliance will be provided by the ICRA team.
   ii. Changes to the original design plans shall be documented, updated, and continually shared between the ICRA team and the designers/architects/planners, owner, and contractor.
   iii. The ICRA will be sent to Safety Officer when project completed and discussed at Safety Committee and Infection Control Committee.
   ~~iii.~~

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). (2015). Infection prevention manual for construction and renovation. Washington, DC: APIC

Title: Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Remediation, or New Construction Projects	
Scope: NIHD	Manual: CPM - Infection Control-Environmental (ICE)
Source: Director of Quality and Infection Prevention	Effective Date: 1/31/2017

2. Centers for Disease Control and Prevention. (2016). Infection Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/hai/pdfs/IC/CDC_IC_Assessment_Tool_Hospital.pdf
3. The Joint Commission. (2016). EC. 02.06.05 EC.02.06.05 The Critical Access Hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.
4. The Joint Commission. (2016). LS.01.02.01 The Critical Access protects occupants during periods when the Life Safety Code is not met or during periods of construction.

Approval	**Date**
Safety Committee	04/14/2021
CCOC	02/11/2021
Infection Control Committee	03/24/2021
MEC	05/11/2021
Board of Directors	12/14/2016
Last Board of Director review	7/18/18

Developed: 11/16 RC
Reviewed: 7/18rc
Revised: 01/12/2021 RC
Supersedes:
Index: ICRA, Construction and Renovation

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Remediation, or New Construction Projects	
Scope: NIHD	Manual: CPM - Infection Control-Environmental (ICE)
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Step 1. Use the following table to identify the type of construction.

Definitions of Construction Activities	
Construction Type	**Description**
A	Inspections and non-invasive activities. Includes, but is not limited to removal of ceiling tiles for visual inspection, limited to 1 tile per 50 square feet; painting with minimal dust production; installing wall covering; electrical trim and minor plumbing work; and activities that do not generate dust or require cutting of walls or access to ceilings other than for visual inspections.
B	Small-scale, short-duration activities that create minimal dust. Includes, but is not limited to installation of telephone and computer cabling, access to chase spaces, cutting of walls or ceiling where dust migration can be controlled.
C	Any work that generates a moderate to high-level amount of dust or requires demolition or removal of any fixed building components or assemblies. Includes, but is not limited to sanding of wall for painting or wall covering, removal of floor coverings, ceiling tiles and case work, new wall construction, minor duct or electrical work above ceilings, major cabling activities, and any activity that cannot be completed within a single work shift.
D	Major demolition and construction projects. Includes but is not limited to activities that require consecutive work shifts, require heavy demolition or removal of a complete ceiling system, and new construction.

Step 2. Use the following table to identify high-risk groups.

Infection Control Risk Assessment (Circle One)			
Low	**Medium**	**Medium-High**	**High**
♦ Office areas ♦ Other:	♦ All patient care areas (unless stated in medium to high or high risk areas) ♦ Other:	♦ Emergency Room ♦ Radiology/MRI ♦ Labor & Delivery ♦ Nurseries ♦ Pediatrics ♦ Nuclear Medicine ♦ Admission/Discharge Units ♦ Physiotherapy (tank areas) ♦ Dining Facility ♦ Laboratories (specimens) ♦ Special Procedures ♦ Other:	♦ Transplant Patients ♦ Operating Rooms ♦ PACU ♦ Sterile Processing Areas ♦ All ICUs ♦ Cardiac Catherization/ Angiography Area ♦ Pulmonary Function ♦ Dialysis Units ♦ Endoscopic Areas ♦ Pharmacy Mixture Areas ♦ Oncology Units ♦ Other:

Step 3. Use the following table to define risk.

Risk Assessment Matrix				
	Construction Activity			
Risk Group	***A***	***B***	***C***	***D***
Low	I	II	II	III/IV
Medium	I	II	III	IV
Medium-High	I	II	III/IV	IV

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High	III	III/IV	III/IV	IV

Step 4. Complete the Infection Control Construction Permit.

Infection Control Construction Permit	
Project Name:	**Project Type:** ____Maintenance ____Renovation ____Demolition ____Construction ____Other:
Estimated Start Date:	**Estimated Completion Date:**
Facility Project Manager:	**Phone Number:**
Project Contractor:	**Phone Number:**
Infection Control Officer:	**Phone Number:**
Location:	**Area Supervisor/Phone Number:**

NORTHERN INYO HOSPITAL
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Construction Type: (Circle or Highlight One) ***A B C D***	**Risk Group:** (Circle or Highlight One) ***Low Medium Medium-High High***	**Risk Assessment:** (Circle or Highlight One) ***I II III III/IV IV***

Projected Utility Outages Impacting Infection Control (Mark all that apply)

Electrical	Potable Water	HVAC	Medical Vacuum	Sewer	Other:

List All Construction Equipment that may Generate Noise, Vibration, and/or Interference with Medical Equipment (Electro Magnetic Interference)

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Prevention and Control Measures (Mark all that apply)	
Risk Assessment	
I	__ Use work practices that will minimize generation of dust from construction operations __ Immediately replace any ceiling tiles displaced for visual inspection
II	__ Provide means (e.g., fire-rated plastic sheeting) to prevent airborne dust from dispersing into the atmosphere __ Water mist work surfaces to control dust while cutting __ Seat unused doors with low tack __ Block off and seal air vents __ Wipe surfaces with disinfectant __ Contain construction waste before transport in tightly covered containers __ Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area __ Place dust mat at work area entrances and exits __ Isolate HVAC system in work area
III	__ Isolate HVAC system in work area __ Install fire-rated barriers or implement control cube method before construction begins __ Maintain negative air pressure within work area, utilizing HEPA equipped air filtration units __ Keep barriers in tact until project is completed and area is thoroughly cleaned by housekeeping __ Vacuum work area with HEPA-filtered vacuums frequently __ Wipe surfaces with disinfectant __ Remove barriers carefully to minimize spreading dirt and debris associated with construction __ Contain construction waste before transport __ Cover waste transport containers or carts, tape coverings if lids or covers are not tight
IV	__ Isolate HVAC system in work area __ Install fire-rated barriers or implement control cube method before construction begins __ Maintain negative air pressure within work area, utilizing HEPA equipped air filtration units __ Seal holes, pipes, conduits, and punctures appropriately __ Construct anteroom and require all personnel to pass through this room so then can be vacuumed with HEPA vacuum cleaner before leaving work area, or wear cloth or paper coveralls that are removed each time they leave the work area. __ Require all personnel entering work area to wear shoe covers __ Keep barrier in tact until project is complete and thoroughly cleaned by housekeeping __ Vacuum work with HEPA-filtered vacuums daily or more frequently as needed __ Wet mop adjacent areas with disinfectant daily or more frequently as needed __ Remove barriers in a manner to minimize spreading dirt and debris associated with construction __ Contain construction waste before transport __ Cover waste transport containers or carts, tape coverings if lids or covers are not tight

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Other Risk-Reduction Strategies

Title: Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Remediation, or New Construction Projects	
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__ Keep patient doors adjacent to the construction area closed

__ Seal exterior windows to minimize infiltration from excavation debris

__ Designate alternate routes in the facility that detour staff, patients, and visitors around the construction site

__ Schedule major construction projects during winter months when risk of fungal infection is lowest

__ Designate a construction-only elevator, entrance, and walkway for construction crew

__ Remove construction debris through a window on floors above the ground level

__ Relocate high-risk patients to an area removed from the construction site

__ Post signage related to non-authorized entry into the work area

__ Designate storage areas for construction materials

__ Patient care equipment and items removed from construction area if applicable

__ Select on or more of the Life Safety Codes deficiencies when identified during construction if applicable

___ Notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm or sprinkler system is out of service more than 4 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented

___ Posts signage identifying the location of alternative exits to everyone affected if applicable

___ Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired

___ Provides additional firefighting equipment

___ Use temporary construction partitions that are smoke-tight, or made of noncombustible or limited- combustible material that will not contribute to the development or spread of fire

___ Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices

___ Enforces storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level

___ Provides additional training to those who work in the critical access hospital on the use of firefighting equipment

___ Conducts one additional fire drill per shift per quarter

___ Inspects and tests fire protection systems monthly. The completion date of the tests is documented

___ Conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety

____ Train and educate healthcare staff, facility workers, construction workers (Mark all that apply):
Infection Control Exposure Control Plans, Hazardous Chemicals, Life Safety, Accident Reporting, First Aid, Personal Protective Equipment, Reporting unexpected environmental emergencies (e.g., lead paint, asbestos, etc.)

__ Infection ~~Rounding will be completed based on risk~~rounding will be completed based on risk

____ ~~Daily~~Daily

____ ~~How~~ How ~~often~~ often _____ times ~~per week.~~per week

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Step 5. Complete final infection control inspection upon completion of construction/renovation/remediation.

Infection Control Checklist **Final Upon Completion of Construction/Renovation**			
Inspector:	**Location:**	**Date:**	**Time:**

Equipment			
	Soap dispensers properly installed and filled		Towel dispensers properly installed and filled
	Sinks functional		Sharps containers properly installed
Housekeeping			
	Waste and excess equipment/supplies removed		Surfaces and floors dust free
Ventilation			
	Appropriate pressure relationships verified		Air intake/exhaust vents free of protective coverings

COMMENTS/ACTIONS TAKEN:

~~Submitted~~ ICRA Prepared ~~by:~~ (list team members)
~~Titles:~~
Date:

Safety Officer: Scott Hooker
Date:

Safety Committee
Date:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cleaning and Care of Surgical Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 12/1/15

PURPOSE:
Personnel in Sterile Processing have a vital role in the continuing battle against microorganisms. The proper handling of equipment that has been used or contaminated is not a mere function, but an obligation for patient and personnel safety. Continuous emphasis must be exerted in order to have personnel carry out the necessary steps.

POLICY:
Manufacturer's written, validated instructions for handling and reprocessing should be obtained and evaluated to determine the ability to adequately clean and reprocess the equipment. Manufacturer's written instructions should be used to determine how to properly clean and sterilize instruments.
It is our policy NOT TO REPROCESS SINGLE USE ITEMS for patient use. All personnel practice standardized precautions and wear protective gown, glasses, goggles and gloves when appropriate.

New, Repaired, or Refurbished Instruments:

- All new, repaired or refurbished instruments should be examined, cleaned, and sterilized according to manufacturer's written instructions before use.
- All moving parts, tips, box locks, ratchets, screws and cutting edges should be examined for defects and to ensure proper working order.
- Instruments should be pre-treated according to manufacturer's written instructions, when indicated.
- All instruments should be decontaminated according to manufacturer's written instructions before use.
- All instruments should be sterilized according to manufacturer's written instructions before use.

Loaner Instruments

Upon scheduling a procedure that requires loaner instrumentation, the Surgery Manager, Materials Management Analyst or designee contacts the vendor or other hospital facility to arrange a timely delivery of instruments and implants.

- Loaner instruments should be requested when the surgery is scheduled, and delivered in time for the surgical procedure to allow inspection and inventory of instruments.
- Loaner instruments should be logged in and inventoried before use.
- Loaner instruments should be considered contaminated and are delivered to the decontamination area for processing.
- All moving parts, tips, box locks, ratchets, screws and cutting edges should be examined for defects and to ensure proper working order.
- Vendors will provide manufacturers' written instructions for disassembly, cleaning, packaging and sterilization of instruments and implants.
- All loaner instruments and implants will be cleaned, inspected, inventoried, wrapped, sterilized, cooled, documented and tracked to each patient according to published standards and Manufacturer instructions, and hospital policy and procedure.
- Quality control sterilization monitoring will be done per hospital policy and procedures.
- If an item must be released from quarantine because of a documented necessity, all other monitors: sterilization cards, chemical integrator, and biological indicator should be reviewed and documentation

reflects that the item was released without the results of the Biological Indicator being known. The physician will be notified of the situation.

- After the surgical procedure is completed, the borrowed instruments should be disassembled, cleaned, and decontaminated.
- The instruments are to be returned to the source from which they were borrowed per their instruction.

Preliminary Steps in Surgery

- Instruments should be wiped with sterile water moistened sponges as needed during the surgical procedure to remove gross soiling to prevent corrosion, rusting and pitting.
- Instruments with lumens should be irrigated with sterile water as needed throughout the surgical procedure.
- Cautery tips should be cleaned frequently to prevent eschar build-up.
- Instruments needing repair should be tagged or labeled and removed from service until repaired.

Cleaning and decontamination of Surgical Instruments.

- Decontaminate the instruments at the point of use – see above.
- All instruments opened in the operating or procedure rooms need to be decontaminated whether or not they have been used.

Sorting

- Sharp instruments should be segregated from other instruments.
- Disposable sharps should be removed and discarded into proper receptacles.
- Reusable sharp instruments, including scissors, should be placed in a separate puncture proof receptacle for transportation, such as emesis basin.
- Reusable scalpel handles should be considered sharp instruments, and placed in a separate receptacle-knife blades are to be removed and disposed of prior to placing in receptacle.
- Instruments composed of more than one piece, should be open, disassembled, and arranged in an orderly fashion within the original set configuration.
- Instruments should be placed in a perforated or mesh bottomed instrument tray before mechanical decontamination.
- Instrument box locks should be fully opened, and the instruments secured to prevent closing by using stringers, racks, or instrument pegs designed to contain instruments.
- Delicate instruments should be protected from damage. Avoid placing heavy weighted instruments on top.
- Microsurgical instruments should be segregated into separate containers.
- Heavy instruments should be placed on the bottom of storage containers or a separate tray.

Transportation To Decontamination Area

- Soiled instruments must be transported covered and contained in a manner to prevent exposure to patients or personnel to blood borne pathogens, and other potentially infectious organisms.
- Soiled instruments from the ancillary departments and clinics will be transported to the decontamination area in covered containers by the perioperative courier.
- Hand-carried must be contained in a container with a lid.

- Large quantities of items must be contained in a cart or transport container with doors or plastic cover.
- Items placed on top of cart must be contained safely to prevent falling off.
- Items with sharp or pointed edges must be contained in a puncture-resistant container.
- Liquids must be contained in a spill-proof container.
- Transport carts must be labeled to indicate biohazardous contents.
- Avoid contaminating the outside of transport cart – clean cart if contamination has occurred.
- Transport of soiled instruments should be separate from delivery of clean and sterile supplies to the operating rooms.
- Contaminated surgical instruments should be transported to the decontamination area as soon as possible.

Cleaning

Instruments should be decontaminated in an area separated from locations where clean activities are performed.

- Instruments should not be decontaminated in scrub or hand sinks.
- The decontamination area should be physically separate from clean areas and include a door.

The area should contain:

Sinks
Hand washing facilities
Eye wash station
Automated equipment consistent with the types of instruments to be decontaminated
Compressed air supply
Adaptors and accessories to connect instruments with cleaning equipment and utilities.

- The decontamination area, heating, ventilation, and air conditioning systems should be controlled and monitored according to local requirements.
- Doors should be kept closed except when moving personnel or equipment.
- The decontamination area should be stocked with the following supplies:
    - Soft-bristled brushes
    - Cleaning cloths
    - Alcohol
    - Appropriate PPE
    - Enzymatic cleaner

Water Quality

- Potable water should be used for manual or mechanical decontamination cleaning methods unless contra-indicated by manufacturer's instructions.
- Softened or de-ionized water should be used for the final rinse.
- Water quality assessment should be performed periodically or after maintenance to water sources. Impurities in the water can reflect insufficient filtration, necessitating repairs bases on testing.

Manufacture's Instructions

Following manufacturer's instructions decreases the possibility of cleaning agents harming instruments.

- Manufacturer's written instructions should be followed for cleaning agent selection and proper use.
- Neutral, low-foaming, free-rinsing detergents (pH 7) should be used for cleaning of instruments and equipment unless contra-indicated.
- Highly acidic or alkaline detergents should be handled carefully, and used only if recommended.
- Cleaning agent manufacturer's written instructions should be followed.
- A titration unit may be used to efficiently dilute chemicals at a consistent ratio.
- Abrasive cleaning devices and agents should not be used.

Cleaning Methods

Manufacturer's instructions should be followed regarding types of cleaning methods (e.g. manual, automated) to be used for decontamination.

Manual cleaning

- Before beginning the cleaning process, instruments should be rinsed in cold running water to remove gross debris.
- Instruments should be thoroughly washed.
- Some delicate instruments, power equipment and other instruments that cannot be submerged should be cleaned manually.
- Instruments should be completely submerged in warm water and appropriate detergent for 5 minutes prior to cleaning.
- Instruments should be completely submerged in rinse solution after cleaning.
- Mechanical cleaning of surgical instruments is accomplished by ultra-sonic cleaners, washer-decontaminators/disinfectors, or washer-sterilizers.

Ultrasonic cleaners

- Ultra-sonic cleaners should be used according to manufacturer's instructions.
- Ultra-sonic cleaners should be used only after gross soiling has been removed.
- Manufacturer's instructions regarding detergent selection and "degassing" should be followed.
- Only instruments made of similar materials should be combined, unless specified otherwise.
- Some instruments should not be placed in an ultra-sonic cleaner
    - Chrome-plated instruments
    - Power instruments
    - Rubber, silicone, or plastic instruments
    - Endoscopic lenses

- Instruments with lumens should be submerged and filled with cleaning solution to remove air from within the channel.
- Instruments should be thoroughly rinsed after ultra-sonic cleaning.
- A lid should be in place to prevent aerosolization of contaminants.
- Cleaning solutions should be checked between cycles and changed if visibly soiled.
- Ultra-sonic cleaners should be emptied each day, cleaned, rinsed with sterile water, and chamber wiped with alcohol or other disinfectant, as per manufacturer recommendation.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cleaning and Care of Surgical Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 12/1/15

Automated washer decontaminators or disinfectors, washer/sterilizers

- Use according to manufacturer's instructions.
- The amount of time necessary to efficiently clean and rinse instruments is determined by manufacturer's instructions.
- The operator should ensure that the correct cycle is being used.

Inspection of surgical instruments.

- Instruments should be inspected for
  - Cleanliness
  - Alignment
  - Corrosion, pitting, burrs, nicks, and cracks
  - Sharpness of cutting edges
  - Loose set pins
  - Wear and chipping of inserts and plated surfaces
  - Missing parts
  - Any defects
  - Removal of moisture
  - Proper functioning
  - Instruments should be thoroughly dried.

Lubricants

- Use manufacturer's written instructions for selection and use of lubricants
- Instruments should be clean before lubrication.
- Lubricants should be compatible with the method of sterilization to be used.

Disinfection of Instruments

- **Instruments will be disinfected prior to handling in the washer disinfector following policy and procedure.**

Packaging

- Instruments to be processed should be packaged and sterilized according to AORN recommendations.

Sterilization

Cleaned surgical instruments should be organized for packaging to allow the sterilant to contact all exposed surfaces.

- Instruments should be placed in a container that is large enough to evenly distribute the metal mass in a single layer.
- Broad-surfaced or concave surfaced instruments should be placed on edge to facilitate drying.
- Instruments with hinges should be opened, and those with removable parts should be disassembled when placed in trays designed for sterilization, unless indicated to the contrary.
- Instruments should be kept opened and unlocked using instrument stringers, racks, or instruments pegs designed to contain instruments.

- Delicate and sharp instruments should be protected using a device such as tip protectors.
- Heavy instruments should be positioned in the bottom of the tray to prevent damage to delicate items.
- Only validated containment devices should be used to organize or segregate instruments within sets.
- Rubber bands should not be used to keep instruments together.
- Paper-plastic peel pouches should not be used inside the tray unless validated by the manufacturer.
- Small accessory baskets or boxes with lids should not be used inside the tray unless validated by the manufacturer.
- Non-absorbent, non-woven disposable wrap material should not be used as a tray liner, or to organize or segregate small items within an instrument set.
- Devices with channels or lumens (suction tubes) should be flushed with distilled, demineralized or sterile water before steam sterilization.
- Stylets should be removed from lumens.
- The instrument tray or basket should be lined with an absorbent, lint-free surgical towel if indicated.
- Non-absorbent plastic or silicone fingered mats should be used according to the manufacturer's instructions.
- Proper placement of instruments should follow container manufacturer's instructions.

Powered Surgical Instruments

Powered surgical instruments and all attachments should be decontaminated, lubricated, assembled, sterilized, and tested before use according to manufacturer's written instructions.

- Powered instruments and attachments should be cleaned and maintained according to manufacturer's instructions.
- Attachments should be properly affixed to instruments and tested before use.
- Trigger handles should be placed in safety position when changing attachments.
- Medical-grade compressed air or nitrogen should be used to operate air-powered equipment according to manufacturer's instructions.
- To determine the correct pressure settings use the manufacturer's instructions.
- Only grounded outlets shall be used for electrical powered equipment.
- Powered equipment and air hoses should be inspected for damage or wear before being cleaned and decontaminated, with approved detergent or germicide, following manufacturer's instructions.
- Blades and drill bits should be removed from power equipment before leaving the OR.
- Powered equipment and air hoses should not be immersed or placed under running water, in ultra-sonic cleaners, washer-disinfectors, or washer –sterilizers, unless indicated.
- When pneumatic hand pieces are cleaned, air hoses should be attached.
- All traces of detergent or germicide, and excess fluids, should be wiped from the equipment, air hoses and attachments, and dried with lint-free towels.
- Powered equipment and attachments should be lubricated with a specific lubricant according to manufacturer's instructions.
- Manufacturer's instructions for packaging powered equipment, attachments and batteries should be followed, including validated sterilization parameters.

Ophthalmic Surgical Instruments

Special precautions shall be taken before reprocessing ophthalmic surgical instruments.

- Instruments should be wiped clean with sterile water and lint-free sponge during the surgical procedure to remove viscoelastic solution, which can harden quickly.
- Instruments should be immersed in sterile water immediately at the end of the procedure.
- Single-use cannulae should be used whenever possible.
- Manufacturer's instructions for cleaning each instrument should be reviewed and followed.
- Irrigation and aspiration ports, phacoemulsification handpieces, tips and tubing should be flushed before disconnecting the handpiece from the unit. (see manufacturer instructions for the Quick Rinse system)
- Intraocular lens injectors, lens inserters, should be carefully cleaned.
- Single-use items must be used only once and discarded.
- Detergents and enzymatic detergents should be used and diluted according to manufacturer's instructions when recommended.
- After cleaning or decontamination, instruments should be thoroughly rinsed in de-ionized or sterile water and dried.
- After cleaning, lumens should be thoroughly flushed with sterile water and dried with filtered, oil-free compressed air.
- Syringes and brushes used to clean ophthalmic instruments, and cleaning solutions, should be discarded after each use.
- After manual or ultrasonic cleaning, instruments should be wiped with alcohol before preparation for sterilization.
- After cleaning and disinfection, instruments containing viscoelastic material should be inspected for residue under magnification.
- Records should be maintained of all cleaning methods; detergent solutions used, and lot numbers of cleaning solutions.
- Adequate time should be allowed for thorough instrument cleaning and sterilization.

Insulated electrosurgical instruments

- Insulated electrosurgical instruments should be inspected for small breaks in insulation before initial use and after decontamination.
- Insulated instruments should be kept away from sharp instruments, and segregated from sharp objects after the case.
- Insulated electrosurgical instruments should be decontaminated according to manufacturer's instructions.
- Abrasive cleaning may damage instruments
- Stray current leakage tests at the end of the decontamination cycle shall be done.
- Equipment with damaged insulation shall be removed from service, and repaired or replaced.
- Limited use insulated instruments with specific time frame or reprocessing times should be followed according to manufacturer's instructions.

Personnel protective equipment

Personnel handling contaminated instruments and equipment must wear appropriate personal protective equipment (PPE) and should be vaccinated against Hepatitis B virus.

- PPE consistent with the anticipated exposure should be worn.
- The appropriate PPE for this exposure should include, but not be limited to,

  - A fluid-resistant gown
  - Heavy-duty gloves
  - Mask
  - Face protection
- Hands must be washed after removing PPE**.**
- Reusable PPE must be decontaminated and the integrity of the attire checked between each use.
- Two pairs of gloves should be worn when cleaning instruments and equipment, if there is a risk for perforation.
- Personnel working with contaminated equipment should be vaccinated against the Hepatitis B virus.
- Exposure to blood borne pathogens should be reported immediately through the employee health care channels.

Competency
Ongoing education, competency and validation of personnel facilitate the development of knowledge, skills, and attitudes that affect patient and worker safety.

Documentation
Documentation should be completed to enable the identification of trends and demonstrate compliance with regulatory and accreditation agency requirements.

- Records should be maintained for the time period specified (life of equipment plus 6 years)

PRECAUTIONS:
Care must be taken at all times to assure that no sharps, i.e., knife blades or needles are mixed in with instruments to be cleaned. Care must be taken to assure that careful handling of instruments is followed to prevent injury from sharp instruments such as towel clips, skin hooks etc.

References: Central Supply Technician Training Manual
AORN RP Cleaning and Care of Surgical Instruments
AAMI ST79
TJC: IC.02.01.01, IC.02.05.01
Title 22 Standards: 70831 (Central Sterile Supply), 70833 (Autoclaves and Sterilizers)

Approval	**Date**
CCOC	3/30/2021
Infection Control	4/21/2021
MEC	5/11/2021
Board of Directors	10/21/15
Last Board of Director review	3/18/2020

Developed:
Reviewed:
Revised: 02/01 BS; 4-6-2011 BS; 5-2015 BS, 3/21aw
Index listings Cleaning and Care of Surgical Instruments, cleaning instruments

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Packaging, Wrapping, and Dating Trays and Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 02/01

PURPOSE:
To insure proper sterilization of instruments and supplies, and prevent the use of these items when outdated: (6 months for peel pouches 1 year for blue wrapped instruments and rigid trays) or packaging integrity has been compromised.

POLICY: The following procedure will be utilized by the sterile processing personnel for selection, use, dating, and storage of packaging products for trays and instruments that undergo sterilization through the Sterile Processing unit at NIHD. Procedure tray requirements and supplies are periodically updated. Information regarding special trays and packs can be accessed online through One Source and some information is contained in the Tray Procedure book (alphabetized) in sterile processing alphabetized.

EQUIPMENT:
Heat sealer appropriate for sealing of paper/plastic packaging product set at appropriate temperature for product being used. (Follow manufacturer guidelines)

Heat sealer appropriate for sealing Tyvek pouches that are specific for the V-Pro sterilizer with the temperature set at 270 degrees. (Follow manufacture guidelines)

Paper wraps (various sizes)
Paper packages (various sizes
Paper-plastic pouches (various sizes)
Tyvek pouches
Rigid trays

PRODUCT EVALUATION:
Packaging systems should be evaluated before purchase and use to ensure that items to be packaged can be sterilized by the specific sterilizers and or sterilization methods to be used.

1. Packaging systems should be appropriate for items being sterilized. The package system should:
- Provide an adequate barrier to microorganisms, particulates, and fluids
- Maintain sterility of package contents until opened
- Allow sterilant penetration and direct contact with the item and surfaces, and removal of sterilant
- Be free of toxic ingredients and non-fast dyes and be low linting
- Permit aseptic delivery of contents to the sterile field
- Permit complete and secure enclosure of items
- Protect package contents from physical damage
- Provide adequate seal integrity: be tamper- proof and able to seal only once
- Resist tears, punctures, abrasions, and prevent the transfer of microorganisms
- Permit adequate air removal
- Permit identification of contents
- Be large enough to evenly distribute the mass
- Allow ease of use by personnel preparing and/or opening the package or container
- Have favorable cost/benefit ratio
- Include manufacturer's instructions for use

2. Packaging systems should be appropriate to the method of sterilization.

3. Purchasers should evaluate and test the performance of each packaging system before selection and use this information to determine that conditions for sterilization, shelf life, transport, storage, and handling can be met. If the packaging represents a major change in product type (increased weight of trays) product testing should include:

- Placing biological indicators (BIs) inside a variety of items to be processed (basin sets, instrument sets, etc.). The BI should be located in the most challenging location inside the package, like the center of the pack.
- Packages containing the test BIs should be placed in the most challenging locations inside the sterilizer (e.g. over the drain) in a full chamber.
- Sterilization of the test packages and removal and incubation of the BIs. Test package contents should be reprocessed before use.
- Documentation of the test results should be maintained with sterilization records.

PACKAGING COMPATIBILITY

Packaging should be compatible with the specific sterilization process for which it is designed.

- Packaging systems for steam sterilization should permit adequate drying.
  Several conditions may affect the efficacy of steam sterilization: humidity; altitude; packaging materials; package contents; load; position of items within the sterilizer; size; weight, and density the pack or container; and the parameters of sterilization cycle.
- Packaging systems for low-temperature gas plasma sterilization should
  - Allow sterilizing plasmas to penetrate packaging materials;
  - Be compatible (ie. nondegradable, nonabsorbable) with the sterilization process. Pouches used in low-temperature gas plasma sterilizers should be made of plastic (polypropelene)
  - Be constructed of a material recommended by the sterilizer manufacturer;
  - Be used according to the packaging manufacturer's written instructions.

DESIGN, MATERIAL, AND CONSTRUCTION OF CONTAINMENT DEVICES

Design, material, and construction of the containment device (e.g. rigid containers, instrument case/cassettes, organizing trays) should be considered before selection, purchase, and use.

- Purchasers should verify that the containment device has been tested and validated for the sterilization method and cycles to be used.
- Pre-purchase evaluation and biological testing of the containment device should be performed to determine:
  - whether the facility can verify the manufacturer's test results;
  - if the container device has been cleared by the US food and Drug Administration (FDA) for use in sterilization process;
  - if the container device is compatible with the design of the sterilizer in which it will be used;

  - if the container device will allow complete air removal, adequate sterilant penetration, and drying;
  - requirements for disassembly and cleaning
  - **Pre-purchase biological testing** should be performed according to Association for the advancement of Medical Instrumentation standards. Each size container should be tested under the sterilization methods and cycles to be used.
- The recommended sterilization method and cycle times for each rigid container system should be provided in the manufacturer's data and instructions. Construction materials and container design may affect compatibility with the sterilization process (eg, penetration of sterilant (gas plasma), and release of moisture).
- Rigid containers with single use or reusable filters and valve systems should be secured and in proper working order before sterilization.
- Rigid container systems should be cleaned after each use.
- The manufacturer's written instructions for cleaning, inspection repair and preventive maintenance should be followed.
- The manufacturer's recommended filter material, security locks, and external chemical indicators should be followed.
- Additional materials placed inside rigid containers (eg, silicone mats, surgical towels) should not be used unless the container manufacturer has approved validation for their use.
- The manufacturer's technical data for types of devices validated for use inside the container (eg, power equipment, items with lumens) should be obtained and special instructions for sterilization followed.

STORAGE OF PACKAGING MATERIALS

Packaging materials should be stored and processed to maintain the qualities required for sterilization.

- Reusable textiles should be laundered between every use for rehydration.
  - When woven textiles are not rehydrated after sterilization, and/or if repeated sterilization is attempted, the textiles may absorb the available moisture present in the steam, thereby creating a dry or superheated steam effect. Superheating could be a deterrent to achieving sterilization.
- Packaging materials should be stored at 20 deg C – 23 deg C (68 deg F – 73 deg F) and a relative humidity of 30% - 60% for at least two hours before use.
  - Maintaining room temperature and moisture content of packaging materials facilitates steam penetration and prevents superheating during the sterilization process.
  - Single-use packaging materials should be used for one sterilization cycle. Disposable packaging material should be discarded after opening.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Packaging, Wrapping, and Dating Trays and Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 02/01

ASEPTIC PRESENTATION OF PACKAGE CONTENTS

Package contents should be assembled, handled, and wrapped in a manner that provides for an aseptic presentation of package contents.

- The appropriate size wrapping material should be selected to achieve coverage packaged item.
- The method of packaging should facilitate the aseptic presentation of contents.
    - Sequential wrapping using two barrier-type wrappers provides a tortuous pathway to impede microbial migration and permits ease of presentation to the sterile field without compromising sterility.
    - A fused or bonded, double layer, disposable, non-woven wrapper used according to manufacturer's written recommendations may provide a bacterial barrier comparable to the sequential double wrap, allowing safe and easy presentation to the sterile field.
- Count sheets should not be placed inside wrapped sets or rigid containers.
    - There is no available research regarding the safety of toners and/or various papers subjected to any sterilization method.
    - Chemicals used in the manufacture of paper and toner ink pose a theoretical risk of reaction in some sensitized individuals.

CHEMICAL INDICATOR/INTEGRATOR

A chemical indicator/integrator should be placed inside each package to be processed.

- **External indicators:** Such as Class I chemical indicators (eg, indicator tape), should be specific to the sterilization process selected.
- **Internal indicators:** We use a Class V internal chemical integrator (multi-parameter), which has a combined chemical and biological detection capabilities.
- Follow the chemical indicator manufacturer's instructions for storage, use, and expiration.
- The chemical indicator/integrator should be placed in the center of the package, not on top, to verify that air has been removed and that sterilant has penetrated into the center of the pack or set.
- The indicator should be visible to the user when the package is opened so the user can see that the indicator has changed before has changed before touching the contents.
- Multi-level containers should have a chemical indicator/integrator placed on two opposite corners (e.g. one in each of two corners) of each level.

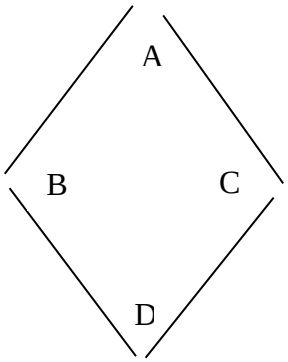
NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Packaging, Wrapping, and Dating Trays and Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 02/01

WRAPPING

PAPER WRAPPING

Wrap instruments in appropriate wrap. If the instruments are sharp, protective tips are used to cover the ends. If there are multiple items, they are placed in small paper bag then are placed together in the paper wrap. Insert a sterilometer inside each set. Secure the outside with autoclave tape. Write the name of the item or instruments on the tape, select a color-coded outdate label and place an autoclave load number and sterilization date tag. After autoclaving by sterile processing, instruments and supplies are considered sterile until outdate or their integrity has been compromised. Seldom used items may be wrapped in a plastic dust cover after cooling process.



- Select proper sized wrapper
- Place item and a chemical indicator in center of wrapper.
- Bring "D" up, covering item, and fold corner down.
- Bring "C" and "B" over to center, fold corner back.
- Bring "A" down over "B" and "C" and tuck under "B" and C".
- For a double wrap (needed for treatment and procedure trays); place this first wrap into the center of the second wrap and repeat the wrapping procedure.
- Mark autoclave tape with name of tray or item (description of package contents), and initial,
- Apply label with sterilization date, autoclave number, and load number
- Apply color–coded outdate label (1 year)
- Sterilize per policy and procedure.
- Sterilized items are considered sterile until outdate unless the integrity of the packaging has been compromised.

PAPER-PLASTIC POUCHES

Paper-plastic pouch packages should be used according to manufacturers' written instructions.

- Paper-plastic pouch packages should be used only for small, lightweight, low-profile items (e.g., one or two clamps, scissors).
  - Package seal breakage or wet packages following sterilization may occur if heavy weighted instruments are sterilized in peel pouches.
- Paper-plastic pouch packages should have as much air removed as possible before sealing.
  - Air acts as a barrier to heat and moisture.
  - Expansion of air may cause rupturing of packages during the sterilization process.
- Paper-plastic pouch packages should provide a seal of proven integrity and not allow resealing.
- Paper-plastic pouch packages should be sealed airtight.
- Paper-plastic pouch packages should be inspected for intact seals and barrier integrity before and after sterilization and before use.

Title: Packaging, Wrapping, and Dating Trays and Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 02/01

- Double paper-plastic pouch packaging is not routinely required for sterilization; however, double packaging may be used to facilitate containment of multiple small items to be sterilized and facilitate aseptic presentation in the sterile field.
    - Double paper-plastic pouch packages should be used in such a manner as to avoid folding the inner package to fit into the outer package. **Folding the edges of inner peel packages may entrap air and inhibit the sterilization process.**
    - During sterilization of double paper-plastic pouch packages, the paper portions should be placed together to ensure penetration and removal of sterilant, air, and moisture
- Paper-plastic pouches should not be used within wrapped sets or containment devices because the pouches cannot be positioned to ensure adequate air removal, sterilant contact, and drying.
- Paper-plastic pouch packages should be opened without tearing, linting, shredding, or delaminating.

RIGID TRAYS

- Ensure all instruments have been cleaned, inspect all items for proper working condition.
- Unlock all hinged or jointed instruments.
- Select proper size rigid container
- Inspect rigid container filter for cleanliness and any defects.
- Select appropriate sized wrapper and follow wrapping instructions carefully.
- Follow instructions in tray procedure manual each time you assemble a tray.
- Sterilize per procedure and when cooled and apply color-coded label for one year outdate.

PACKAGE LABELING:

Packages to be sterilized should be labeled before sterilization

- Mark autoclave tape with name of tray or item (description of package contents), and initial
- Apply label with sterilization date, autoclave number, and load number
- Apply color–coded outdate label:
    - 6 months for peel pouches
    - 1 year for blue wrapped instruments and rigid trays

Label information should be written on indicator tape and not on the packaging material.

- Markers used to label packages should be indelible, non-bleeding, and non-toxic.
- If a marking pen is used to label peel-pouch packages, the information should be written only on the plastic side of the pouch.
- If a marking pen is used to label wrapped packages, the information should be written on the indicator tape or affixed labels.

Package labels should be visible and remain securely to the package throughout processing, storage, and distribution to the point of use. If a tape or a computer-generated label is used, it may be placed on either side of the peel-pouch package.

- Manufacturer sterilized items that have no expiration date are considered sterile unless the package has been damaged or opened.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Packaging, Wrapping, and Dating Trays and Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 02/01

ROTATION OF SUPPLIES

Sterile packages are rotated on a daily basis, placing newly autoclaved items in back of previously autoclaved items, ensuring the use of the oldest items first, dates are checked weekly and the integrity of the packages are checked for any signs of compromise. If packages are compromised in any way, they are retrieved, repackaged and reprocessed in the appropriate manner for reuse.

QUALITY ASSURANCE

- **Product testing** should be performed whenever there is a major change in packaging systems, materials, tray configuration, or content density.
- **Biological testing** should be performed after any maintenance of the sterilizing equipment
- **Wet packs should be investigated and resolved.**
  Internal and external moisture has the potential to provide a pathway for microorganism to enter and contaminate sterilized items.
    - Measures to resolve wet packs should include, but are not limited to,
    - Determine the set/tray configuration and weight,
    - Evaluate the packaging materials and methods used,
    - Evaluate the pan/tray used to contain the set,
    - Determine the placement (ie, location) of the tray/set on the sterilizer cart,
    - Determine the entire contents of the sterilizer load in question (e. g. the number and various types of items) including placement on the sterilizer cart.
    - Determine if the chamber drain line basket is clogged,
    - Investigate the steam quality with the engineering department, and
    - Determine if the steam sterilizer is functioning properly (e. g. insufficient vacuum during the drying cycle).
    - One method that maybe used to minimize wet pack is to "precondition" the load.
    - Place instruments inside the steam sterilizer before starting the cycle for 10 -15 minutes with the door closed. The heat in the chamber, from steam stored in the jacket, will heat the instruments. This may resolve wet pack issues that are not associated with steam quality or packaging/loading errors.
- Evaluation and biological testing of rigid containers should be performed periodically in each specific sterilizer and with each cycle type used.
- Quality assurance should include sterility testing and verification using commercial verification test to ensure instruments and scopes are clean (the Resi-test for example is used to detect presence of protein residue which would indicate the instrument or scope has not been cleaned sufficiently). Testing should be performed regularly and the data should be reported at least quarterly and presented as part of the unit performance improvement program.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Packaging, Wrapping, and Dating Trays and Instruments	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: Surgery / Sterile Processing Manager	Effective Date: 02/01

DEMONSTRATION OF COMPETENCE

Personnel should be trained and demonstrate competence in the use of sterilization equipment and supplies

- Education will be provided during orientation period. Personnel should be competent in the proper selection and use of packaging systems. An introduction to related policies and procedures should be included in orientation to Sterile Processing.
- Personnel selecting and using packaging systems should be knowledgeable about the principles of sterilization, manufacturers' instructions, risks, measures to minimize these risks, and corrective actions to employ in the event of the failure of the packaging system.
- Training and education should be presented whenever new equipment or supplies are put into use and on an annual basis. Additional periodic educational programs will be provided to reinforce safe use; new information on changes in technology, its application, and compatibility of sterilization equipment and processes; and potential hazards.

REFERENCE: AORN RP Selection and Use of Packaging Systems for Sterilization
AAMI ST 79 (2017)
Manufacturer literature: "Verify" Resi-Test

Approval	**Date**
CCOC	3/29/2021
Infection Prevention	4/21/2021
MEC	5/11/2021
Board of Directors	10/21/15
Last Board of Director review	1/16/19

INDEX LISTINGS: Selection and use of packaging systems/ Packaging systems, Special Procedure Trays/Trays Special Procedure
REVISED: 02/01 BS; 4-6-2011 BS; 5/2015 BS, 3/21aw

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Precleaning and Returning of Instrument to Central Sterile Processing*	
Scope: RHC, Emergency Dept, Med-Surg, ICU, Perinatal	Manual: CPM - Infection Control-Environmental (ICE)
Source: Surgery / Sterile Processing Manager	Effective Date: 11/1/15

PURPOSE: To identify the process for the immediate pre-cleaning of used instruments prior to transport to Sterile Processing**.**

POLICY:

A. Each department/office will have a designated, rigid container with a lid to soak reusable instruments prior to return to Sterile Processing.
B. PPE (Personal Protective Equipment) will be worn when pre-cleaning instruments.
C. Instruments are to be soaked, cleaned, and free of debris prior to transport to Sterile Processing. Corrosion, rusting, and pitting occur when blood and debris are allowed to dry in or on surgical instruments. Cannulas or lumens can become obstructed with organic material.
D. Each department/office is responsible for the cleaning of instruments used in the department and the removal/disposal of sharps prior to placing them in the transport containers.
E. Transport of instrument to Sterile Processing will be in a designated container for transport.
F. The Sterile Processing Department will be responsible for the final decontamination and terminal sterilization of reusable instruments and medical devices.

PROCEDURE:

Step 1: <u>Pre-cleaning</u>

Apply appropriate PPE for type of pre-cleaning

Step 2: <u>Removing Sharps</u>

All sharps must be removed and properly disposed of prior to handling / cleaning instruments.

Step 3: <u>Cleaning, Soaking, and Washing</u>

Remove visible gross debris from reusable instruments or medical devices at point of use with approved enzymatic cleaner per manufacturer's directions.

A. Place manufacturer approved enzymatic detergent and water into appropriate empty container, verifying expiration date of enzymatic detergent.
B. Place instruments in container.
C. Leave hinged instruments in open position and disassemble those with removable parts
D. Soak instrument per manufacturer's guidelines.
E. Scrub all surfaces with scrub brush or other cleaning tools, paying special attention to serrated edges, box locks and other hard to reach places. Brush delicate instruments carefully and handle separate from general instruments.
    a. Instruments must be scrubbed while submerged in enzymatic cleaner to prevent aerosolization of blood borne pathogens.
    b. Discard one time use brushes and cleaning tools after use.
    c. Discard enzymatic detergent after use.

Step 4: <u>Rinsing</u>

Rinsing with water is part of the washing process so any sediment left on the washed items may be removed.

Step 5: Checking

Opening and closing instrument to ensure soil is not trapped in the box locks of the instrument. Observation also ensures the cleaning process is thorough and complete.

Step 6: Transport

Monday – Friday a courier will pick up and transport pre-cleaned reusable instrument or medical device in approved container to the Sterile Processing Department for completion of the terminal sterilization process. The transport container must be labeled to indicate bio-hazardous contents to communicate to others the items are potentially infectious. The transport container should be labeled with unit specific (colored) autoclave tape to ensure each department/ office receives the correct instruments after sterilization.

Step 7: Return / Pickup

Return of Sterile Instruments and Clean Transport Containers will be done Monday through Friday by courier (when the courier comes to pick up instruments, the sterilized instruments will be returned to the clinic/office or department). If after hours pick up is necessary please contact the House Supervisor.

REFERENCES:

1. Association of PeriOperative Registered Nurses (2013) Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Settings. AORN: Denver, CO.

Approval	Date
CCOC	3/30/21
Infection Control Committee	4/21/21
MEC	5/11/21
Board of Directors	10/21/15
Last Board of Director review	1/17/18

Developed: 02/01
Reviewed:
Revised: 04/14 PN, 3/21aw
Supersedes: Returning of Instruments to Central Sterile Processing
Index Listings: Cleaning process; Instrument cleaning; Precleaning Soiled Instruments

NORTHERN INYO HEALTHCARE DISTRICT MEDICAL STAFF
POLICY AND PROCEDURE

Title: Medical Staff Department Policy – Outpatient Medicine	
Scope: Rural Health and IM Practitioners	Manual: Medical Staff
Source: Chief of Outpatient Medicine	Effective Date:

PURPOSE: To delineate clear expectations for Outpatient Medicine practitioners within Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners (physicians and Advanced Practice Providers) granted privileges in the Rural Health Clinic or Internal Medicine Clinic will adhere to the following protocols.

PROTOCOL:

1. Patient Care Responsibilities:
    a. Practitioners will be expected to see patients according to their individual schedules, which shall be arranged in conjunction with the Chief Medical Officer (CMO) and the director of their department.
    b. Practitioners will be expected to evaluate, diagnose, and manage conditions within their scope of practice.
    c. Advanced Practice Providers (APPs) will be assigned a supervising physician as per California regulations, if required.
    d. Practitioners will complete appropriate documentation for any given patient encounter within 48 hours.
    e. Lab, imaging, and pathology results should be reviewed within 96 hours of receipt. Critical values should be addressed within 24 hours.
2. Call
    a. Physicians will participate in after-hours call (remotely) on a rotating schedule as set by their home department. Advanced Practice Providers may participate in after-hours call, but must have physician back-up readily available. Call requirements and guidelines will be dictated by a practitioner's home department.
3. Credentialing:
    a. Outpatient Medicine physician practitioners must be board certified or board eligible by the American Board of Medical Specialties or the American Osteopathic Association in their field.
    b. Nurse Practitioners must be certified by a nationally-recognized agency in their field (ex., American Association of Nurse Practitioners).
    c. Physician Assistants must be certified by the National Commission on Certification of Physician Assistants (NCCPA).
4. Meeting Attendance:
    a. Practitioners are expected to attend committees as assigned:
        i. Outpatient Medicine Committee Meeting, quarterly
        ii. Provider meetings per home department
        iii. Additional meetings per Medical Staff Bylaws requirements (General Medical Staff meetings, specific committee meetings)
5. Coverage:
    a. During vacation times, practitioners will be expected to coordinate with other practitioners or team members to ensure continuous delivery of service.

6. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to undergo 100% chart review for a minimum of two weeks.
    b. Procedural competency will be demonstrated through five directly observed procedures by a practitioner who has privileges in the procedure.
7. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE.
    b. Five percent of APP charts will be reviewed by the supervising physician(s) on an ongoing basis.
8. Peer Review:
    a. Outpatient charts identified by critical indicators will be peer reviewed by the Chief of Outpatient Medicine or delegated practitioner. Selected cases will be reviewed at the Outpatient Medicine committee at its next scheduled meeting. A standardized peer review form will be utilized in the process (for example, refer to Attachment 1). Records are confidential and will be kept by the Medical Staff Office.
9. Re-Entry:
    a. Outpatient practitioners may be eligible for re-entry as per policy.

REFERENCES:

1. None

CROSS REFERENCE P&P:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. *Focused and Ongoing Professional Practice Evaluation Policy*
3. *Practitioner Re-Entry Policy*

Approval	**Date**
Outpatient Medicine Committee	05/05/2021
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Developed: 04/2021 aw,sb,jj
Reviewed:
Revised:
Supersedes:
Index Listings:

Outpatient Medicine

2021

1. Upon request of the patient, patient's DPOA if patient lacks capacity, or staff
2. Any UOR
3. Unexpected deaths of patients outside of the hospital
4. More than 1 hospital admission within 30 days, AND need identified by UR committee for outpatient review (Dr. Schunk to be our committee liaison for this)
5. Documented specific procedure complication such as hemorrhage, infection, poor healing, impairment of body function to a level less than prior to the procedure and less than commonly expected as a result of the procedure.

Approved:

Outpatient Medicine Committee: 4/14/2021
Medical Executive Committee: 5/11/2021
Board of Directors:

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

Emergency Medicine

Delineation of Privileges

Applicant's Name: ,

Instructions:

1. Click the Request checkbox at the top of a group to request all privileges in that group.
2. Uncheck any privileges you do not want to request in that group.
3. Sign form electronically and submit with any required documentation.

Facilities

☑ NIHD

Required Qualifications

Education/Training (for initial applicants)	Completion of an ACGME or AOA accredited Residency training program in Emergency Medicine. OR Completion of an ACGME or AOA accredited Residency training program in Family Medicine.
Certification	Current certification or active participation in the examination process leading to certification in Emergency Medicine by the American Board of Emergency Medicine or AOA equivalent. OR Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or AOA equivalent with current ATLS, ACLS and PALS certification.
Clinical Experience (Initial)	Applicant must provide documentation of provision of emergency medicine services representative of the scope and complexity of the privileges requested in a hospital comparable to Northern Inyo Hospital in census and acuity of patients during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide evidence of ongoing clinical practice representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications	Applicant must have a contract with the Eastern Sierra Emergency Physicians to provide services in this specialty.

Core Privileges in Emergency Medicine

Description: Immediate recognition, evaluation, care, stabilization and disposition of a generally diversified population of patients in response to acute illness and injury. Focus on the immediate decision making and action necessary to prevent death or any further disability.

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Perform history and physical examination
☐	Evaluate, diagnose and initially treat patients of any age who present in the emergency department with any symptom, illness, injury or condition and provide services necessary to ameliorate minor illnesses or injuries; stabilize patients with major illnesses or injuries and to assess all patients to determine if additional care is necessary.

FPPE (Service Chief to select)	
☐	Retrospective evaluation to include all cases meeting critical indicators for a minimum of 6 months.
☐	Evaluation from Emergency Medicine Director.
☐	Evaluation from ED Nurse Manager.
☐	Evaluation from Hospitalist Director.

Emergency Focused Ultrasound

Description: Investigational ultrasound for trauma or other indication.

Qualifications

Education/Training	Documentation of training and experience during residency OR Attendance at a 2-day course by a recognized provider that included varied simulations and was followed by supervised cases.
Clinical Experience (Initial)	Applicant must provide evidence of ongoing clinical practice representative of the scope of privileges requested during the past 24 months.
Clinical Experience (Reappointment)	Applicant must provide evidence of ongoing clinical practice representative of the scope of privileges requested during the past 24 months.

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Perform and interpret emergent, focused or investigational ultrasound

FPPE (Service Chief to select)

☐	Retrospective review of 5 varied cases.

Procedural Sedation (Must perform 6 every 2 Years)

Qualifications

Clinical Experience (Initial)	Applicant must provide documentation of a minimum of 6 sedations during the previous 24 months. AND Applicant must complete sedation tutorial at initial granting of privileges and every 2 years thereafter.
Clinical Experience (Reappointment)	Documentation of at least 6 cases within the last 24 months. AND Sedation tutorial completed within the last 24 months.
Additional Qualifications	Current ACLS certification (waived for physicians with Emergency Medicine Board certification).

Check the Request checkbox to select all privileges listed below.
Uncheck any privileges you do not wish to request in the group.

Request	
☐	Dissociative sedation
☐	Moderate sedation
☐	Deep sedation

FPPE (Service Chief to select)

☐	Retrospective review of 3 cases of administration of moderate sedation
☐	Feedback from involved clinical or administrative personnel

Transesophageal Echocardiography (TEE)

Description: Placement of the transesophageal probe, image acquisition and interpretation.

Qualifications

Education/Training	Successful completion of an ACGME accredited residency or fellowship training program that included education and direct experience in transthoracic echocardiography (TEE) with performance and interpretation of supervised cases. Confirmation of completion of level 2 training and current clinical competence from the residency or fellowship program director if the training was completed during the previous 24 months OR National Board of Echocardiography certification in TEE.
Clinical Experience (Initial)	Documentation of ongoing clinical practice representative of the scope of privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Documentation of ongoing clinical practice representative of the scope of privileges requested during the previous 24 months.

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Transesophageal Echocardiography (TEE) including probe placement, image acquisition and interpretation

FPPE (Service Chief to select)

☐	Concurrent review of 1 case
☐	Retrospective review of 3 cases

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, health status, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Northern Inyo Healthcare District and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature NIHD

Service Chief Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

CALL TO ORDER

The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair.

PRESENT

Robert Sharp, Chair
Jody Veenker, Vice Chair
Mary Mae Kilpatrick, Secretary
Topah Spoonhunter, Treasurer
Jean Turner, Member-at-Large
Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer
Joy Engblade MD, Chief Medical Officer
Allison Partridge RN, MSN, Chief Nursing Officer
Sierra Bourne MD, Interim Chief of Staff
Keith Collins, General Legal Counsel (Jones & Mayer)

OPPORTUNITY FOR PUBLIC COMMENT

Mr. Sharp announced that the purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes being allowed for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. No comments were heard.

NEW BUSINESS

COVID 19 UPDATE

Interim Chief Executive Officer and Chief Operating Officer Kelli Davis MBA provided a monthly Covid 19 update which included the following:

- Inyo County's number of positive Covid 19 cases have decreased significantly and continue to trend downward
- Covid 19 Incident Command meetings continue. Key healthcare partners and community stakeholders participate in meetings with Northern Inyo Healthcare District (NIHD) on a weekly basis.
- Inyo County recently transitioned from the purple (widespread) Covid tier to the red (substantial) tier
- NIHD's Respiratory Care Unit is in the green zone (1 or fewer patients)
- A second mass vaccination event will be held this upcoming weekend, and appointments are still available for those who wish

to be vaccinated. NIHD also continues to offer vaccinations to members of the public on Tuesday and Thursday of each week.

MOMENT OF APPRECIATION FOR DISTRICT STAFF AND PROVIDERS

The District Board took a moment to appreciate NIHD staff and providers for their continued dedication during the Covid 19 pandemic. Mr. Sharp reported that Covid Hero awards for the month of April were presented to:

- William Timbers MD (*NIHD Emergency Department physician and former Interim Chief Medical Officer*)
- Nicole Cooper (*NIHD Women's Clinic*)
- Lisa Davis (*NIHD and Reach Air*)

BRONCO CLINIC UPDATE

Ms. Davis introduced Colleen McEvoy RN, MSN, C-PNP to provide an update on the Bronco Clinic, a school-based Health Center at Bishop Union High. During Ms. McEvoy's presentation, the following items were noted:

- The Bronco Clinic represents a joint effort and partnership between NIHD and Bishop Unified High School (BUHS) to provide students with access to care
- Services provided at the Clinic include medical care; mental health services; reproductive health services and education; dental services; and youth engagement
- The Bronco Clinic opened in January of 2018. It was later temporarily closed in order to improve operations and implement needed changes. The Clinic remains closed at this time, but will re-open as soon as possible.
- Benefits of school-based clinics include providing services to students where they are; a resulting decrease in student absences; increased access for students to healthcare; promoting responsibility in youth for their own health; and helping busy parents to stay at work
- Future plans for the Clinic include becoming a Medi-Cal and Family Pact Provider; implementing insurance billing; consideration of providing student sports physicals; and improving student access to mental health services
- The BUHS Bronco Clinic is a member of the California School-Based Health Alliance

VENDOR CREDENTIALING POLICY AND PROCEDURE

Ms. Davis called attention to a proposed District-wide *Vendor Credentialing* Policy and Procedure which outlines the process for credentialing all vendors and representatives from outside businesses or organizations, according to state and federal guidelines and Joint Commission recommendations. It was moved by Jean Turner, seconded by Jody Veenker, and unanimously passed to approve the proposed *Vendor Credentialing* Policy and Procedure as presented.

REVIEW OF NIHD BOARD AD HOC COMMITTEE MEMBERSHIP

Mr. Sharp called attention to possible re-organization and membership review of the following active NIHD Board of Directors Ad Hoc Committees:

1. Board/Medical Staff Relations Committee (*Directors Sharp and Turner, members*)
2. Physician Compensation Subcommittee (*Directors Sharp and Veenker, members*)
3. Joint Conference Committee (*Directors Sharp and Veenker, members*)
4. NIHD/SMHD Joint Relations Committee (*Directors Sharp and Veenker, members*)
5. NIHD Medical Staff Wellness Survey Committee (*Directors Sharp and Veenker, members*)

Discussion followed on the continuing need for each Committee as well as areas of potentially overlapping efforts. As a result of the discussion the following changes were made:

- NIHD Board/Med Staff Relations Committee: *dissolved*, can resume if a future need arises (moved by Mary Mae Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve dissolving the NIHD Board/Med Staff Relations Committee). If this Committee is reinstated in the future, the Board Chair will appoint 2 Board members to serve on that Committee.
- Physician Compensation Subcommittee: *remains* (it was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to appoint Directors Sharp and Spoonhunter to serve as Physician Compensation Subcommittee members going forward).
- NIHD/SMHD Joint Relations Committee: *remains the same* with no changes being made
- NIHD Medical Staff Wellness Survey Committee: *remains the same* with no changes being made

Director Veenker additionally asked that selection of Board members to serve on a Chief Executive Officer Selection Ad Hoc Committee be placed on the agenda for the next meeting of the District Board.

CHIEF OF STAFF REPORT

POLICY AND PROCEDURE APPROVALS

Interim Chief of Staff Sierra Bourne, MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following District-Wide Policies and Procedures:

1. *Echocardiogram Performance Protocol*
2. *Medical Staff Department Policy – Hospital Medicine*
3. *Stabilization and Resuscitation of the Newborn*
4. *Standardized Procedure for the Admission of the Well Newborn*
5. *Standardized Procedure for COVID-19 Test Results*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve all 5 Policies and Procedures as presented.

MEDICAL STAFF APPOINTMENT

Doctor Bourne additionally reported the Medical Executive Committee recommends approval of the following Medical Staff appointment:

- Cheryl Olson, MD (*general surgery*) – Courtesy Staff

It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously

passed to approve the Medical Staff appointment of Cheryl Olson MD as requested.

REQUESTS FOR ADDITIONAL PRIVILEGES

Doctor Bourne also reported the Medical Executive Committee requests approval of the granting of Additional Privileges for the following:

1. Stefan Schunk, MD (*internal medicine*) – request for outpatient core privileges and trigger point injection privileges
2. Monika Mehrens, DO (*family medicine*) – request for outpatient core privileges

It was moved by Ms. Veenker, seconded by Topah Spoonhunter, and unanimously passed to approve the granting of Additional Privileges for Doctors Schunk and Mehrens as requested.

MEDICAL STAFF RESIGNATIONS

Doctor Bourne also reported that the Medical Executive Committee recommends approval of the following Medical Staff resignations:

1. Rainier Manzanilla, MD (*cardiology*) – effective 3/1/21
2. Diana Havill, MD (*psychiatry, Adventist Health*) – effective 4/30/21

It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and unanimously passed to approve both Medical Staff resignations as requested.

MEDICAL STAFF ORGANIZATIONAL CHART

Doctor Bourne additionally called attention to an updated NIHD Medical Staff Organizational Chart, noting the following Medical Staff leadership positions:

- Chief of Staff: *Sierra Bourne, MD*
- Vice Chief of Staff: *Anne Wakamiya, MD*
- Chair of Surgery, Tissue, Transfusion, and Anesthesia (STTA): *Robbin Cromer-Tyler, MD*
- Chair of Inpatient Medicine: *Monika Mehrens, DO*
- Chair of Outpatient Medicine: *Anne Wakamiya, MD*
- Chair of Peri-Peds: *Martha Kim, MD*
- Chair of Emergency Department: *Adam Hawkins, DO*
- Chair of Radiology: *Edmund Pillsbury, MD*

CONSENT AGENDA

Mr. Sharp called attention to the Consent Agenda for this meeting, which contained the following items:

- *Approval of minutes of the March 10 2021 special meeting*
- *Approval of minutes of the March 14 2021 special meeting*
- *Approval of minutes of the March 17 2021 regular meeting*
- *Financial and Statistical reports as of February 28 2021*
- *Policy and Procedure annual approvals*
- *Cerner Implementation update*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all six Consent Agenda items as presented.

BOARD MEMBER REPORTS

Mr. Sharp also asked if any members of the Board of Directors wished to report on their attendance at any NIHD Committee meetings. Director Spoonhunter reported he recently met with NIHD Leadership and District legal counsel to discuss the structure and best practices for NIHD's construction projects going forward. Director Kilpatrick reported on her recent attendance at an NIHD Quality Council meeting, and Director Turner reported on attendance at an Association of California Healthcare Districts (ACHD) Advocacy Committee meeting. No other reports were heard.

ADJOURNMENT TO CLOSED SESSION

At 7:10 pm Mr. Sharp reported the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9*). Name of case: Inyo County LAFO and NIHD v. SMHD, Case No. 3-2015-8002247-CY-WM-GDS-Sacramento County.
B. Conference with Labor Negotiators, Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
C. Significant exposure to litigation (*pursuant to Government Code Section 54956.9*), 3 cases.
D. Conference with legal counsel, existing litigation (*pursuant to Gov. Code Section 54956.9(d)(1*). Name of case: Robin Cassidy v. Northern Inyo Healthcare District.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:46 pm the meeting returned to Open Session. Mr. Sharp reported that the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 8:47 pm.

_____
Robert Sharp, Chair

Attest: _____

Mary Mae Kilpatrick, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: May 19, 2021

TO: Board of Director's
Northern Inyo Healthcare District

FROM: Kelli Davis, Interim Chief Executive Officer (CEO)

RE: Bi-Monthly CEO – Northern Inyo Healthcare District

REPORT DETAIL

Leadership
Chief Medical Officer (CMO) - Dr. Joy Engblade has transition into her role as Chief Medical Officer (CMO) with amazing grace. She is focused on many projects and one-on-one meetings with providers and other District team members. The Executive Team is pleased to have Dr. Engblade on board!

Director of Rehabilitative Services - Simone Mata, DPT, has accepted the position of Director of Rehab Services at NIHD. She will provide support and leadership to the Rehab Services team. Simone is an experienced physical therapist with a focus in interdisciplinary collaboration, data driven practices, community outreach, and a passion for the Eastern Sierra communities she serves. Simone started in her new role on Monday, April 12, 2021. This position was previously held by Thad Harlow, who relocated out of state in March.

LEAD (Leadership*Engagement*Accountability*Development) **Academy**- continues with 2 hour + meetings every other Thursday through August.

As you will recall, NIHD has partnered with the Hospital Association of Southern California (HASC) to bring an "intensive 12-module training experience using innovative tools and experiential learning" virtual academy to NIHD leaders. "LEAD is built on the underlying principle that effective leadership requires productive relationships to support excellence in patient care, sustainable business objectives and a safe patient environment" (HASC).

NIHD recognizes our employees are the greatest asset we have. Ensuring our leaders have the resources, tools and core foundation to lead with excellence is our top priority. All leaders at NIHD will have the opportunity to participate in the LEAD Academy during one of the sessions taking place over the next year. The first group to participate in the LEAD Academy beginning March 4, 2021, include:
Greg Bissonette, Kelli Davis, Patty Dickson, Bryan Harper, Scott Hooker, Frank Laiacona, Barb Laughon, Neil Lynch, Andrew McKie, Richard Miears, Jason Moxley, Dianne Picken, Marjorie Routt, Annette Saddler, Amy Stange, Scott Stoner, Thomas Warner, Larry Weber, and Sarah Yerkes.

The 12-modules will be delivered through a 2-hour virtual e-learning session every 2 weeks for 6 months.

COVID-19

NIHD continues to be fully focused on prevention, testing and caring for patients who are COVID-19 positive. At the time of this report, the NIHD Lab was reporting zero reactive tests in the last 7-days, with no COVID patients in-house. Inyo County has now moved into the Orange/Moderate Tier on May 4th. The District has noted a slowing in the vaccination process with 123 during the week of April 28 – May 5th. Community messaging to emphasize the importance of vaccinations is being developed.

The NIHD Incident Command team meets every Wednesday to evaluate current state, regulatory directives, data, resource and equipment needs, action planning and input from key resources to ensure we remain ahead of the pandemic in all ways possible. This team continues to discuss how to transition back to full operations with regulatory guidance.

Sierra Cerner Project

NIHD continues to move toward the May 17th "go-live" date with our new electronic health record (EHR), Cerner. The District team has been in full force with testing, training and preparing, on top of already heavy workloads. To say the team, including providers of course, is impressive goes unsaid. What can be said, is the amazing work, sheer diligence, team work, peer support and desire to see the success of Cerner when it meets NIHD as the "switch gets flipped", has been inspiring, humbling, and pride filled. They've taken what some could have said were "stumbling blocks" and turned them into "stepping stones" for success! More to come….. (Please see Daryl Duenkel's report later in the agenda packet).

NIHD Strategic Plan

The NIHD Board members, Executive Team, Chief of Staff, physicians and staff members met on April 10th for a full day of strategy discussion, resources, presentation and more, with facilitator David Sandberg. Having come away with some insight, input and key focus areas of vision from the Board, the Executive Team has met several times with David Sandberg and have worked in the Action Strategy platform to define the elements of what we believe will be instrumental in providing a visionary strategic plan for the Board to review and approve. David Sandberg and the Executive Team will provide an update and elements for review and approval as discussed during the April 10 Board Meeting.

Department Reports

Please find the reports from the department leaders I support in the next pages. You are sure to see much work underway, some challenges and of course, some celebration of the amazing work and service provision taking place at NIHD.

Closing

The support and guidance by the NIHD Board of Director's is greatly appreciated. As always, please do not hesitate to contact me with any questions or to share any concerns you may have.

Respectfully submitted,
Kelli Davis - Interim CEO

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(760) 873-5811 Ext. 3415

DATE: May 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Barbara Laughon, Manager, *Marketing, Communications & Strategy*

RE: Department Update

REPORT DETAIL

Old Marketing Business

- We continued to support the County's efforts with distributing the COVID vaccine and recently hosted an informational News Conference for the local media. We pressed the County to form a coalition of the local healthcare marketing teams to provide a unified message going forward as vaccine interest declines. The group features Genoa Menses (Inyo County), Samantha O'Hara (Southern Inyo Healthcare District), Ethan Dexter (Toiyabe), Ethan Aukee (Valley Health), and Barbara Laughon (NIHD). The group will meet once a week as needed.
- NIHD marked Doctors Day (March 30) with print and social media presences, encouraging the public to share their gratitude with our physicians. We received a large number of thank you letters, which we distributed. This led to the development of a permanent "Gratitude Gram" option on the NIHD website.

New Marketing Business

- Digital Marketing Specialist Caroline Casey Britton tendered her resignation effective April 27 after accepting a position with Mammoth Hospital. We are currently recruiting applicants for the Digital Marketing Specialist position and have negotiated a short-term contract with Amanda Long of Social Media Squad to assist with Digital Marketing while we conduct recruiting and interviews for a local candidate.
- We are preparing for the Cerner Go Live events. Many thanks to Sarah Yerkes and Linda Ramos for their assistance in this area.
- Many thanks to Jotendra "Jay" Ranabhat for speaking on KIBS about Occupational Therapy at NIHD. Board Chair Robert Sharp will be speaking during the ASK NIHD segment this month. Date TBD.
- NIHD showed its support for Child Abuse Prevention Month and the County's Children's Memorial Day with a display of blue and silver pinwheels and support banners in front of

the hospital. Many thanks to Jean Turner, Tanya DeLeo, Michelle Garcia, James Nichols, Leroy Charley and Paul Laughon for their assistance in making this display a reality.

Digital Marketing Update

Top Performing Facebook Posts:

NorthorninyoH...
Wed 4/14/2021 3:00 pm ...

Tomorrow **#California** extends eligibility of the COVID-19 vaccine to

Total Engagements	**3,535**
Reactions	9
Comments	3
Shares	1
Post Link Clicks	21
Other Post Clicks	3,501

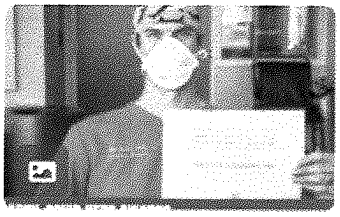
NorthorninyoH...
Fri 4/23/2021 7:00 am PDT

Happy Lab Week! We are so proud of our Lab Team here at NIHD which consists of clos

Total Engagements	**127**
Reactions	48
Comments	6
Shares	3
Post Link Clicks	-
Other Post Clicks	70

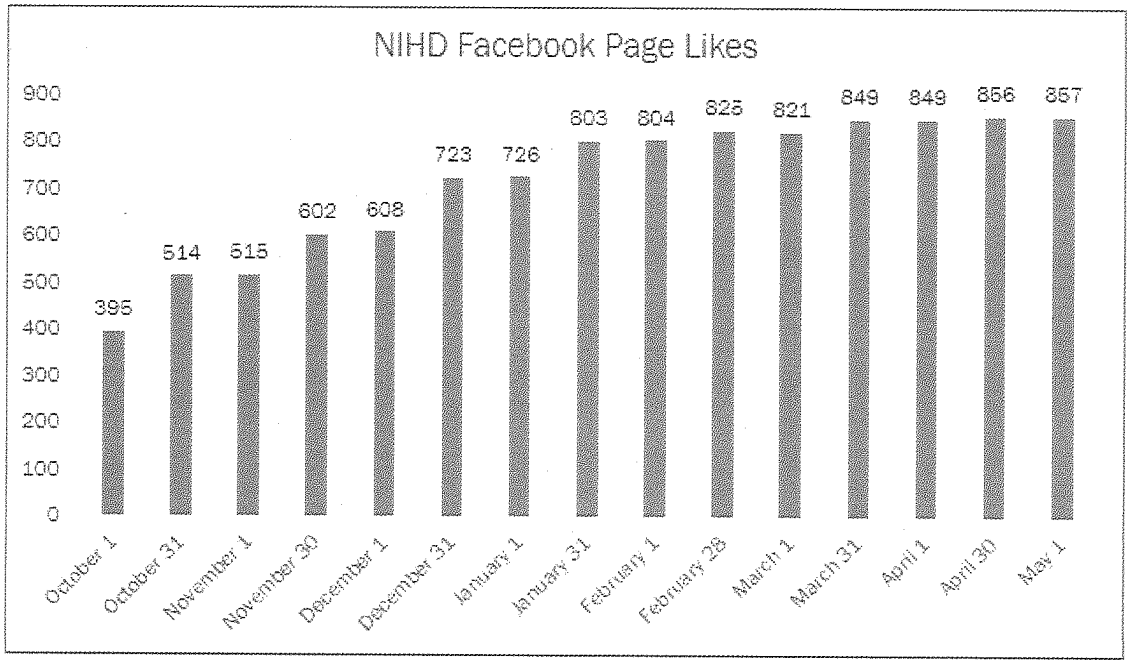
NorthorninyoH...
Mon 4/19/2021 10:52 a...

NIHD Medical Staff Unveil COVID Heroes for April
Barbara Laughon, NIH



Total Engagements	**83**
Reactions	29
Comments	2
Shares	0
Post Link Clicks	9
Other Post Clicks	43

NIHD Facebook Page Overall Likes:



NIHD Website Statistics:

- Visitation:
  - March: 9,478
  - April: 8,426
  - Total for 2021: 37,018
- Average Time On Site:
  - March: 1:42
  - April: 1:22
- Most Popular Day and Hour:
  - March: Tuesday, 8 a.m. followed by 9 a.m.
  - April: Thursday at 9 a.m. and 10 a.m. followed by 4 p.m.
- 40% on Mobile Devices vs 58% Desktop (2% Tablet)
- Most Popular Browser: Chrome (almost double to anything else)

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150 Pioneer Lane
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DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Scott Hooker, Director of Facilities

RE: Department Update

REPORT DETAIL

MAINTENANCE/FACILITIES

New Business:

Work has continued on the building separation project Colombo Construction will be providing an update to the Board in May. Pharmacy relocation documents will be re submitted to OSHPD in May. OSHPD has agreed to review and accept them but not issue a permit until the separation project is complete.

Ping and Associates Architectural firm is preparing OSHPD documents for the Omnicell replacement project.

Old Business:

Work continues on the chiller plant upgrade. Contract signed documents being prepared.
This is a very technical and complicated project. OSHPD is requiring many details and documents for this project. We will continue to push as hard and fast as we can on this project so that we can get the temporary chiller returned.
Ping and associates have provided a quote to do the design and engineering phase of the work.

Work is ongoing with the building maintenance program. Access points for this system are being installed at key points in the plant system is up and running training to take place in the next week.

Temp Chiller

Work continues to meet OSHPD requirements.

SECURITY

New Business:

Security is running smoothly we had two officers retire so we will be interviewing to fill some positions.

Old Business:
Security is currently operating with 4 officers. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

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(760) 873-5811

DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

REPORT DETAIL

Environmental Services
The Environmental Service team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph House to our OR's and PACU. We currently have 24 fulltime employees in ES with one vacant spot to fill.
ES hasn't had a Covid spike in a while, but we have been staying busy.

Laundry
The Laundry team operates Monday –Friday from 500am to 1630pm. We currently have 4 employees with one spot open that stagger start thru the day. Our chemical line is still safe. All equipment is working well. Our staff is doing great.
Our washable PPE is at a great back-up level, so we are prepared for the next Covid spike.
The Laundry staff hasn't had to work on the weekends for a while since we have slowed down on Covid.

Other Information
Talent Pool: Talent Pool is currently at 6 employees, with 1 other Talent Pool employee joining us 5/17/21. We do plan on hiring a Talent Pool to our vacant fulltime spot into ES soon. The applicants in ADP for Talent Pool are still trickling in very slowly.

Screeners: We have 5 temporary screeners from Sierra Employment to cover Radiology 5 days per week, Main and the ED entrance 7 days per week. No new screeners lately. They are all really nice and do a great job!

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150 Pioneer Lane
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DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Bryan Harper, Director of ITS

RE: Department Update

REPORT DETAIL

NEW BUSINESS

ITS is working on using the heat maps built to identify known wireless interference and resolve some outstanding issues reported by staff.

ITS continues on working on all hardware and prep work for Cerner along with supporting the upcoming Go-Live.

ITS has just completed a large NetApp Storage upgrade. This will allow us to move our Exchange (outlook) databases from older slow storage to new faster storage and hopefully address staff issues.

Internal Security Pre-Penetration testing is starting in the next few months after Cerner Go-Live.

ITS is testing a Secure in house messaging platform that could be used for Provider communications.

Clinical Engineering is in the final stretches working with Cerner for Patient Monitor, Fetal Monitor, EKG, Anesthesia, and OR integration with Cerner. We are currently waiting for availability to finish the Internal Medicine Efficiency project, all parts and pieces are here.

OLD BUSINESS

ITS is finishing up the last of the computer upgrades for the district

Clinical Engineering had been working on the Patient Monitor, Fetal Monitor, EKG, and Anesthesia, integration with Cerner. In addition, we had also been working on the Internal Medicine Efficiency project.

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DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Neil Lynch, Purchasing

RE: Department Update

REPORT DETAIL

NEW BUSINESS
Purchasing continues to work on Cerner preparation, workflow, and integration. PPE supply chain is stable. GPO transition is in progress.

OLD BUSINESS
Cerner preparation, workflow, and integration. Covid supply shortages, as this is ongoing. GPO transition, determine scope and project team members.

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DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION

March and April saw board meetings take place with work culminating on the fundraising training for the board members in March. April's board meeting saw Senior Leadership give introductions to the Foundation board to strengthen the relationships and connections there. The board also had a presentation by Colleen McEvoy on the Bronco Clinic and the need for support on its reopening. The Foundation approved $10,000 to purchase equipment and supplies for that clinic.

I also attended a couple of professional development trainings around fundraising that were sponsored by the association I belong to, the Southern California Association for Healthcare Development.

GRANT WRITING

On the Grant Writing side, the District was successful in securing another Opioid treatment grant from The Center at Sierra Health Foundation in the amount of $174,128.91. This grant will further support physician outreach to a very vulnerable population as well as supporting the work being done by all those members in the RHC working to treat this epidemic.

Administration and maintenance for our current grants is ongoing. There were no new grants that were under consideration or being applied for.

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DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Larry Weber, Director of Diagnostic Services

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Cardiopulmonary:

As will be the trend in this report, the cardiopulmonary Department has been very busy preparing for Cerner go-live. Work flow development, interface building, end to end testing, and end user training has been the primary focus for this department. EKG is ready to implement a new EKG platform that will lead to an electronic workflow that allows for automated patient entry, relevant patient information download, and electronic interpretation and storage of EKGs. This is a significant improvement for the department and will lead to a more efficient process that culminates in a higher quality product for our community. This is also true as we move Echocardiography into an electronic workflow for most aspects of the echocardiography workflow. Staffing was improved this month with Amy Stange and team successfully recruiting a full time permanent RT, James Buge from Tehachapi California. James will replace our traveling therapist who will be departing on May 17. Clinically, the continued decline in Covid cases in our community has given a reprieve to what was an almost unachievable work load during the height of the pandemic. A big thank you to all staff who persevered throughout the height of the pandemic in Inyo County.

Diagnostic Imaging:

The Diagnostic Imaging team has been very busy preparing for Cerner go-live. Diagnostic Imaging is very complex when it comes to replacing our electronic health record. Interfaces are required between the Radiology Information System (RIS). Each piece of imaging equipment in the department, and then on to two picture archiving communication systems (PACS) so that the image can be interpreted both locally and remotely. After interpretation, an interface is required back from the PACS to the RIS so that the interpretive reports can be viewed by ordering providers and saved in the permanent record. All interfaces and functionality has been completed and the DI team is ready for go live. While preparing for the EHR conversion, the Diagnostic Imaging team has resumed to pre-pandemic volumes. Our Diagnostic Imaging

department is currently preparing for ACR accreditation renewal for our Mammography program.

Laboratory Services:
Our Medical Laboratory Department is also very busy preparing for Cerner Go-Live. Our Lab is in the process of implementing two new electronic applications within the lab. In addition to the general lab information system and the microbiology lab information system that we have historically used, we are going live with an electronic blood bank module and an anatomic pathology module for our histology/pathology department. The lab is still awaiting our biannual Joint Commission Survey that was due to happen late April 2021. Joint Commission has commented that they are running "several months" behind schedule so we are unsure when to expect the survey to occur. We remain survey ready and Rich Hayden, Laboratory Manager, continues to fine tune lab practices as we continue to seek continuous quality improvement. Clinically, lab services have seen a 14% increase in testing volume as compared to pre-pandemic volumes. This increase is primarily a result of SARS CoV 2 testing.

OLD BUSINESS
Cardiopulmonary:
No old business to report

Diagnostic Imaging:
No old business to report on for Diagnostic Imaging

Laboratory Services:
The medical laboratory Services now has a consistent supply chain for stand-alone SARS-CoV2 testing. With the flu season being over, we will be discontinuing routine use of the Respiratory panel that has been in use for in house testing since February. This transition reduces the cost of Covid testing to both NIHD and our patients. We will re-institute use of the respiratory panel when the 2021/2022 flu season begins.

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NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Alison Murray, Acting Director of Human Resources

RE: Department Update

REPORT DETAIL

Recruitment (Brittney Watson): New recruitment process has been finalized in April. HR will be providing leaders with the information this month and launching training sessions as well. Comprehensive review of all job descriptions has begun so that job postings accurately reflect position requirements. This review will also coincide with launching our Performance Management module in ADP so job descriptions and evaluations will be separated instead of being incorporated onto on document. Reviewing the process and policy for sign-on bonuses and relocation assistance for new hires.

Onboarding (Sarah Rice): New Onboarding/Compliance processes have been implemented. Procedures have been put into place in be sure that all new hire paperwork is completed prior to orientation. Review of the Org Chart software in ADP as well as making sure that all employees have current pictures uploaded completed. Audits of current employee requirements underway (licensure, certification, fit tests, OIG, I-9, TB testing, etc.). Personnel file audit to begin July 2021.

Payroll (Reuben Morgenstein): ADP Payroll go-live June 6. Training for managers and staff launched this month. New employee badges are required so HR has been collecting data to be sure to have all required information on each badge. District-wide survey went out to bet staff input on new badge design. New badges will be printed and handed out this month.

Benefits (Carlos Madera): Ongoing support for employees who have COVID-related absences and other leaves of absences. Review of LOA platforms underway. Audit of all current accommodations to be completed this month. Implementation of retirement plan changes.

HR/District Education (Marjorie Routt): Continuing to support other departments who are going through the Cerner implementation. District-wide civility training launched to leaders and moving into departments this month (after Cerner go-live). Review of all ADP modules including employee self-service underway so that we can be sure we are using the system as

efficiently as we can. Employee engagement survey results being released to leaders for strategic planning.

Human Resources (Alison Murray):
District-wide compensation review underway. Search for an HR Consultant to provide the team with additional resources to complete large projects. Desk audits being performed for every position in HR for strategic planning purposes to be completed this month. Employee Handbook policy revisions and review by legal to be completed this month.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Lynda Vance, Project Management Specialist

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Cerner Project: Integrated Testing (IT) Session 2.0 and 2.5 completed in April. A large amount of work goes into update SmartSheet for test script tracking. Detailed overview of the testing to ensure success was completed by Project Management. Worked with Education Department to set up training rooms for end-user training. Attending Informatics daily wrap up calls to review issues and resolutions. Assistance with Preparation for Cerner go live May 17 under way.

Project Budgets: Working on process for tracking project costs starting in July.

Projects *(this is a summary of the high-level work, not a complete list)*

Discovery – 3 (Plant Chiller Upgrade, OR Flooring, Omnicell Cabinets)
Kick Offs – 1 (GHX)
Actively Working – 10 (i2i with athena, Roche/ Cobas POC middleware, Steris/ HexaVue OR EHR integration; ADP to Replace Kronos Time areas; Bronco Clinic Restart; Cerner (EHR); Experian Pricing transparency; Cerner Project outside Wipfli Scope; OneContent DMS update; GPO replacement to CHC, Internal Med Office update)
Closing – 2 (InQdocs Subscription Service, PPM Navex)
Moves Completed - 6 (Internal Med Nursing area, Credit and Billing Office, CMO office, Rev cycle Director office, HIMS manager office, Compliance Staff update)
On Hold General Projects - 6 (HIMS Desk redo, Logisticare/Motivcare Transport, SAP Concur; Door Access Badge standard workflow, Myla Lab/Micro Middleware, Employee Health Management System)

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: May 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Andrew McKie, Interim Director of Revenue Cycle

RE: Department Update

REPORT DETAIL

NEW BUSINESS
Month End Financials:
Charges - $15,346,202.05 (April) and $58,879,213.17 (2021)
Payments - $7,996,217.76 (April) and $31,126,129.61 (2021)
AR - $29,109,800.46

HIMS: New manager - Helen Zurek started in April. She is supervising medical records, coding and charge capture teams.

Staffing: Currently looking to hire in all departments

OLD BUSINESS
Revenue Cycle: Cerner Go-Live schedule for May 17. Teams have been very busy to prepare for Cerner conversion and also have all work done in Athena ASAP

NORTHERN INYO HEALTHCARE DISTRICT
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Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Date: 5/7/21

To: Board of Directors

From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer

Re: Bi-Monthly CMO report

Medical Staff Department update

As noted in previous CMO reports, we will have a new pediatrician Jane Yoon, MD to replace Dr. Helvie. Jane comes from New York but she has family in California and Nevada and is excited to return to the west coast.

We will also be welcoming a new Anesthesiologist Kevin Efros, who will be starting in June. Dr. Efros will be taking over for Amy Saft, who will be leaving us at the end of this month. Amy has done a wonderful job for us and she will be missed. Dr. Efros comes to us from USC where he has been working and teaching. He is a cardiac fellowship trained anesthesiologist who will be offering transesophageal echocardiograms as part of his practice. We are very excited to having him join our team.

We continue to recruit for a permanent general surgeon and we appreciate the continued service of Dr. Allison Robinson who is coming once every 5 weeks and Dr. Jon Bowersox who comes once a month to help Dr. Cromer Tyler cover the general surgery practice.

Dr. Nickoline Hathaway retired on April 30, 2021. She had many touching well-wishers and certificates of achievement, including one from the Board of Directors. She wishes to thank everyone who showed their appreciation. Many of Dr. Hathaway's patients will be able to transition to Dr. Anne Wakamiya and Alissa Dell, FNP-BC, NP. Dr. Hathaway will continue to work in the Cardiopulmonary department, reading EKG's and doing stress tests, and she will continue to remain on several medical staff committees.

Dr. Cathy Leja made the transition to the Internal Medicine office during the week of May 3rd. She will be continuing to see her own panel of patients and will be helping to see any of Dr. Hathaway's patients if needed.

We will be establishing a "Finder's Fee" program where anyone from the District who refers a physician for employment to NIHD could be eligible for a cash bonus. Details are coming and will be announced in the next 1-2 months.

Dianne Picken and Alison Bishop continue on their project of changing over their paper credentialing process to an electronic system. They will also be taking on Provider Enrollment with insurance companies this summer, which is a big undertaking.

Pharmacy Department update

Construction continues at a fairly slow pace, limited by regulations. Our pharmacy department continues to support NIHD and Inyo County Covid 19 vaccination efforts. We will also be taking a closer look at our 340b program, which is a program that offers discounted medications to NIHD as a CAH. Over the next 60 days we will be completing the semiannual Board of Pharmacy Department assessment with the annual site visit from Board Inspector planned for later this summer.

Quality Department update

The Quality and Informatics department has been the center of Cerner clinical activity including order set creation and verification, interoperability, clinical workflows…. You name it, they are on it! Moving forward, we will be leading Cerner staff and provider training.

We have also finished the five year PRIME grant focused on antibiotic stewardship. We continue to abstract and submit required data for quality programs across the District which includes a new three-year Quality Improvement Pool program (QIP). Specific areas of focus will be in the ambulatory areas to improve our population health care deliveries. We continue to prepare for the implementation of i2i application which will help with continued quality reporting across the District.

Covid 19

Thankfully Covid 19 is slowing around the country as well as in Inyo County. We haven't had a Covid hospitalization for several weeks. We are encouraging everyone to get Covid 19 vaccinated and we hosted another Covid 19 Physician roundtable involving the Women's Health team to discuss concerns. For now, we continue to wear masks around the District, stay socially distanced, and wash our hands.

Physician Compensation

We continue to engage in conversations around appropriate physician compensation. The ad hoc Physician Compensation committee met this month and will be developing our overarching philosophy as a District.

Cerner Transition

By the time you are reading this update, we will have gone live with Cerner – May 17th! It's been a long road preparing for Go Live and our teams have done an incredible job. There will be bumps in the road, so please be patient with us. Overall, this change to Cerner is welcomed. Cerner will help us be more efficient, safer, faster, and more informed but it will take us some time to get there. We will also be

offering our patients a new Patient Portal to access clinical notes, labs, radiology, etc. There will be more details to come.

Strategic Planning

We had a strategic planning session last month and we are working on creating tasks that align with our mission and vision. The Executive team is currently prioritizing items from the general list developed by the Board, Executive team and physicians. We are excited to develop these tasks with our teams.

Community Partners

We have had great partnerships with SIHD, Toiyabe, BCC, and Inyo County during our Incident Command (Covid) weekly meetings and our Press releases. We will continue this practice until we are back to full operations. This has given us the opportunity to develop relationships with our community partners that will help us all in the future.

NIHD Board Meeting

Pioneer Home Health Care, Inc. (PHHC)
Quarterly Summary Report
May 19, 2021

Distinguished Board Members;

Please see the attached summary of the services we have provided from January-March 2021:

1. Admission Analysis by referral source for Home Health services. We continue to receive referrals from many different institutions, physician offices, acute rehab centers, and skilled nursing facilities. Northern Inyo continues to be the leader in these referrals.
2. Admission Analysis by referral source for Hospice services.
3. Home health visit totals, with historical visit numbers included for comparison.
4. Hospice visit totals, with historical visit numbers included for comparison.
5. Home Health visits average miles. This high average is because our service area is from Lone Pine to June Lake, to Benton.
6. Hospice visit average miles. This indicates most of these patients are local.
7. Personal Care Program (PCP) hours

PROGRAM REPORTS

Home Health Program

Worked with Cerro Coso Community College to provide learning clinical opportunities for their 12 LVN students. They completed a rotation of 13 weeks at PHHC. Their focus of learning was on the specialties of home health and hospice care, and nursing services in the home.

Staffing: Have hired a Per Diem PT and OT to round our therapy team. Therapy is well covered at this point with the continued support from NIH contract therapy pool. We are still working with a recruitment company, use of Face book, Indeed, "word of mouth" etc. to procure another Full Time RN Case Manager, hopefully with interest in progressing to a Clinical Supervisor role, and we continue to need certified home health aides (CHHAs).

We will be participating in the California Association for Home Services at Home (CAHSAH) virtual conference May 25-26, 2021. Some topics included are: Health Service Leadership, Wage Hour laws for 2021, National Government PDGM updates, Home Health transitions to hospice, Hospice eligibility documentation, Hospice regulatory updates, compliance and quality programs for successful Quality Assurance Performance Improvement (QAPI) projects, Spiritual care plans to increase patient/ family satisfaction.

Hospice Program

Fundraiser planned for May 22nd, Saturday 08:30-12:00 "Breakfast, Bids and Blooms" is an outdoor garden themed event, which will include breakfast and bakery items for sale, vendor booths, live music, popcorn, Starbucks coffee and donated Silent Auction items. All are invited to attend! All proceeds benefit Hospice of the Owens Valley.

The employees and volunteers completed a successful yard sale event in March, yielding $1,800. Many donations were received and it was well supported by the community.

A "Volunteer Training" class was offered and was successfully completed in April. Our goal is to boost the volunteer pool for more bedside, bereavement, clerical, fundraising, and overall support for the patients on our hospice program.

Another "Grief Support Group" was offered to the community via Zoom in April, as part of our bereavement outreach. We had several participants joining the group from Lone Pine, Hamill Valley, and Bishop. This was a 6-week course, which included a personal journal and handbook, and was presented by our Hospice Chaplain Patrick Thompson. This course was free to the community.

We have obtained a new shed donated by volunteer Marga Foote RN, to house our durable medical equipment (DME). It has been installed on a cement pad on the north side of the building. We are working on a protocol to lend out our equipment if needed.

Personal Care Program

Have continued to work on providing our home care aides with additional education for personal care service improvement. They have participated in our Wellness and Injury Prevention program and our goal is to provide these learning opportunities to our home care aides on a quarterly basis.

We are currently in the process of clarifying use and improving our "telephony" system which is used to allow our home care aides of the Personal Care Program the ability to "clock in and out" of a client's home for each shift, in order to provide supervision and proof of attendance on site. We are always working on improving our quality of care, which is both supervised and safe for the community.

The Personal Care Program is currently working with Inyo County, who received a grant to provide in home services for Medi-Cal recipients of the Valley Apartments. Because of this relationship we are able to provide our personal care services to those that otherwise would not have been able to afford these services.

Financials

We have been working with NIHD during their 2019 audits, and have complied with the multiple requests for information from the audit team.

Overall the agency is in the black, able to meet payroll, however, PHHC shows a current loss of $96,939.78 for the first quarter as many annual bills are paid in the first 3 months of the year.

PDGM the current Medicare reimbursement system continues to pay better than the previous PPS reimbursement system. It so far appears to be beneficial to the patient as well, in being able to allow us the ability to safely meet care plan goals.

Daily Census has been proven to be very high over the early months of 2021. Average daily census for the agency as a whole has been at 35. The old aged receivables have been caught up on, and a new process is in place to avoid untimely follow-up and loss of funds in the future.

Agency Projects

Parking lot project has been put on hold indefinitely. Mike Saunders from Central Nevada Supply evaluated the potential for issues if the gravel parking lot was to be covered with cement or asphalt. While 3 bids from cement contractors were obtained for the project, none addressed potential drainage issues. With the office building on the lower side of the street, Mike determined a drain of some sort would have to be put in, and possibly a pump to augment removal of water onto the street. Also he noted that the multiple large trees on the property could potentially cause root infiltration into the drainage system causing problems. At this time there are too many concerns, and it appears the costs of the project are escalating, thus putting us over budget for the project so it is on hold indefinitely.

PHHC is working on updating its Employee Handbook. It has been several years since the last update. We are enlisting the help of attorney Elizabeth Murphy, an expert in Wage/Hour regulations, to complete this update. This is a costly endeavor that was included in the budget for this year. Plan is to have the Employee Handbook completed by June end.

PHHC will be reviewing its current strategic plan, may need to begin another one as great strides have been made in the last plan, created in 2019-2020. One of the many goals met was utilizing a secure texting app, DocsInk, which has allowed for quick and easy communication while maintaining HIPPA compliance.

Pioneer Home Health Care / Home Health
Admission Analysis by Referral Source

for period ending 033121

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
Acute Rehab - Carson													0
Acute Rehab - Renown Health			1										1
Acute Rehab - Other													0
Clinic - Mammoth Lakes Fam Med		2											2
Clinic - Rural Health NIH	1	5	2										8
Clinic - SIH													0
Clinic - Toiyabe													0
Family / Friend / Self													0
Hospital - Carson/Tahoe													0
Hospital - Glendale Adventist													0
Hospital - Loma Linda													0
Hospital - Mammoth Lakes	1	1	2										4
Hospital - Northern Inyo	9	6	10										25
Hospital - Renown Medical Center	2	3	3										8
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - St. Mary's													0
Hospital - UCLA Medical Center	1												1
Hospital - USC / Keck Med			1										1
Hospital - VA													0
Hospital - Other	1	1	1										3
Other													0
Physicians' Office Local	2		1										3
Physicians' Office Out-of-Counties	1												1
SNF - Bishop Care Center	2		2										4
SNF - Southern Inyo													0
SNF - Other	1	1											2
Another HH Agency													0
Workers Comp Insurance													0
Totals	21	19	23	0	0	0	0	0	0	0	0	0	63

Hospice of the Owens Valley / Hospice
Admission Analysis by Referral Source

for period ending 033121

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
Acute Rehab - Carson													0
Acute Rehab - Renown Health													0
Acute Rehab - Other													0
Clinic - Mammoth Lakes Fam Med													0
Clinic - Rural Health NIH													0
Clinic - SIH													0
Clinic - Toiyabe													0
Family / Friend / Self													0
Hospital - Carson/Tahoe													0
Hospital - Glendale Adventist													0
Hospital - Loma Linda													0
Hospital - Mammoth Lakes													0
Hospital - Northern Inyo		1											1
Hospital - Renown Medical Center			1										1
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - St. Mary's													0
Hospital - UCLA Medical Center													0
Hospital - USC / Keck Med													0
Hospital - VA													0
Hospital - Other		2											2
Other													0
Physicians' Office Local		3											3
Physicians' Office Out-of-Counties													0
SNF - Bishop Care Center													0
SNF - Southern Inyo													0
SNF - Other													0
Another Hospice Agency													0
Totals	0	6	1	0	0	0	0	0	0	0	0	0	7

Pioneer Home Health Care
2021 Home Health Visit Totals

Home Health Visits
through March 2021

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
SN	66	61	48	0	0	0	0	0	0	0	0	0	175
PT	59	62	58	0	0	0	0	0	0	0	0	0	179
OT	10	7	13	0	0	0	0	0	0	0	0	0	30
ST	2	3	2	0	0	0	0	0	0	0	0	0	7
MSW	4	10	7	0	0	0	0	0	0	0	0	0	21
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**141**	**143**	**128**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**412**

Average visits per month = **137**

2020	121	124	134	189	148	191	202	242	203	195	153	174	**2076**
2019	91	118	116	134	131	129	131	142	94	165	147	160	**1558**
2018	61	75	71	107	73	49	73	120	93	160	138	93	**1113**
2017	104	86	72	88	63	65	70	84	53	75	61	49	**870**
2016	143	117	161	139	126	138	98	87	92	67	87	78	**1333**
2015	144	180	164	154	170	174	197	144	127	124	130	101	**1809**
2014	211	210	172	143	170	143	217	172	191	153	140	139	**2061**
2013	213	178	195	207	152	226	133	138	211	260	185	192	**2290**
2012	134	173	196	219	201	175	158	160	156	195	197	149	**2113**
2011	199	239	230	152	203	215	199	169	200	184	159	177	**2326**
2010	243	193	228	185	226	209	172	195	151	189	219	231	**2441**
2009	237	193	237	170	179	233	256	196	172	178	154	203	**2408**
2008	177	159	145	156	172	202	216	154	208	184	199	205	**2177**
2007	146	119	135	134	124	99	157	118	137	121	138	169	**1597**

Hospice of the Owens Valley
2021 Hospice Visit Totals

Hospice Visits

through March 2021

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
SN	3	10	20	0	0	0	0	0	0	0	0	0	33
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	1	4	0	0	0	0	0	0	0	0	0	5
MSW	0	3	2	0	0	0	0	0	0	0	0	0	5
Aide	0	0	0	0	0	0	0	0	0	0	0	0	0
Chaplain	0	2	10	0	0	0	0	0	0	0	0	0	12
Bereavement	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**3**	**16**	**36**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**55**

Average visits per month = **9.5**

2020	51	30	36	21	24	23	24	23	25	19	11	23	**310**
2019	25	27	12	39	25	22	26	36	37	38	66.0	62	**415**
2018	27	25	50	39	53	51	23	56	32	32	37.0	16	**441**
2017	2	9	0	0	0	20	15	24	21	12	24	19	**146**
2016				2	1	11	19	18	18	14	16	0	**99**

Pioneer Home Health Care
2021 Home Health Mileage

Average Miles and Visits through March 2021

	YTD # of Visits	YTD # of Miles	Ave MI Per Visit
SN	175	5450	31.14
PT	179	3340	18.66
OT	30	1073	35.77
ST	7	312	44.57
MSW	21	565	26.90
CHHA	0	0	#DIV/0!
TOTALS	412	10740	26.07

	Prior CF Miles	New Monthly Miles	SUMS
SN	4127	1323	5450
PT	2149	1191	3340
OT	580	493	1073
ST	251	61	312
MSW	333	232	565
CHHA	0		0
Totals	7440	3300	10740

Hospice of the Owens Valley
2021 Mileage

Average Miles and Visits through March 2021

	YTD # of Visits	YTD # of Miles	Ave MI Per Visit
SN	33	289	8.76
PT	0	0	
OT	5	11	
MSW	5	24	4.80
Aide	0	0	#DIV/0!
Chaplain	12	91	7.58
Bereavement	0	0	
TOTALS	55	415	7.55

	Prior CF Miles	New Monthly Miles	SUMS
SN	135	154	289
PT	0	0	0
OT	2	9	11
MSW	19	5	24
Aide	0	0	0
Chaplain	40	51	91
Bereavement	0	0	0
Totals	196	219	415

Pioneer Home Health Care
Personal Care Program Hours

For period ending March 31, 2021

	15-Jan	31-Jan	15-Feb	28-Feb	15-Mar	31-Mar	15-Apr	30-Apr	15-May	31-May	15-Jun	30-Jun
PCA Billable Hours	469.75	432.92	454.00	486.00	572.00	516.00						
PCA Billable Charges	11743.75	10823.00	11350.00	12150.00	14300.00	12900.00	0.00	0.00	0.00	0.00	0.00	0.00

	15-Jul	31-Jul	15-Aug	31-Aug	15-Sep	30-Sep	15-Oct	31-Oct	15-Nov	30-Nov	15-Dec	31-Dec	Totals
PCA Billable Hours (2)													**2930.67**
PCA Billable Charges	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**$ 73,266.75**

Hours by Month:

January	902.67
February	940.00
March	1088.00
April	0.00
May	0.00
June	0.00
July	0.00
August	0.00
September	0.00
October	0.00
November	0.00
December	0.00
	2930.67

Hospice of the Owens Valley

is presenting **Breakfast, Bids and Blooms!**

Come and enjoy

the Silent Auction, Raffles

and Bake Sale!

Saturday Morning, May 22nd

363 Academy Avenue, Bishop

Outdoor Silent Auction

opens at 8:30am

Breakfast and Bakery Sale!

Starbucks Coffee!

Popcorn!

Yogurt Bar!

Auction tables will begin

closing at 10:00am

Live Music!

Vendors!

Support Hospice!

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time. One Team. One

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: May 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: John "Adam" Hawkins, DO

RE: Eastern Sierra Emergency Physicians (ESEP) Quarterly Report

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Recruitment

ESEP is pleased to welcome Dr. Kevin Efros, MD who will be joining the Anesthesia department at NIH. Kevin comes to us from Keck School of Medicine USC where he served as a Clinical Assistant Professor of Anesthesiology within the Cardiac division. Dr. Efros completed his residency training at UCSF San Francisco. He completed Fellowship training in Adult Cardiothoracic Anesthesiology at NYU School of Medicine. Dr. Efros plans to start clinical practice at NIH at the beginning of this upcoming summer.

Hospitalist Program

Hospital Medicine Clinic

Program Update:
The Hospital Medicine Clinic has had great success since opening its doors last month. Currently the clinic is running two half days per week. However, patient demand has been even higher than we anticipated and we hope to expand clinic hours ahead of schedule!

Emergency Medicine Program

Program Update:
I will take this opportunity to formally introduce myself to the board! My name is John "Adam" Hawkins and I have taken over the directorship role of ESEP and the Medical Director role for the emergency department at Northern Inyo Hospital as Dr. Bourne has transitioned into the Chief of Staff role. I have served as the Assistant Medical Director for the emergency department for the past year and a half. I am very excited to continue to build upon the legacy and the hard work that Dr. Bourne has provided during her time as director.

The emergency department continues to work tirelessly to update protocols to improve patient care. Lately, we have been focusing on improved collaboration with the Inyo County Mental Health Department, Bishop and Inyo County Police Departments, and The Progress House to solve many of the issues that are affecting the members of our community suffering from mental health crises. We are participating in bi-monthly meetings which have already translated to improved patient outcomes in the vulnerable patient population. Although much more work is still needed, we are grateful for our community partnerships and look forward to continued progress.

On a personal note, I am sorry I am not able to provide this update in person (or over zoom). I will hopefully be present at the next board meeting to provide this update. I look forward to getting to know each of you. I am very grateful to assume this role on behalf of a group and health care district that I care for deeply.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Therapy Animals and Pets*	
Scope: Acute/Subacute Services, Critical Care Services, Infusion Center	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Infection Prevention/Social Services	Effective Date: 3/18/2016

PURPOSE:
Animals have an increasing presence in healthcare facilities. There are proven benefits for patients, visitors, and even staff; but there are also concerns.
This policy delineates the safety guidelines that are to be followed, as defined by the Society for healthcare epidemiology of America (SHEA).
The goal of animal therapy and service animals is to keep patients, family, visitors, and staff all safe while still allowing the patient the comfort of a four-legged friend during a hospital stay.

POLICY:
There are 3 different areas where the guidance is grouped by the role of the animals.

1. **Animal assisted activities,** i.e. the pet therapy and volunteer program)
   Animal Assisted Therapy: These animals are certified by a recognized certification organization for animal-assisted therapy, and may be admitted for therapeutic visits. These visits have been shown to benefit patients socially, psychologically, and physiologically.
   a. "Paws 4 Healing" is the local chapter, working in both Inyo and Mono counties, and is part of the nationally recognized **Pet Partners** organization.
   b. Dogs from other established pet therapy training organizations may also be allowed if they present their credentials prior to the visit.
   c. The handler who has been approved to visit with the dog, almost always the dog's owner, has completed and passed the Pet Partner course.
   d. The dog has also passed an in-depth course with an approved evaluator; covering all areas from appearance, temperament, response to the unusual equipment and noises that may be experienced in a healthcare facility, training to commands known to be essential, and a review of the health examination required by a licensed veterinarian. All therapy dogs have been vaccinated against rabies.
2. **Service animals** The service animal is one that provides a specific service to the patient or visitor, most typically that is a guide-dog for the blind.
   a. NIH allows service animals of patients and visitors into the facility to be compliant with the Federal Americans for Disability Act (ADA).
   b. Only dogs and miniature horses are recognized as Service Animals under federal law.
   c. Staff may ask the patient to describe the tasks that the animal performs but it is against the law to require patients to produce "certification" papers proving the need the animal's assistance.
   d. The hospital's infection prevention team and nursing supervisor should be notified of the animal's presence to ensure that the procedures are followed.

3. **Personal pet visitation** Are visits requested by a patient, visitor and/or family of the patient to allow a personal pet.
   a. Admission of any pet is at the discretion of the nursing supervisor or department manager.
   b. In general, personal pets should not be allowed in hospitals, simply because it is harder to determine whether they have been cleaned, socialized, trained, or if they have the required vaccinations.
   c. Exceptions to this rule can and should be made in cases where the benefit of having a

patient's pet visit outweigh the risks- though visits should still be restricted to dogs. No reptiles or birds will be allowed. Other mammals may be considered for approval in extenuating circumstances and under control.

Note: Cat visits are not allowed

a. Cats typically cannot be trained as well as dogs can.
b. They pose a bigger infection risk: Cats are more likely to bite and scratch humans than trained dogs are, and cat injuries tend to spread more bacteria.
c. People are *generally* more likely to be allergic cats than dogs.

PROCEDURE:

1. Handler Volunteers and their therapy Animal will check in at the NIHD lobby desk. The House Supervisor (HS) will be notified of the Therapy Animal visitation. The HS will contact patient care areas to work with nursing staff and patients to determine which patients will be provided with pet therapy.
2. The patient and any other visitor in the same room must be asked if they would like a visit from the therapy dog and if they have any allergies to animals.
3. Exclude visits to patients with allergies; open wounds, burns, tracheotomies, immunosuppression (per patient's physician), agitation, aggression, fear of animals.
    a. The visit may still be approved if the open wounds or burns can be safely covered and the team will avoid any closeness with those areas.
4. If there is specialized equipment in the room, as in the intensive care unit, the handler will ask for guidance from the nurse regarding the best way for the animal to approach the patient.
5. Patients will be excluded if they are infected with any organism that requires isolation, such as tuberculosis or chickenpox; with any bacteria resistant organism such as MRSA. Other infections that would preclude a visit are salmonella, campylobactor, shigella, guard or other amebiasesis. Patients who have had a splenectomy must be excluded due to a heightened susceptibility to dysgenic fermenter type 2 present in normal saliva of dogs and cats called (DF2 Sepsis)
6. Specifically, before any visits take place, they must be approved by both the patient and the nursing staff. The staff will not relate what illness it is that patient may have to the team, just that the visit cannot take place.
7. All dogs will have to be on no longer than a 6 foot lead.
8. If an animal from any of the above groups is allowed on the bed, then a barrier such as a towel or sheet will be placed between the dog and the linen. The barrier is removed immediately after the visit is concluded.
9. Paws 4 Healing animals are required, through the certification process, to be clean for visits with short nails, clean hair and ears. They are trained not to lick, scratch, or jump up. Other dogs need to meet these same requirements before a visit.
10. Animals are restricted from food preparation and service areas.
11. The patient being visited should not eat or drink during the visit.
12. The patient is required to clean his or her hands both before and after touching or petting the dogs.

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13. All animal handlers' volunteers must comply with hospital vaccination policies: An annual negative TB test and an influenza vaccination. The influenza vaccination must be done by November 1st of each year. Proof of vaccinations should be sent to NIH Infection Preventionist for record keeping.
14. All animal handler volunteers must complete competencies as directed by Human Relations Chief and Compliance Chief annually.

REFERENCES:

1. APIC Textbook of infection Control and Epidemiology, 4th Ed, 2014
2. Scientific American: *New hospital Guidelines Say No Cats Allowed*, March 3, 2015 by Rachael Rettner and Live Science
3. SHEA Abstract March 2, 2015: I*nfection Control Experts Outline Guidance for Animal Visitations in Hospitals*

CROSS REFERENCE P&P:

1. Lippincott Procedures; Pet therapy, pediatric (revised Nov. 20, 2020).
2. Lippincott Procedures: Pet Therapy, long-term care (reviewed Aug 21, 2020).

Approval	**Date**
CCOC	1/11/16
Infection Control	2/23/16
MEC	3/1/2016
Board	3/16/2016
Last Board of Director review	4/18/18

Developed:
Reviewed: 5/18ta, 2/19ta, 4/21ta
Revised: 12/22/2015
Supersedes:
Index Listings: Dog Therapy; Animal Visitation; Pets; volunteers

Overview: March billed charges were over budget by $6.1M.

March YTD is $128M compared to budget of $104M.

	Charges	Budget
January 2020	16,271,574	14,095,678
February 2020	13,886,140	13,186,280
March 2020	12,141,181	14,095,678
April 2020	6,887,085	13,640,980
May 2020	10,687,793	14,095,678
June 2020	13,443,103	13,640,980
July 2020	14,939,822	11,862,737
August 2020	13,989,077	11,533,455
September 2020	14,652,230	10,715,581
October 2020	14,539,677	12,487,777
November 2020	12,978,658	11,166,411
December 2020	15,139,508	11,863,789
January 2021	13,060,873	13,778,625
February 2021	12,879,445	11,639,016
March 2021	15,505,494	9,383,779

Gross Accounts Receivables in Athena total $36.7M, down from $389.2M at the end of February.

Gross Legacy AR is at $1,9M, Totally reserved for as Uncollectable.

Salaries and Wages for hospital operations were up from January but within budget.

	Salaries & Wages	Cost Per Day
January 2020	2,169,008	69,968
February 2020	2,144,412	73,945
March 2020	2,306,958	74,418
April 2020	1,999,126	66,638
May 2020	2,082,141	67,166
June 2020	2,130,598	71,020
July 2020	2,244,335	72,398
August 2020	2,263,144	73,005
September 2020	2,142,762	71,425
October 2020	2,227,959	71,870
November 2020	2,161,607	72,054
December 2020	2,596,191	83,748
January 2021	2,096,158	67,618
February 2021	2,104,702	75,168
March 2021	2,316,452	74,724

March 2021 Financial Results: Revenues trended higher than budget in March

Direct costs were higher than budget due to pharmacy charges trending 150k higher per month,

Athena costs were up 228k vs 69k prior month, Pensions costs in total 200k higher than February.

Labcorp testing of 200-400k per month, and G&A costs were 128k higher than budget-professional fees.

FY2021

Unit of Measure	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021
Cash, CDs & LAIF Investments	56,272,847	55,214,586	52,965,190	53,539,618	50,491,090	47,413,188	44,556,758	42,840,110	48,843,100
Days Cash on Hand	226	225	220	218	153	143	162	150	166
Gross Accounts Receivable	46,949,619	48,287,230	45,195,462	39,988,328	38,951,324	41,570,823	39,066,151	38,262,376	36,741,318
Average Daily Revenue	481,930	466,595	473,708	472,527	464,702	468,886	462,027	461,791	466,134
Gross Days in AR	97.42	103.49	95.41	84.63	83.82	88.66	84.55	82.86	78.82
Key Statistics									
Acute Census Days	263	275	232	203	210	310	246	198	216
Swing Bed Census Days	42	44	34	8	20	8	16	28	15
Observation Days	44	32	46	48	39	28	37	37	68
Total Inpatient Utilization	349	351	312	259	269	346	299	263	299
Avg. Daily Inpatient Census	11.3	11.3	10.4	8.3	9.0	11.2	9.6	9.4	9.6
Emergency Room Visits	691	639	581	624	516	504	524	480	583
Emergency Room Visits Per Day	22	21	19	20	17	16	17	15	19
Operating Room Inpatients	31	26	39	23	27	18	21	12	10
Operating Room Outpatient Cases	81	74	74	74	79	90	38	68	89
RHC Clinic Visits	2,670	2,614	2,535	2,730	2,490	2,758	2,954	3,282	3,533
NIA Clinic Visits	1,792	1,794	1,918	1,681	1,555	1,642	1,290	1,408	1,640
Outpatient Hospital Visits	4,431	3,558	4,139	3,560	3,531	3,837	4,140	4,188	5,139
Hospital Operations									
Inpatient Revenue	3,201,903	3,105,168	3,469,234	2,495,776	2,626,028	4,084,113	3,318,446	2,323,227	2,335,831
Outpatient Revenue	10,836,050	10,143,216	10,036,379	10,848,725	9,124,901	10,195,061	8,853,180	9,762,269	12,073,580
Clinic (RHC) Revenue	901,868	740,693	1,146,616	1,195,178	1,227,729	896,334	889,247	793,949	1,096,083
Total Revenue	14,939,822	13,989,076	14,652,230	14,539,679	12,978,658	15,175,508	13,060,873	12,879,445	15,505,494
Revenue Per Day	481,930	451,261	488,408	469,022	432,622	489,533	421,318	459,980.18	500,177.23
% Change (Month over Month)		-6.36%	8.23%	-3.97%	-7.76%	13.15%	-13.93%	9.18%	8.74%
Salaries	2,244,335	2,263,143	2,142,762	2,227,959	2,161,607	2,596,191	2,096,158	2,104,702	2,316,452
PTO Expenses	221,460	234,078	225,291	249,855	258,672	124,932	370,227	234,842	248,272
Total Salaries Expense	2,465,795	2,497,221	2,368,053	2,477,814	2,420,279	2,721,123	2,466,385	2,339,544	2,564,724
Expense Per Day	79,542	80,556	78,935	79,929	80,676	87,778	79,561	83,555	82,733
% Change		1.27%	-2.01%	1.26%	0.93%	8.80%	-9.36%	5.02%	-0.98%
Operating Expenses	6,681,333	6,598,376	6,443,189	6,700,067	7,141,845	9,200,728	7,485,656	7,229,565	7,316,935
Operating Expenses Per Day	215,527	212,851	214,773	216,131	238,062	296,798	241,473	258,198.75	236,030
Capital Expenses	118,728	243,872	146,626	47,518	24,398	47,743	1,042,766	27,227	13,867
Capital Expenses Per Day	3,830	7,867	4,888	1,533	813	1,540	33,638	972.39	447.33
Total Expenses	8,056,147	7,962,211	7,811,638	7,971,619	8,554,701	10,596,071	8,859,968	8,349,803	8,558,640
Total Expenses Per Day	259,876	256,846	260,388	257,149	285,157	341,809	285,805	298,207	276,085
Gross Margin	2,200,258	1,770,841	1,569,390	1,411,167	667,943	(182,482)	699,801	225,290	941,939
Debt Compliance									
Current Ratio (ca/cl) > 1.50	1.51	1.49	1.47	1.47	1.53	1.52	1.42	1.36	1.43
Quick Ratio (Cash * Net AR/cl) > 1.33	1.41	1.38	1.36	1.37	1.41	1.39	1.29	1.23	1.33
Days Cash on Hand > 75	226	225	220	218	185	143	162	150	166

	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2020	February 2021	March 2021
Total Net Patient Revenue	8,881,591	8,369,217	8,239,709	8,111,234	7,809,788	9,018,246	8,185,457	7,454,855	8,258,874
Cost of Services									
Salaries & Wages	2,244,335	2,263,143	2,142,762	2,227,958	2,161,607	2,596,191	2,096,158	2,104,702	2,316,452
Benefits	1,285,813	1,444,212	1,418,815	1,486,044	1,593,888	1,473,236	1,676,074	1,403,697	1,733,968
Professional Fees	1,729,883	1,641,804	1,519,996	1,734,533	1,989,323	2,046,081	2,153,241	1,928,594	2,092,969
Pharmacy	176,452	304,490	373,754	268,114	263,434	403,646	333,834	343,360	474,852
Medical Supplies	373,322	237,452	307,119	362,431	784,257	284,134	198,902	445,225	418,016
Hospice Operations	-	-	-	-	-	-	-		
Athena EHR System	85,401	86,356	129,219	145,890	103,674	89,294	70,400	68,680	228,428
Other Direct Costs	592,164	492,312	420,847	475,097	521,573	608,146	457,047	485,307	628,147
Bad Debt	193,962	128,607	161,285	-	-	1,700,000	500,000	450,000	(575,896)
Total Direct Costs	6,681,333	6,598,376	6,473,796	6,700,067	7,417,757	9,200,728	7,485,656	7,229,565	7,316,935
Gross Margin	2,200,258	1,770,841	1,765,913	1,411,167	392,031	(182,482)	699,801	225,290	941,939
Gross Margin %	24.77%	21.16%	21.43%	17.40%	5.02%	-2.02%	8.55%	3.02%	11.41%
General and Administrative Overhead									
Salaries & Wages	341,944	326,215	323,043	340,706	348,981	335,953	331,284	299,846	356,050
Benefits	280,576	230,351	242,620	273,351	315,017	235,101	253,272	225,528	(5,740)
Professional Fees	182,344	187,479	170,202	172,012	230,121	263,864	324,397	150,882	437,286
Depreciation and Amortization	348,949	350,898	350,981	351,061	351,070	351,786	332,743	333,225	322,062
Other Administrative Costs	196,201	195,246	152,383	134,422	174,792	208,639	132,616	110,757	132,047
Total General and Administrative Overhead	1,350,014	1,290,188	1,239,230	1,271,552	1,419,981	1,395,343	1,374,312	1,120,238	1,241,705
Net Margin	850,244	480,653	526,683	139,614	(1,027,950)	(1,577,825)	(674,511)	(894,948)	(299,766)
Net Margin %	9.57%	5.74%	6.39%	1.72%	-13.16%	-17.50%	-8.24%	-12.00%	-3.63%
Financing Expense	121,150	119,676	114,676	134,694	146,215	115,920	111,327	113,408	115,513
Financing Income	56,337	56,337	56,337	56,337	1,076,210	56,337	56,337	56,337	56,337
Investment Income	49,812	29,010	34,393	52,775	23,405	31,044	29,189	20,452	15,723
Miscellaneous Income	91,226	52,266	51,822	35,727	310,748	88,180	28,264	147,902	123,663
Net Surplus	926,469	498,589	554,560	149,759	236,198	(1,518,184)	(672,048)	(783,665)	(219,555)

	March 2021
Assets	
Current Assets	
Cash and Liquid Capital	10,029,699
Short Term Investments	36,985,736
PMA Partnership	574,941
Accounts Receivable, Net of Allowance	20,925,144
Other Receivables	-
Inventory	3,082,560
Prepaid Expenses	1,640,094
Total Current Assets	73,238,173
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,193,799
Short Term - Restricted	668,957
Limited Use Assets	
LAIF - DC Pension Board Restricted	1,064,632
DB Pension	18,895,468
PEPRA - Deferred Outflows	8,320
PEPRA Pension	79,568
Total Limited Use Assets	20,047,988
Revenue Bonds Held by a Trustee	2,913,814
Total Assets Limited as to Use	24,824,558
Long Term Assets	
Long Term Investment	1,510,116
Fixed Assets, Net of Depreciation	75,454,309
Total Long Term Assets	76,964,425
Total Assets	175,027,157
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	1,506,736
Accounts Payable	4,732,986
Accrued Payroll and Related	9,360,341
Accrued Interest and Sales Tax	198,919
Notes Payable	8,927,628
Unearned Revenue	21,142,074
Due to 3rd Party Payors	2,341,874
Due to Specific Purpose Funds	(25,098)
Other Deferred Credits - Pension	3,045,352
Total Current Liabilities	51,230,813
Long Term Liabilities	
Long Term Debt	37,634,947
Bond Premium	429,098
Accreted Interest	14,244,849
Other Non-Current Liability - Pension	39,799,580
Total Long Term Liabilities	92,108,474
Suspense Liabilities	(1,183,027)
Uncategorized Liabilities	432,222
Total Liabilities	142,588,482
Fund Balance	
Fund Balance	31,989,311
Temporarily Restricted	668,920
Net Income	(219,555)
Total Fund Balance	32,438,675
Liabilities + Fund Balance	175,027,157

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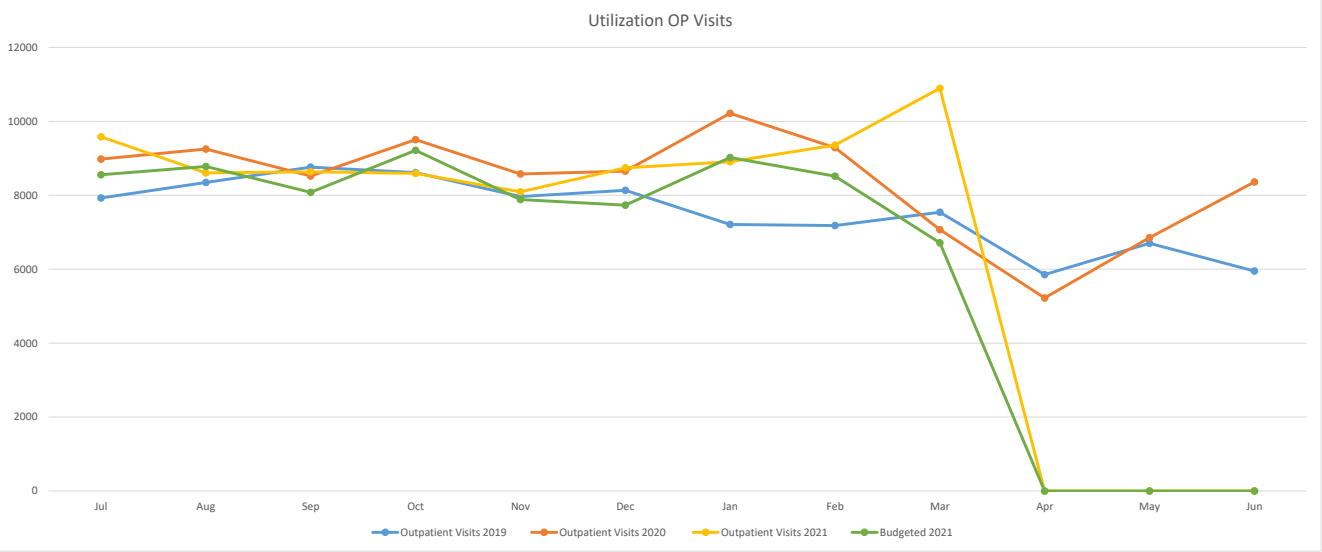
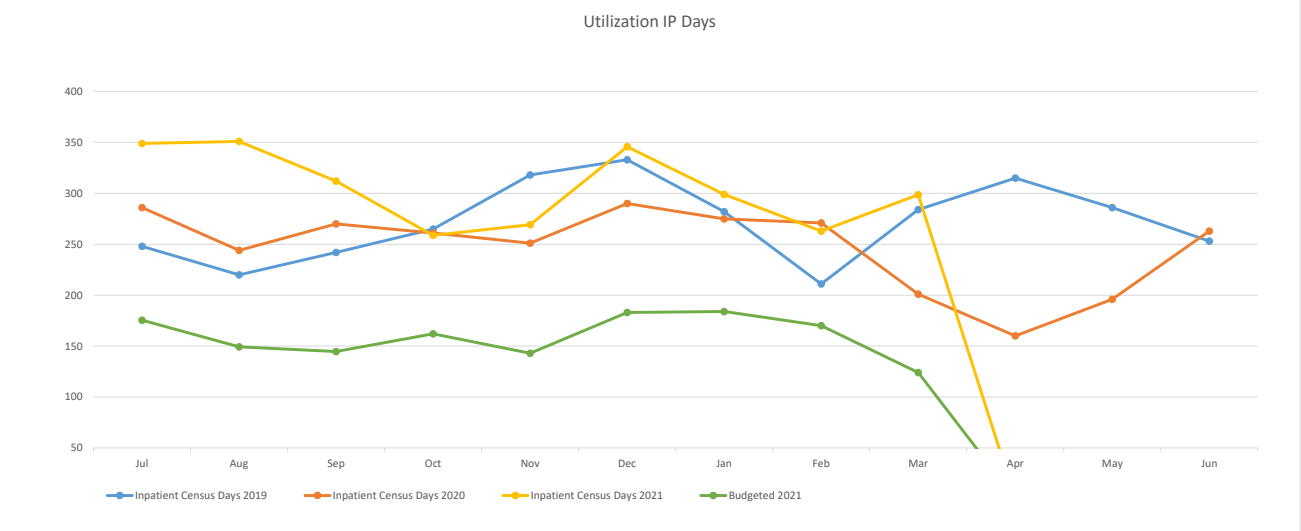
	Budget 3/31/2021	Actual 3/31/2021	Budget Expense as a % of Revenue 3/31/2021	Actual Expense as a % of Revenue 3/31/2021
Total Net Patient Revenue	5,161,078	8,258,874		
Cost of Services				
Salaries & Wages	1,739,479	2,316,452	33.70%	28.05%
Benefits	1,098,133	1,733,968	21.28%	21.00%
Professional Fees	1,206,660	2,092,969	23.38%	25.34%
Pharmacy	146,348	474,852	2.84%	5.75%
Medical Supplies	267,953	418,016	5.19%	5.06%
Hospice Operations	33,511	-	0.65%	0.00%
Athena EHR System	91,867	228,428	1.78%	2.77%
Other Direct Costs	147,091	628,147	2.85%	7.61%
Bad Debt	-	(575,896)	0.00%	-6.97%
Total Direct Costs	4,731,041	7,316,935	91.67%	88.59%
Gross Margin	533,390	941,939		
Gross Margin %	10.33%	11.41%		
General and Administrative Overhead				
Salaries & Wages	360,390	356,050	6.98%	4.31%
Benefits	278,618	(5,740)	5.40%	-0.07%
Professional Fees	189,830	437,286	3.68%	5.29%
Depreciation and Amortization	297,460	322,062	5.76%	3.90%
Other Administrative Costs	51,017	132,047	0.99%	1.60%
Total General and Administrative Overhead	1,177,315	1,241,705	22.81%	15.03%
Net Margin	(747,278)	(299,766)		
Net Margin %	-14.48%	-3.63%		
Financing Expense	175,593	115,513	3.40%	1.40%
Financing Income	150,677	56,337	2.92%	0.68%
Investment Income	32,627	15,723	0.63%	0.19%
Miscellaneous Income	20,763	123,663	0.40%	1.50%
Net Surplus	(718,804)	(219,555)		


Utilization OP Visits
12000
10000
8000
6000
4000
2000
0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Outpatient Visits 2019
Outpatient Visits 2020
Outpatient Visits 2021
Budgeted 2021


Utilization IP Days
400
350
300
250
200
150
100
50
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Inpatient Census Days 2019
Inpatient Census Days 2020
Inpatient Census Days 2021
Budgeted 2021

Management Discussion and Analysis

Revenue continues to be robust given strong inpatient days and outpatient visits
- Inpatient days in Mar were 299 compared to budgeted of 124
- Outpatient visits in Mar were 10,895 compared to 6,715 budgeted for the month
- Salaries are in line with budget
- Gross margins were consistent with historical performance and loer due to lessor number of days in February and corresponding lower revenu
- Strain on AR continues with cleaning up of old AR and providing more bad and doubtful reserves
- Cash balances have stabilized due to good collections at $ 47 Million
- AR days trending lower with increased collection efforts and new Rev Cycle Director in place
.- change in method of contractual accounting is resulting in changes to gross profit

CALL TO ORDER	The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair.
PRESENT	Robert Sharp, Chair Jody Veenker, Vice Chair Mary Mae Kilpatrick, Secretary Topah Spoonhunter, Treasurer Jean Turner, Member-at-Large Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer Joy Engblade MD, Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Sharp announced at this time members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No comments were heard.
APPOINTMENT OF BOARD MEMBERS TO CEO SELECTION AD HOC COMMITTEE	Mr. Sharp called attention to the need to select two Northern Inyo Healthcare District (NIHD) Board members to serve on the Chief Executive Officer (CEO) Selection Ad Hoc Committee. He then proposed that as District Board Chair he appoint Directors Jean Turner and Topah Spoonhunter to serve as members of that Committee. No objections to the appointment of Directors Turner and Spoonhunter were heard.
APPROVAL OF MINUTES OF THE APRIL 10 2021 SPECIAL BOARD MEETING	Mr. Sharp then called attention to approval of the minutes of the April 10 2021 Special Board of Directors meeting. It was moved by Jody Veenker, seconded by Ms. Turner, and unanimously passed to approve the minutes of the April 10 2021 Special Board meeting as presented.
APPROVAL OF DISTRICT BOARD RESOLUTION 21-03	Director Sharp also called attention to approval of proposed District Board Resolution 21-03 designating Interim Chief Executive Officer Kelli Davis and NIHD Financial Consultant Vinay Behl to act as Authorized Officers for the District's line of credit with Eastern Sierra Community Bank (ESCB). It was moved by Mary Mae Kilpatrick, seconded by Mr. Spoonhunter, and passed by a 4 to 0 vote to approve District Board Resolution 21-03 as presented, with Director Sharp abstaining from the vote.
APPOINTMENT OF NEW ADVISORS FOR THE NIHD PENSION PLANS	Ms. Davis introduced Isabel Safie with Best Best & Krieger to present a proposal to appoint new advisors for the NIHD Pension Plans, in order to realize better returns on Plan investments and to generally improve the overall health of the Plans. Ms. Safie stated the information presented represents the culmination of months of work by District staff and legal

counsel to determine the best set of advisors to take over administration of the District's three retirement Plans: the NIHD/NICLHD Defined Benefit Retirement Plan; the NIHD 401 (a) Retirement Plan; and the NIHD 457 Retirement Plan. During Ms. Safie's presentation the following items were noted:

- The proposed transition of administrators is being recommended by the District Pension Committee, which is made up of District staff and advised by District legal counsel
- The Defined Benefit Plan agreement is 40 years old and a review of the contract is long overdue. The agreement is significantly out-of-date and should have been re-negotiated and modernized decades ago in order to maximize the return on Plan investments.
- The Pension Committee has recommended that *Empower Retirement* be appointed as the new record-keeper for the Defined Contribution (DC 401 (a)) Plan and the 457 Plan effective as of April 28 2021 or as soon as practical thereafter
- The Pension Committee recommends that *Great-West Trust Company, LLC* be appointed as the trustee for the DC Plan and the 457 Plan effective as of April 28 2021 or the date of the execution of the agreements, if later
- The Pension Committee has recommended that *Hooker & Holcombe Investment Advisors, Inc*. be retained as the new consultant and actuary for the Pension Plans effective as of April 28 2021 or as soon as practical thereafter
- The Pension Committee recommends that *Charles Schwab Trust Bank* be selected to act as the custodian of the Pension Plans effective as of April 28 2021 or the date of the execution of the agreements, if later
- A *Trust Agreement* under Internal Revenue Code section 501 (a) for the Pension Plans has been prepared for the purpose of holding Pension Plan assets for the exclusive benefit of participants and their beneficiaries
- The Pension Committee and District legal counsel propose that the NIHD Chief Executive Officer, the Chief Financial Officer, and the Director of Human Resources be designated as the Trustees of the Trust to the Pension Plans effective as of April 28 2021 or the date of the execution of the agreements, if later
- The Pension Committee recommends that *Hooker & Holcombe Investment Advisors Inc*. be further retained to act as the new investment advisor providing discretionary 3(38) investment advisory services for the Plans effective as of April 28 2021

It was also noted that the proposed Pension Plan Trust Agreement will guarantee that the assets of the Plans will be used solely for the benefit of the Plan participants, and that the District is legally prohibited from accessing pension funds for other purposes. Ms. Safie additionally noted that the transition to new service providers will take a certain amount of time to accomplish. The exact cost of the proposed transitions has not yet

been determined, but the change will allow for better cost savings overall and will help to improve the District's cash position.

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and passed by a 5 to 0 vote to approve new the new advisors for the NIHD Pension Plans as recommended.

APPROVAL OF PENSION PLAN TRUST AGREEMENT

It was additionally moved by Ms. Veenker, seconded by Ms. Turner, and passed by a 5 to 0 vote to establish a Pension Plan Trust Agreement designating the NIHD Chief Executive Officer, Chief Financial Officer, and the Director of Human Resources to act as the Trustees for the NIHD Pension Plans.

APPROVAL OF DISTRICT BOARD RESOLUTION 21-04

Ms. Davis called attention to proposed District Board Resolution 21-04 which will memorialize the changes of Advisors for the NIHD Retirement Plans (as presented by Ms. Safie) and will also approve establishing the Trust Agreement for the Pension Plans designating the NIHD Chief Executive Officer, Chief Financial Officer, and Director of Human Resources to be the Trustees of the Trust to the Pension Plans. It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve District Board Resolution 21-04 as presented.

ADJOURNMENT TO CLOSED SESSION

At 6:04 pm Mr. Sharp reported the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conduct a Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b*)), title: Interim Chief Executive Officer.

Mr. Sharp noted that no action was expected to be reported out following the conclusion of Closed Session.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 7:42 pm the meeting returned to Open Session. Mr. Sharp reported that the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 7:42 pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary