February 16 2022 Regular Board Meeting

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

February 16, 2022 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this 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

The Governor of the State of California has issued Executive Orders that temporarily suspend certain requirements of the Brown Act. Please be advised that the NIHD Board Room is closed to the public and that some or all of the District Board members may attend this meeting telephonically or via video conference. This meeting will be accessible to members of the public virtually and telephonically who seek to observe and address the Board of Directors, including giving public comments.

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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. Auxiliary Bylaws *(Board will consider the approval of the revised changes to these bylaws)*
B. Approval of the Global Services by Hyland One Content Agreement (*Board will consider the approval of this agreement)*
C. Northern Inyo Healthcare District Governance Committee Update *(Board will receive this information)*
D. Northern Inyo Healthcare District Committee's with Board participation (*Board will receive this information and consider appointment/reappointments of Board members to committees)*
E. Letter to the White House regarding Nurse Staffing Agencies concerns (*Board will receive this information*)

4. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Reappointments (*Board will consider approval of these Medical Staff Reappointments*)

1. The following practitioners have submitted an application to renew their privileges at Northern Inyo Healthcare District for calendar years 2022-2023 and have been recommended for approval.

	Practitioner	**Title**	**Specialty**	**Category**
1	Ahmed, Farres	MD	Radiology	Courtesy
2	Alim, Muhammad	MD	Pulmonology	Telemedicine
3	Atwal, Danish	MD	Cardiology	Telemedicine
4	Bowersox, Jon	MD	General Surgery	Active
5	Brieske, Timothy	MD	Family Medicine	Active
6	Brown, Stacey	MD	Family Medicine	Active
7	Bryce, Thomas	MD	Radiology	Telemedicine
8	Chan, Brandon	MD	Radiology	Telemedicine
9	Dell, Alissa	FNP	Family Nurse Practitioner	APP
10	Dillon, Michael	MD	Emergency Medicine	Active
11	Ebner, Benjamin	MD	Cardiology	Telemedicine
12	Erogul, John	MD	Radiology	Courtesy
13	Farooki, Aamer	MD	Radiology	Telemedicine
14	Figueroa, Jennifer	PA-C	Family Practice	APP
15	Firer, Daniel	MD	Emergency Medicine	Active
16	Fong, Nancy	FNP	Family Nurse Practitioner	APP
17	Garg, Shilpi	MD	Cardiology	Telemedicine
18	Gaskin, Gregory	MD	Emergency Medicine	Active
19	Graves, Casey	MD	Emergency Medicine	Active
20	Harvey, Carly	MD	Radiology	Courtesy

21	Hathaway, Nickoline	MD	Internal Medicine	Active
22	Hawkins, John (Adam)	DO	Emergency Medicine	Active
23	Hewchuck, Andrew	DPM	Podiatry	Active
24	Jesionek, Adam	MD	Internal Medicine	Active
25	Kamei, Asao	MD	Internal Medicine	Active
26	Khine, Htet	MD	Cardiology	Telemedicine
27	Kim, Martha	MD	OB/GYN	Active
28	Klabacha, Rita	PA-C	Family Practice	APP
29	Loos, Stephen	MD	Radiology	Active
30	Ma, Ruhong	DO	Internal Medicine	Active
31	Majlessi, Azadeh	MD	Rheumatology	Telemedicine
32	Maki, Erik	MD	Radiology	Courtesy
33	Malloy, Sarah	FNP	Family Nurse Practitioner	APP
34	Meredick, Kristin	MD	Pediatrics	Active
35	Meredick, Richard	MD	Orthopedic Surgery	Active
36	Norris, Jennifer	CNM	Nurse Midwife	APP
37	O'Neill, Tammy	PA-C	Family Practice	APP
38	Patel, Nilem	MD	Endocrinology	Telemedicine
39	Peterson, Snow	DO	Sleep Medicine	Telemedicine
40	Pflum, Jeannie	DO	OB/GYN	Courtesy
41	Pillsbury, Kinsey	MD	Radiology	Telemedicine
42	Plank, David	MD	Plastic Surgery	Courtesy
43	Pomeranz, David	MD	Emergency Medicine	Active
44	Quach, Truong	MD	Internal Medicine	Active
45	Reid, Thomas	MD	Ophthalmology	Active
46	Ricci, Lindsey	MD	Pediatrics	Active
47	Rowan, Christopher	MD	Cardiology	Telemedicine
48	Saft, Amy	CRNA	Nurse Anesthesia	APP
49	Schweizer, Curtis	MD	Anesthesia	Active
50	Starosta, Sarah	PA-C	Family Practice	APP
51	Sullivan, Laura	MD	Cardiology	Telemedicine
52	Swackhamer, Robert	MD	Cardiology	Telemedicine
53	Tiernan, Carolyn	MD	Emergency Medicine	Active
54	Tseng, Ian	MD	Radiology	Telemedicine
55	Turner, Gary	MD	Radiology	Courtesy
56	Wakamiya, Anne	MD	Internal Medicine	Active
57	Wasef, Eva	MD	Pathology	Active
58	Wei, Stephen	MD	Radiology	Telemedicine
59	Wilson, Christopher	MD	Cardiology	Telemedicine

B. Medical Staff Appointments (*Board will consider the approval of these Medical Staff Appointments*)
    1. Jennifer Lizcano, MD (*internal medicine*) – active staff
    2. Geoffrey McWilliams, MD (*musculoskeletal radiology*) – telemedicine staff, Tahoe Carson Radiology

C. Medical Staff Appointments – Credentialing by Proxy (*Board will consider the approval of these Medical Staff Appointments*)

    As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Quality Nighthawks's credentialing and privileging decisions.
    1. Ara Kassarjian, MD (*teleradiology, Quality Nighthawk*) – telemedicine staff

D. Medical Staff Resignations (*Board will consider the approval of theses Medical Staff Resignations*)
    1. Shabnamzehra Bhojani, MD (*telepsychiatry*) – effective 12/15/2022

E. Policies (*Board will consider the approval of these Policies*)
    1. *Medical Staff Department Policy – Hospital Medicine*
    2. *Medical Staff Department Policy – Radiology*
    3. *Practitioner Re-Entry Policy*
    4. *Scope of Service for the Respiratory Care Department*
    5. *Weights for Infant and Pediatric Patients*
    6. *Death in the Operating Room*
    7. *Medical Students in the OR*
    8. *Operating Room Attire*
    9. *Standardized Procedure for Registered Nurse First Assistant*
    10. *Surgical Procedures that Require Special Consents*

F. New Medical Staff Privilege Forms (*Board will consider the approval of these New Medical Staff Privileges*)
    1. General Surgery
    2. Colon & Rectal Surgery
    3. Podiatry
    4. Orthopedic Surgery
    5. Obstetrics & Gynecology

G. Annual Review of Critical Indicators (*Board will consider the approval of these Annual Review of Critical Indicators*)
    1. Neonatal
    2. Pediatric
    3. Anesthesia
    4. Surgery

H. Medical Executive Committee Meeting Report (*Board will receive this information*)

Consent Agenda

5. Approval of District Board Resolution 22-03, to continue to allow Board meetings to be held virtually *(Board will consider the approval of this District Board Resolution)*
6. Approval of minutes of the January 19, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
7. Operating Room Flooring Replacement Update (*Board will consider accepting this update)*
8. Pioneer Home Health Care Quarterly Report *(Board will consider accepting this report)*
9. Financial and Statistical reports as of December 31, 2021 (*Board will consider accepting this report)*

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10. Reports from Board members (*Board will provide this information*).
11. Public comments on closed session items.
12. Adjournment to Closed Session to/for:
    A. Report involving trade secret – Health & Safety Code Section 1462
    Discussion will concern proposed new service, program, or facility.
    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. Conference with legal counsel, existing litigation (pursuant to Gov. Code Section 54956.9(d)(1) One case. Cassidy v. NIHD
13. 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.

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: February 16, 2022

Title: **AUXILIARY BYLAWS**

Synopsis: It is recommended that the Board of Directors review and approve the attached Auxiliary Bylaws with the following 2 changes:

1. Article VII, Section 2.

Old version: Active shall pay annual dues and participate in service programs of the Auxiliary to the extent of 50 hours.

Now reads: Active shall pay annual dues and participate in service programs of the Auxiliary.

2. Article X, Section 4.

Old version: Ten voting members present shall constitute a quorum of any General Meeting of the Auxiliary.

Now reads: Six voting members present shall constitute a quorum of any General Meeting of the Auxiliary.

Prepared by: Cori Stearns
Name
Title: Administrative Assistant to CEO

Reviewed by: Reviewed and Approved by Compliance Officer
Name
Title of Chief who reviewed

Approved by: Kelli Davis, CEO
Name
Title of Chief who approved

Bylaws of the
Northern Inyo Hospital Auxiliary
1/12/22

Article I
NAME

The name of this organization shall be the NORTHERN INYO HOSPITAL AUXILIARY. This organization is formed in the County of Inyo, State of California.

Article II
PURPOSE

This organization is formed exclusively for charitable, religious, educational, and/or scientific purposes, including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 501©(3) of the Internal Revenue Code, or corresponding section of any future federal tax code.

Article III
EARNINGS RESTRICTED

No part of the net earnings of the organization shall inure to the benefit of, or be distributable to its members, trustees, officers, or other private persons, except that the organization shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article II hereof.

Article IV
ACTIVITIES RESTRICTED

No part of the activities of the organization shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the organization shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of these articles, the organization shall not carry on any other activities not permitted to be carried on (a) by an organization exempt from federal income tax under section 501 © (3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or (b) by a organization, contributions to which are deductible under section 170©(2) of the Internal Revenue Code, or corresponding section of any future federal tax code.

Article V
DISSOLUTION

Upon the dissolution of the organization, assets shall be distributed for one or more exempt purposes within the meaning of section 501©(3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by the Court of Common Pleas of the county in which the principal office of the organization is then located, exclusively for such purposes or to such organization or organizations.

Article VI
OFFICERS

Section 1. The elected officers of the Auxiliary shall be a President, a Vice-President, a Recording Secretary, a Corresponding Secretary and a Treasurer.

Section 2. Officers of the Auxiliary shall be elected for terms of one year. No officer shall be eligible for more than three consecutive terms in the same office.

a. The Treasurer may serve past the 3 year limit, as long as the person is qualified.

b. The President may serve past the 3 year limit, as long as the person is qualified.

Article VII
TYPES OF MEMBERSHIP

Section 1. Membership in the Auxiliary shall be open to persons who are interested in Northern Inyo Hospital. All Auxiliary memberships shall be renewed annually. Prior to Active membership, a Counselor will educate and inform the prospective member as to function, purpose, and history of the Auxiliary.

Section 2. There shall be the following types of memberships:

a. ACTIVE: shall pay annual dues and participate in service programs of the Auxiliary. Any Active Member in good standing shall have the right to vote, participate in meetings, and to hold office in the Auxiliary.

b. ASSOCIATE: shall be interested in the purpose of the Auxiliary, shall pay annual dues, but have no active membership responsibilities. Any Associate Member in good standing shall have the right to vote, may participate in meetings and chair Standing Committees of the Auxiliary.

c. LIFE: A Life Membership may be purchased at a one time price of $100.00. Any Life Member in good standing shall have the right to vote, participate in meetings and to hold office in the Auxiliary.

d. HONORARY LIFE: The highest honor awarded by the Auxiliary is an Honorary Life Membership. It is awarded rarely and only to those individuals who have served over and above the normal membership requirements. These members have served in leadership roles as officers and committee chairmen. In addition, they have given countless hours participating in ALL functions of the Auxiliary. These individuals are chosen in recognition of outstanding service to the Auxiliary or the Hospital, and shall pay no dues. Any Honorary Life Member in good standing shall have the right to vote, participate in meetings, and to hold office in the Auxiliary. Those who receive this honor truly earn it, and their dedication to the Auxiliary inspires us all.

ARTICLE VIII
DUTIES OF OFFICERS

Section 1. The President shall be the chief executive officer of the Auxiliary and the Executive Board, and shall have the supervision of general management of the Auxiliary. The President shall appoint the Parliamentarian, chairmen of the standing committees, special committees as occasion may demand, and chairmen caused by vacancies. The President shall be a member ex officio of all standing committees of the Auxiliary, except the Nomination Committee. The President shall work closely with the Hospital Administrator and perform all duties pertaining to the office.

Section 2. The Vice - President shall be in charge of membership and shall be Chairman of the Membership Committee. In the absence, disability or resignation of the President, the Vice President shall have the executive powers and perform duties of the President.

Section 3. The Recording Secretary shall be responsible for keeping an accurate record of meetings of the Northern Inyo Hospital Auxiliary and of the Executive Board, in books belonging to the Auxiliary. These minutes shall be open to the inspection of any member at any reasonable time.

Section 4. The Corresponding Secretary shall be responsible for the Auxiliary's general correspondence.

Section 5. The Treasurer shall be responsible for keeping an accurate record of all financial affairs of the Auxiliary, and shall present a financial report at each General Meeting, All expenses, other than routine operating, must be approved by the members at a General Meeting, except for emergencies. The Treasurer's book shall be audited at the end of each financial year by three members appointed by the President.

Section 6. The Parliamentarian shall be the Chairman of the Bylaws Committee, keep a current list of the Standing Rules, and shall advise the Auxiliary board on the validity of any question of Parliamentary Law.

ARTICLE IX
THE EXECUTIVE BOARD

Section 1. The Executive Board shall consist of the Officers of the Auxiliary, the immediate past President and the chairmen of the standing committees. The Administrator of the Hospital shall be an ex officio member of the Executive Board.

Section 2. All actions of the Executive Board are subject to the approval of the Northern Inyo Hospital Board of Directors or its representative, the Hospital Administrator. With this limitation, management and control of property and funds, the affairs of the Auxiliary shall be administered by the Executive Board. The Executive Board shall adopt its own rules of procedure not inconsistent with the Bylaws of the Auxiliary.

Section 3. Regular meetings of the Executive Board are combined with the General Meetings. Special meetings of the Board may be held at any time and place determined by the President, and in addition shall be called when requested in writing by not fewer than five members of the board.

Section 4. Five members shall constitute a quorum at any meeting of the Board. In the absence of a quorum, the meeting shall be adjourned.

ARTICLE X
GENERAL MEETINGS

Section 1. There shall be regular meetings of the Auxiliary membership, the number to be determined by the Executive Board.

Section 2. The time and place of the General Meetings may be determined by the President and/or the Executive Board. Meetings are ordinarily scheduled the second Wednesday of each month. Meetings are to be held at Northern Inyo Hospital Annex, unless otherwise designated.

Section 3. The annual Meetings shall be held in May of each year for the Installation of Officers and Presentation of Awards.

Section 4. Six voting members present shall constitute a quorum of any General Meeting of the Auxiliary.

ARTICLE XI
COMMITTEES

Section 1. Standing Committees: There shall be Standing Committees necessary to conduct the business and program of the Auxiliary. The personnel of such committees shall consist of members designated by the Chairman of the Committee with the approval of the President. The duties of each committee will be outlined in detail in the Chairman's Procedure Book. These Chairmen become members of the Executive Board of the Northern Inyo Hospital Auxiliary.

Section 2: Nominating Committee shall be put into being, and act as prescribed in Article IX.

Section 3: Special Committees may be created when necessary by the President, with the approval of the Executive Board.

ARTICLE XII
ELECTION PROCEDURES

Section 1. The Nominating Committee shall consist of three members appointed by the board.

a. Suggested nominations for Officers of the Auxiliary shall be received by the Nominating Committee from the membership. From these suggestions, and as a result of its own deliberations,

the Nominating Committee shall submit to the April General Meeting a slate of candidates for officers during the ensuing year. Nominations may also be accepted from the floor.

b. Members of the Nomination Committee may be candidates for office.

Section 2. The Election of officers shall be held at the April Meeting. The new officers shall be installed at the May Meeting and take office on June 1.

ARTICLE XIII
FUNDS

Section 1. All fund-raising activities, other than regular membership dues, shall be subject to the approval of the Hospital Administration, and the funds shall be expended only for those purposes approved by the Auxiliary.

Section 2. All dues or contributions paid or made to the Auxiliary become the property of the Auxiliary, and the members or contributors shall have no further claim or rights thereto.

Section 3. All documents made, accepted or executed by the Auxiliary shall be signed by the President and/or representative.

Section 4. All checks drawn against the General Funds of the Auxiliary shall be signed by two authorized signatures on file at the banking institution.

Section 5. Funds expended for gifts to Northern Inyo Hospital (NIH) shall be for life saving equipment, or other items, or facility improvements that enhance the ability of NIH to serve the needs of the overall community, as expressed by the Hospital Administration.

ARTICLE XIV
FISCAL YEAR

The fiscal year of the Auxiliary shall commence on June 1, and shall end on May 31.

ARTICLE XV
AMENDMENTS

The Bylaws of the Auxiliary may be altered, repealed, or amended by the affirmative vote of two-thirds of the members present and voting, at any regular or special meeting of the Auxiliary, provided that notice of the proposed alteration, repeal or amendment be contained in a written notice of the meeting two weeks in advance.

ARTICLE XVI
APPROVAL AND ADOPTION

These Bylaws, after approval of the Northern Inyo Hospital Board of Directors, shall be effective immediately.

Approved: _____ _____Date
Kelli Davis, Chief Executive Officer, Northern Inyo Hospital

_____ _____Date
Jody Veenker, Board Chair, Northern Inyo Hospital Board of Directors

ADOPTED BY THE NORTHERN INYO HOSPITAL AUXILIARY:

_____ 1/12/22 Date
Judy Fratella, President

_____ 1/14/22 Date
Vivian Mitchel, Vice President

_____ 1-12-22 Date
Betty Dickey, Recording Secretary

_____ 1-12-22 Date
Carole Sample, Corresponding Secretary

_____ 1-12-22 Date
Sharon Moore, Treasurer

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: 02/02/2022

Title: HYLAND ONE CONTENT UPGRADE

Synopsis: A required upgrade is needed to maintain security and support within our medical achieve system. (Document management system)

It is recommended that the board approves this upgrade to maintain security and support with one of our critical medical management systems.

This system is used by providers to have historical data when doing patient care.

Prepared by: Bryan Harper, ITS Director / CISO

Reviewed and Approved: Vinay Behl, Interim Chief Financial Officer

Global Services by Hyland

PROFESSIONAL SERVICES PROPOSAL

Northern Inyo Healthcare District

OneContent Foundation Uplift w\ Server Refresh

Document Version: 4

Document Date: 20 Dec 2021

THIS PROPOSAL WILL EXPIRE **90** DAYS FROM THE ABOVE DATE UNLESS SIGNED BY BOTH PARTIES.

RFS# 42852734 (Hyland internal request tracking number)
#EU-32438-24053291 (Hyland internal request tracking number)

TABLE OF CONTENTS

INTRODUCTION

The purpose of this document (“Services Proposal”) is to define the goals, scope, fees and other important details supporting the delivery of Professional Services for one or more projects defined in the Project Areas section.

PROPOSAL TERMS & USAGE

Hyland Software Inc. (“Hyland”) is pleased to provide the following estimate for professional services related to the use of the OneContent software (“Software”) for Northern Inyo Healthcare District (“Customer”) as described in the Project Areas section of this document.

The content of this Services Proposal is subject to review and revision by both Hyland and Customer until fully executed by both parties.

Upon execution of this Services Proposal, the Hyland project manager or designated resource will contact Customer project team to discuss project logistics and potential start dates. At this time, Hyland resource availability will be reviewed and presented to Customer. Start times can vary based on existing work volumes. The project(s) will begin upon a mutually agreed upon date as soon as resource availability and Customer availability allow. Once the project start date has been determined, resources will be assigned and scheduled to begin delivery of the services described in this Services Proposal.

Services described in this Services Proposal will be provided in accordance with the terms of Schedule 1 - Terms and Conditions, attached to this Services Proposal (“Schedule”). Such Schedule shall be fully incorporated herein; provided that if Customer and Hyland (or one of its predecessors) have previously entered into a separate contract that governs the Services provided under this Services Proposal (such as a stand-alone services agreement, Master Software License, Services and Support Agreement, Hosting Agreement, Subscription Agreement or Framework Agreement), such contract will control in the event of any conflict between Schedule and such contract (regardless of whether the contract contemplates services performed in accordance with a SOW, Contract Supplement, Sales Order, Order From or a Services Proposal). All terms of any purchase order or similar document provided by Customer including but not limited to any Customer pre-printed terms and any terms that are inconsistent or conflict with this Services Proposal shall be null and void.

Please note that some of the resources assigned to perform the Services may be employees of Hyland Software, Inc.’s subsidiaries located in other countries.

After execution, all changes to this Services Proposal will follow the Project Change Control Process. All changes must be made to this Services Proposal through an authorized Change Order unless otherwise agreed to in writing by both Hyland and Customer.

PROJECT AREAS

Hyland will provide the following Professional Services described within this Services Proposal:

Project 1 – OneContent Foundation Uplift w\ Server Refresh

Hyland will provide Professional Services to Customer to implement the OneContent Foundation EP2 Uplift with Server Refresh solution.

Hyland shall supply OneContent Foundation EP2 to be implemented on all previously licensed OneContent Software modules currently installed and utilized on the Customer's test and production systems. Services within this proposal also include the migration of the solution from the current Microsoft Windows OS and SQL versions to current supported versions to meet requirements of Software.

Also included in the upgrade solution are the following:

1. Go-Live Window
    A. Upgrade downtime shall be scheduled at an agreed upon time between Customer and Hyland between the hours of 8AM and 1PM Eastern Standard Time on a Monday or Tuesday.
    B. Downtime can be scheduled after 1PM EST on Sunday, Monday, or Tuesday

Assumptions

This project is based upon the below assumptions being true. If for some reason these assumptions prove to be false, this could result in a scope change and may have an impact on the proposed cost and timeline to deliver:

1. Release Requirements
    A. Service Proposal assumes an imaging foundation, OneContent version of 17.0
    B. Service Proposal assumes Customer is live on the current version of third-party software and up to date on all maintenance agreements;
    C. Service Proposal assumes Customer will restore a recent copy of the Production database to the future Production system at the agreed upon timing for the software install;
    D. Solution requires Customer to provide current OneContent SQL Fragments to Hyland OneContent Project Team. Hyland resources will provide a script to Customer in order to obtain this information; and
    E. Service Proposal assumes Customer's current OneContent solution has no integrations with third party systems with the exception of Allscripts Paragon. If additional integrations exist, a change order will be required to add additional hours and pricing to the project.

2. Implementation Schedule
    A. Service Proposal has an estimated duration of sixteen (16) weeks;
    B. Service Proposal is defined as the duration between the Planning start (Week 1) to Live transition date (Week 16);
    C. The length of the Service Path may not reflect the length of the full product deployment;

D. Customer and Hyland will mutually develop and agree upon a project implementation timeline no later than thirty (30) day prior to project kick-off which shall include implementation timelines, critical events, and the respective responsibilities of both Hyland and Customer;
E. Service Proposal requires a period of read only access and a period of user downtime that varies dependent upon the size of the database and system configuration; and
F. Any request to reschedule the project subsequent to the start of the regression testing, due to no fault of Hyland, will require Hyland to initiate a change order following the Project Change Control Process outlined within this proposal. Hyland will work with Customer to provide a new schedule. If Customer requires Hyland to remain engaged between the original schedule and the new schedule, then Customer agrees to do so on a separate time and materials change order.

3. Hardware Changes
    A. Service Proposal assumes Customer is on Microsoft SQL 2012 and will be updating to at least a minimum version of Microsoft SQL required to meet OneContent version requirements;
        i. Supported Versions of Microsoft SQL:
            a. Microsoft SQL 2014
            b. Microsoft SQL 2016
            c. Microsoft SQL 2019
    B. Service Proposal assumes all server operating systems are at a release of Microsoft Windows OS 2012 or newer:
        i. Supported Versions of Microsoft Windows Server:
            a. Microsoft Windows Server 2012
            b. Microsoft Windows Server 2012 R2
            c. Microsoft Windows Server 2016
            d. Microsoft Windows Server 2019
    C. Service Proposal assumes no new hardware will be introduced into the production and test environments.
        i. Any requests from Customer to implement new hardware into the solution will require a change order to add additional hours to the contract.

4. Remote Work Requirements
    A. Hyland shall provide all work remotely; and
    B. Remote work requires a mutually agreed upon remote connection to the OneContent environment.

5. Inbound Document Feed Changes
    A. Service Proposal assumes no additions, removals, or modifications will be made to any document feeds, BDI, COLD, or Interfaces. Any inbound feeds requiring modification will require a change order respective of the effort involved in completing the change.

6. Workflow Additions
    A. Service Proposal assumes no additions, removals, or modifications to workflow unless the scope and services for this work is explicitly noted in the Services Overview section of this proposal or functionality of the new release requires changes to support the operation of workflow; and
    B. Custom workflow deployed by Customer will remain the responsibility of Customer.

7. Client Workstation Rollout
    A. Service Proposal does not include application rollout management or execution, including Citrix systems and\or remote access methods.

8. Virtual Infrastructure
    A. Service Proposal assumes Customer has available SAN storage to accommodate new virtual servers per the agreed upon future state design.

9. Testing
    A. Hyland shall provide remote resources during the first week of the testing period;
    B. Customer will develop test cases in advance of the testing period of the project;
    C. Customer performs testing and provides Hyland with a notification of any issues based on the test cases developed by Customer. Hyland tracks the issues during Customer's user testing process using Hyland's issue tracker tool, and updates the Customer once the issues are resolved, whether by Hyland's project team or Customer's project team; and
    D. Once Hyland determines all issues from testing have been resolved, the solution is ready for Go-Live.

10. Training
    A. Hyland will provide one remote instance of uplift training on the new features and functionality which will cover each release from the Customer's currently installed release through the upgrade release;
    B. Customer will be allowed to have up to six (6) resources attend the scheduled new feature and functionality training sessions. Requests for more than six (6) resources will require following the Project Change Control Process requesting a second scheduled training session at an agreed upon time between Hyland and Customer; and
    C. Uplift training does not include in depth, or refresher training on the overall solution.

11. Go-Live
    A. Hyland shall provide remote resource support during go-live week;
    B. Solution will be migrated to Customer's production environment; and
    C. Hyland shall assist Customer's IT Staff with Go-Live issue resolution.

12. Project Closure
    A. Service Proposal includes dedicated time for project closure. Hyland's project manager will schedule a meeting with Customer's project manager and project sponsor. The agenda will include introduction to Hyland's Technical Support Team, discussion of the state of relationship between organizations, and next steps for future opportunities as requested by Customer.

Exclusions

The following items are considered out of scope for this engagement:

1. Hyland will install OneContent Foundation EP2 as part of this proposal. If a newer version of OneContent has been release prior to project kick-off, Customer may request a Change Order to installed newly released OneContent version. Customer understands the newly released version could incur additional costs;

2. In depth or refresher training is not include in the project scope. Any requests from Customer for Hyland to provide additional training will require following the Project Change Control Process outlined in this proposal;
3. Due to new hardware being introduced as part of the uplift proposal, data and image migrations are considered out of scope and responsibility of Customer;
4. Proposal does not include services for the OneContent Medical Records Classification feature. A change order and license will be required to implement as part of the uplift: and
5. In the event the Customer requests any additional services not defined in this proposal, Hyland and Customer will determine the scope of the Additional Services to be provided, and the terms and conditions (including fees to be paid) will be contracted for under a new proposal or an agreed upon change order.

Required Resources

Resource
Project Manager
Integration Engineer
Technical Consultant

For details about the required resources, please review Appendix 1. For information about the rate type, please review pricing.

Deliverables

Deliverable
Project Plan
Project Status Report
Software Solution

For details about the deliverables, please review Appendix 2.

Responsibilities

The following information below is intended to provide Customer an understanding of the associated responsibilities of both Customer and Hyland.

Hyland Responsibilities

Hyland shall provide the following.

1. Prerequisite Management (Remote)
    A. Technical Planning
        i. Hardware and OS pre-configuration consultation
            1. Review Customers current Patient Folder configuration and ensure what is installed is reflected in the Engineering Master; and
            2. Develop the future state configuration relative to the new OneContent software version.
        ii. Consulting, Planning and documentation on LUN configuration requirements
            1. Consult with Customer to ensure they understand and have the information required to provision the appropriate storage requirements for the project.
        iii. Consulting, Planning and documentation on data migration strategy.
            1. Consult with Customer to ensure they have a strategy to perform any data migrations relative to the success of the project.
    B. Application Planning
        i. Consult on future state new feature functionality;
        ii. Consult with Customer on required decisions to implement new features;
        iii. Deliver design documentation and guide Customer through completion; and
        iv. Evaluate existing Workflow and deliver required compatibility updates to maintain current functionality with the new OneContent version.
    C. Interface Planning
        i. Consulting, Planning, and documentation on external/upstream interface changes; and
        ii. Consult with the Customer regarding all future state interface configuration changes relative to the success of the upgrade.
2. Project Management (Remote)
    A. Project Leadership
        i. Align Hyland and Customer goals to ensure a successful project.
    B. Escalation Management
        i. Engage support and escalation resources at Hyland to address critical issues. Any software issues that are discovered during the implementation and are not deemed critical will be logged and prioritized for future release resolution; and
        ii. Provide timelines and set expectations for issue resolution.
    C. Scope Management
        i. The Hyland Project Manager can review additional Service offerings at Customer request. Timelines and scope delivery for any additional Service offerings will be mutually agreed upon.
    D. Issues tracking and issues report
        i. Assign issues to appropriate responsible parties; and
        ii. Follow-up on issues and report back on timelines and set expectations for issue resolution.

E. Customized project plan
    i. Develop and publish a project plan to detail the steps and progression to successfully meet the goals of the project.
F. Test plans
    i. Provide Customer with the baseline test plan;
    ii. Set expectations for Customer to provide updates prior to the testing phase; and
    iii. Track progress of the testing process during the project lifecycle.
G. Weekly status meetings
    i. Provide agendas in advance of meetings and meeting minutes following each call.
H. Live planning, support and transition preparation
    i. Manage live planning tasks and deliverables through presentation and agreement with Customer;
    ii. Provide finalized uplift documentation required for a successful transition to Hyland technical support; and
    iii. Schedule the necessary calls required to transition Customer to Hyland technical support.

3. Technical Assistance (Remote)
    A. Hyland Software load and configuration
        i. Hyland will install and configure the OneContent software and test to ensure it functions as expected.
    B. Regression testing support. (Remote)
    C. Assistance with issue resolution. (Remote)
        i. Hyland will assign owners to issues and set expectations with Customer for related resolutions.
    D. Go Live Support (Remote)
        i. Hyland will assign owners to issues and set expectations with Customer for related resolutions.
4. Application Assistance (Remote)
    A. Provide new feature build guidance
    B. Regression testing support
        i. Application regression testing is the primary responsibility of Customer where Hyland provides product knowledge and expertise to answer Customer questions and provide suggestions relative to Customer needs.
    C. Assistance with issue resolution. (Remote)
        i. Hyland will assign owners to issues and set expectations with Customer for related resolutions.
    D. Go Live Support (Remote)
        i. Hyland will assign owners to issues and set expectations with Customer for related resolutions.
5. Interface support (Remote)
    A. Setup/verify interface feed for new environment
        i. Hyland will configure the OneContent environment to ensure required interfaces are tested in the application and work with Customer to ensure they understand their responsibilities relative to external interface needs to OneContent.
        ii. Implementation of interface release modifications
            1. Hyland will apply all required modifications relative to the new software release required for full functionality.
    B. Assistance with issue resolution

i. Hyland will assign owners to issues and set expectations with Customer for related resolutions.

C. Go Live Support (Remote)
   i. Hyland will assign owners to issues and set expectations with Customer for related resolutions.

6. Education (Remote)
   A. Hyland will provide one instance of uplift training on the new features and functionality which will cover each release from the Customer's currently installed release through the uplift release;
   B. Training is intended for Managers and Super Users who are responsible for the training of others;
   C. This training will include application training covering the changes in the interface and work processes for both super users and technical teams;
   D. Training is intended for up to six (6) individuals; and
   E. Uplift training does not include in depth or refresher training on the overall system.

Customer Responsibilities

Customer shall provide the following.

1. Customer shall cooperate with Hyland in the Services of the implementation, and shall perform the functions assigned to Customer in the implementation plan, including but not limited to:
   A. Completion of the provided Test Plan including any unique process validation not outlined in the baseline test scenarios;
   B. Establishing connectivity to all sending systems and conducting a thorough volume and variety validation of all interfaces. Customer owns any necessary redirection of port/IP/directories on the sending systems;
   C. Validation of all workflow threads;
   D. Completion of application build as outlined during the Application Design period; and
   E. Delivery of end user training to all impacted end users.
2. During the OneContent uplift, Customer must ensure the availability of resources to lead the project effort. The Customer Resource Profile includes:
   A. Project Manager
   F. Interface Analyst
   G. Technical Analyst
   H. Application Analyst
   I. System Administrator
   J. Training Coordinator
   K. Physician Champion
3. Customer must have a dedicated System Administrator.
4. Customer agrees not to initiate new work orders and to temporarily cease work on existing work orders that would change Customer's existing software once the "Software Freeze" date has been established, until after returning to standard Customer support.
5. Prerequisite Management
   A. Customer will complete timely review of all available software release documentation in preparation for design and infrastructure consultation and changes;

B. Customer will provide network connectivity and such network connectivity will be implemented prior to the Start Date. Customer will provide access with detailed list of server names, IP addresses, user names and passwords;
C. Hardware and OS pre-configuration consultation;
    i. Timely review of Customers current OneContent configuration to ensure what is installed is reflected in the Engineering Master.
    ii. Promptly and thoroughly review with Hyland the future state configuration relative to the new OneContent software version.
D. Consulting, Planning and documentation on LUN configuration requirements;
    i. Make available technical resources timely and consistently for review and consultation of infrastructure changes.
    ii. Timely participation, review, and agreement to required storage provisioning needs.
E. Consulting, Planning and documentation on data migration strategy;
    i. Make available technical resources timely and consistently for review and consultation of data migration changes (if applicable).
    ii. Timely participation, review, and agreement to required data migration strategy (if applicable).
F. New feature functionality build decisions; and
    i. Participation in new features review.
    ii. Participation in regular design meetings.
    iii. Timely review and build decision completion for new feature implementation.
G. Consulting, Planning and documentation on external/upstream interface changes.
    i. Participate in consulting efforts regarding all future state interface configuration changes relative to the success of the upgrade.

6. Project Management
    A. Project Leadership
        i. Align Customer and Hyland goals to ensure a successful migration.
    B. Escalation Management
        i. Provide timely details related to issue status, steps to reproduce, severity, and business impact; and
        ii. Provide timely resources and systems required for validation of provided resolutions.
    C. Issues tracking and issues report
        i. Report all issues using the Hyland issue management system;
        ii. Assign issues to appropriate responsible parties; and
        iii. Follow-up on issues and report back on timelines and set expectations for issue resolution.
    D. Test plans
        i. Customize baseline test plan;
        ii. Customer will review the standard system test plan and revise to include any unique testing related to Customer's business operations and use of the system at least 2 weeks prior to the regression testing week Align resources and schedule for testing with the required test expectations;
        iii. Provide regular timely updates on testing progress;
        iv. Customer agrees to complete test plan minimum of two week prior to Go Live;
        v. Customer agrees to provide Hyland a copy of completed Test plan; and
        vi. Failure to provide a Completed Test plan may result in a rescheduling of the project slot until Test plan is completed and the rescheduling fee will be charged.

E. Live planning, support and transition preparation
    i. Participate in live planning and resource assignment for required tasks;
    ii. Setup command center and communication plan for all live support; and
    iii. Report all issues using the Hyland issue management system.

7. Technical Functions
    A. Meet and provide prerequisite deliverables as outlined during design phase and software documentation including:
        i. Setup and deployment of additional virtual machines per agreed upon design efforts;
        ii. Provide and deploy identified storage required per agreed upon design efforts to hardware infrastructure;
        iii. Presentation of LUNS to virtual machines;
        iv. Plan and configure load balancer updates per Hyland best practices; and
        v. Acquire all required SSL certificates and deploy per Hyland best practices.
    B. Deployment planning, testing, and execution including all required scanner setup and installation, all client workstations, Citrix configuration, and any other remote access methods.
    C. Align resources with duration of testing efforts and provide system monitoring as per the Hyland OneContent recommended best practices.
    D. Align resources with duration of go live efforts and provide system monitoring as per the Hyland OneContent recommended best practices.
8. Application Functions
    A. Configuration of new build requirements;
    B. Provide senior leadership and physician engagement for adoption of new features;
    C. Completion of regression and integrated testing test plans;
        i. Align resources with duration of regression and integrated testing efforts.
    D. Timely and thorough issue reporting; and
    E. Align resources with duration of go live efforts.
9. Interface Functions
    A. Setup/verify interface feed for upgrade environment – Customer will configure the external/upstream interfaces to point to the necessary test and production OneContent environments;
    B. Testing of interface release modifications - Customer will validate all modifications relative to the new software release required for full functionality;
    C. Assistance with issue identification and resolution; and
        i. Align all Customer and third party resources with the duration of the regression and integrated testing efforts; and
    D. Go-Live Support
        i. Align all Customer and third party resources with the duration of the go live efforts.
10. Education Coordination
    A. Participants should include the Customer’s project manager, HIM Director or Manager, HIM Imaging Coordinator and other Super Users, Patient Financial Services Director or Manager, Patient Financial Services Imaging Coordinator and other Super Users, Patient Access/Registration Imaging Coordinator and Super Users, System Administrator and Interface Analyst; and
    B. Upon class completion, participants will be responsible for the coordination and delivery of education to all end users.

Generic Implementation Schedule

*Actual schedule may vary

Project Phase	Customer Responsibilities	Hyland Responsibilities
Kick-Off, Planning, and Design	▪ Assign resources according to the OneContent Customer Resource Profile ▪ Participate in kickoff meetings ▪ Verify Hyland remote connectivity to all OneContent system components ▪ Verify backup solution for test and production ▪ Prepare current state and future state rack diagrams for both test and production environments ▪ Verify current interfaces ▪ Procure and deploy new virtual infrastructure ▪ Participate in consulting, discovery, & design meetings (technical, application, & interface) ▪ Complete required new feature build decision documentation ▪ Download all OneContent software ▪ Prepare for software upgrade to future Production and future Test environments ▪ Provide the appropriate MS SQL media ▪ Provide current OneContent SQL Fragment Report	▪ Assign OneContent Upgrade project team ▪ Schedule Project Kickoff meeting ▪ Schedule weekly team calls ▪ Communicate site preparation requirements ▪ Verify connectivity ▪ Conduct Kickoff meeting ▪ Guide Customer in identifying business process changes related to upgrade ▪ Consult on new feature functionality & required build decisions. ▪ Consult on development of Customer end-user training plan and materials ▪ Provide regression and integrated test plan template ▪ Monitor new feature functionality build decision completion ▪ Guide Customer in identifying business process changes related to upgrade ▪ Provide scripts to Customer for SQL Fragment Report
Install and Build	▪ Prepare application deployment plan ▪ Prepare for business process change management ▪ Customize regression and integrated testing plans ▪ Confirm test interfaces are flowing to OneContent future Production & future Test systems or possibly configure interfaces for testing. ▪ Execute new feature functionality builds/configuration	▪ Perform OneContent software and component upgrade/configuration ▪ Perform OneContent interface upgrade/configuration ▪ Provide guidance during new feature functionality builds ▪ Run SQL Conversion Utility
Education	▪ Receive remote OneContent Super User Education ▪ Develop Customer end-user training plan ▪ Schedule Customer end-user training sessions	▪ Provide OneContent Super User Education ▪ Consult on development of Customer end-user training plan and materials

Project Phase	Customer Responsibilities	Hyland Responsibilities
	▪ Execute Customer end-user training	
Test	▪ Execute regression test plan ▪ Prepare for integrated system test ▪ Execute and complete integrated system test ▪ Perform volume testing ▪ Finalize volume testing ▪ Finalize application deployment plan ▪ Validate interfaces to the test environment ▪ Validate configuration of the test environment ▪ Sign off on testing ▪ Deliver completed test plan to Hyland	▪ Assistance executing regression test plan ▪ Issue resolution and management ▪ Provide guidance to Customer on test system configuration and validation
Go-Live Preparation	▪ Identify key people for productive use support ▪ Finalize application deployment plan ▪ Finalize test system readiness ▪ Prepare for Go-Live ▪ Finalize Go-Live plan	▪ Provide Go-Live plan ▪ Assist in issue resolution ▪ Provide guidance to customer on production planning and procedure definition. ▪ Review final preparation of Go-Live plan
Go-Live	▪ Assist in production mode procedures ▪ Attend Go-live meetings ▪ Execute application deployment plan ▪ Evaluate project ▪ Production system use ▪ Post activation issue resolution ▪ Good health validation	Upgrade production environment Provide remote support during upgrade of Production environment Conduct follow-up meeting with Customer to evaluate Implementation Project results ▪ Issue resolution management ▪ Address post activation issues remotely
Transition	▪ Transition Upgrade Project to Hyland Technical Support at the end of first Live week	▪ Structured transition to Hyland Technical Support at the end of first Live week

KEY ASSUMPTIONS

The following are key assumptions that impact the success of the solution, and are applicable to all Project Areas within this Services Proposal:

1. Project start date(s) are subject to a mutually agreed upon schedule after execution of contract;
2. Upon execution of contract by Customer and Hyland, Hyland shall send a Welcome email to Customer with a questionnaire for Customer completion. Customer is responsible for completing questionnaire and returning to Hyland before Hyland can assign project resources and kick-off the project defined within the contents of the executed proposal;
3. Professional Services will be delivered utilizing Hyland's standard implementation methodology;
4. Professional Services will be provided remotely from Hyland offices:
    A. When providing remote services, Hyland and Customer will discuss generally acceptable working hours and take into consideration time zone differences. Issues deemed as non-critical will only be addressed during normal business hours.
5. Each project is intended to be implemented in a timeframe of contiguous weeks. Scheduling delays that impact the project timeline will result in changes to project costs;
6. Each deliverable created will use Hyland's standard deliverable templates. Customer requested changes to deliverable templates may increase project costs or introduce timeline delays; and
7. If necessary, after execution, this Services Proposal or corresponding agreement can be adjusted in scope, or a new agreement issued, following the Project Change Control Process.

CUSTOMER OBLIGATIONS

To facilitate Hyland's execution of the Professional Services, Customer agrees, at a minimum, to the following obligations. The parties acknowledge and agree that failure to meet the responsibilities noted will likely affect project duration, cost and/or quality in the execution and completion of Professional Services.

Project Personnel

1. Customer will assign a project sponsor, who will be actively involved in the project(s) and is the final escalation point for all issues and decisions:
    A. The project sponsor will also ensure that the appropriate Customer personnel are assigned and made available to execute the project(s) successfully.
2. Customer will assign a project manager, who will act as a single point of contact for the Hyland project team and whose responsibilities include, but are not limited to, the following:
    A. Managing all customer obligations as defined within this Services Proposal; and
    B. Coordinating all key departmental decision makers, technical experts, subject matter experts, end user representatives, third party software application resources and project sponsorship.
3. Customer will designate a Software administrator who will undergo any applicable Software training recommended in order to participate actively throughout the project(s) and support all Software environments and solutions:
    A. Software training course(s) (if recommended) are provided separately from this Services Proposal by the Hyland Account Manager.
4. Customer will engage the appropriate business process owners to the project(s), as well as subject matter experts, who are thoroughly knowledgeable about the current business practices in their respective areas and who are capable of performing their assigned project roles:
    A. Business process owners and subject matter experts will be required to attend and contribute to all project meetings to which they have been invited for the duration of the project(s).
5. Customer will provide Information Services (IS)/Information Technology (IT) representative(s) to assist with the Software installation with regard to network and system administration;
6. Customer will provide trained technical team member(s) to assist in supporting and maintaining all aspects of the hardware, network, and/or database maintenance plans throughout the project(s);
7. Customer will provide vendor resources, interface specialists, technical experts, and/or subject matter experts deemed necessary for third party system(s) with which Software will integrate or from which content will be migrated;
8. Customer will make reasonable efforts to maintain consistent resources throughout the project(s):
    A. Any anticipated changes to the core team must be communicated in writing within five (5) business days;
    B. If the change is due to illness or termination of the core team member, the change must be communicated as soon as possible.

Project Management

1. Customer will review the remaining work effort with the Hyland project team throughout the project(s). If, at any time, the number of hours required to complete a project phase exceeds the number of hours estimated by the project teams for that phase, then Hyland will incorporate the Project Change Control Process prior to exceeding the budgeted number of hours;
2. Customer will review all deliverables in accordance to the agreed upon plan. Failure to respond where needed within the designated timelines may result in project delays, loss of resources, and incorporation of the Project Change Control Process;
3. Customer will execute timely decision-making, completion of all deliverables and action items and resolution of issues throughout the course of the project(s); and

Software Installation, Access, Integrations and Deployment

1. Customer will ensure all hardware is in place and made ready as dictated by the implementation schedule. This includes full, independent access to all environments in which Hyland is required to work including environments required for migrations or integrations, or multiple development, testing and production environments for Software:
    A. Local and remote VPN access must be provided to applicable Hyland resources through the use of dedicated user account(s) with appropriate privileges to the Software and/or relevant third party applications; and
    B. Access must be provided prior to Hyland's arrival at Customer facilities and/or project discovery sessions.
2. Customer will provide a properly setup environment in accordance with Hyland's prerequisites. Setup will consist of the installation, configuration and administration of, but not limited to, all hardware and operating systems, database instance(s), networking and required third party software;
3. Customer will have at least one (1) non-production Software environment for installation and deployment;
4. Customer will provide proper setup of networking and required third party software environment(s) in accordance with Hyland's prerequisites;
5. Customer will provide all necessary components including, but not limited to, power, lighting, network connections/rights and environmental controls deemed necessary for the proper functioning of and access to the system;
6. Customer will manage setup, execution, and validation of database maintenance plan(s) for each Software instance;
7. Customer will perform routine, scheduled backups and maintain disaster recovery and contingency plans for each Software instance;
8. Customer will manage third party application setup (i.e. installation, configuration), testing, training, and go-live support related to integration(s) with Software;
9. Customer will package and deploy all Software clients, unless otherwise defined within this Services Proposal; and
10. Customer will deploy all supporting Software client hardware (e.g. scanner, signature device) and related third party software (e.g. drivers, licenses) required for the Software solution.

Testing/Training

1. Customer will manage the deployment of Software testing/training workstation(s) (e.g. PC and scanner) including the installation of all necessary software/clients, unless otherwise defined within this Services Proposal;
2. Customer will prepare and supply the necessary testing/training resources including, but not limited to, the following:
    A. Sample, production-like, content;
    B. Electronic feeds; and
    C. Paper documents.
3. Customer will secure training room(s) ensuring that all resources participating will have the proper workstations and materials, as set forth by the Hyland project team:
    A. If these provisions are not met, Hyland has the right to cancel and reschedule training.
4. Customer will create, maintain, and execute test plans and cases, as well as track and report testing results during the testing cycle(s); and
5. Customer will train additional end users on the use of the Software.

PROJECT CHANGE CONTROL PROCESS

Requested changes to this Services Proposal will be managed using the Project Change Control Process outlined below.

If any party believes that a change to this Services Proposal is warranted, the party shall issue a Change Request in writing. The Hyland and Customer project teams will review the Change Request, determine the impact and attempt to agree to the change(s). Once the change(s) are agreed upon, Hyland will provide a formal Change Order to Customer outlining the change in Professional Services, the impact on hours, resources, timeline and/or cost.

Customer and Hyland will fully execute each mutually agreed upon Change Order prior to the requested changes taking effect. Customer and Hyland acknowledge that this may affect Professional Services, timelines and deliverables, and therefore will make reasonable efforts to execute any changes to this Services Proposal with enough lead-time to minimize the influence on the project. No Change Order is binding upon the parties until it is executed by both Customer and Hyland.

PRICING

Customer acknowledges that the Professional Services pricing is based solely on the information provided to Hyland and referenced in the above Project Areas.

Time and Materials Projects

Project	Work Hours	Totals (USD)
Project 1 – OneContent Foundation Uplift	310	$69,750.00
After Hours for Project 1	28	$9,450.00
15% Discount		($11,879.86)
Total	**270**	**$67,320.14**

Rate Type	Standard Hourly Rate	Discounted Standard Hourly Rate	After-Hours Hourly Rate	Discounted After-Hours Hourly Rate
Project Manager	$225.00	$191.25	$337.50	$286.88
Technical Consultant	$225.00	$191.25	$337.50	$286.88

Pricing Assumptions

The pricing was created using the following assumptions:

1. The above pricing includes estimated Professional Services fees anticipated to complete the project(s) successfully;
2. For Project 1, Hyland recommends all resources to be remote to maximize project success;
3. Customer billing will start from July 1st 2022;
4. The above pricing reflects a one-time, Fifteen percent (15%) discount against Hyland Professional Services rates; and
5. The time and materials estimate(s) provided to complete the Professional Services are provided for convenience only and are an approximation of the anticipated amount of fees needed to complete such Professional Services. Customer will be invoiced monthly based on the amount of time actually required to complete such Professional Services and the applicable hourly fees and any applicable travel expenses;
6. Any additional Professional Services requested of Hyland resources in alignment to this Services Proposal, which have been facilitated by the Project Change Control Process, will be charged at the then current standard Hyland resource rates.

Go-Live After-Hours Support

1. Go-Live After-hours or weekend support will be made available for this project:
    A. After Hours shall be defined as after normal business hours of 8am to 5pm local time, Monday and Tuesday not including observed national holidays;
    B. Weekend Support shall be defined as 1pm to 12am local time, Sunday;
    C. A maximum of eight (8) hours per resource, per shift, with a rest period of eight (8) hours rest between each engagement; and

D. All After Hours work is billed at time and a half (1.5 x bill rate).

SIGNATURES

Northern Inyo Healthcare District	**Hyland Software Inc.**
By:	By:
Name: (Print)	Name: (Print)
Title:	Title:
Date:	Date:

Purchase Order #: _____
(Invoices issued hereunder may not reflect a PO number if this field is not completed)

APPENDIX 1 – RESOURCE DESCRIPTIONS

The following table provides an overview of the Hyland Global Services resource types and their corresponding responsibilities. Please reference the specific Project Areas for a listing of the required resources.

Resource Type	Responsibilities
Project Manager	Provides project management expertise and is the initial point of project escalation.
Manages project initiation, develops the project plan, and coordinates schedules and resources. Tracks burn down rates, project/solution issues, scope creep and impact, generating change orders as needed.	
Technical Consultant	Provides expertise on Software installation and module configuration.
Documents business requirements, installs and configures solutions to meet requirements, provides administrative training and train the trainer courses, migrates solutions to additional environments and provides user testing issue resolution and go-live support.	

APPENDIX 2 – DELIVERABLE DESCRIPTIONS

The following table provides an overview of the Hyland project deliverables. Please reference the specific Project Areas for a listing of the applicable deliverables.

Deliverable	Description
Project Plan	Defines the projected schedule of project events from initiation through closure.
Delivered within the initiation/discovery phase and updated throughout the project.	
Includes the activities, deliverables, assignments and dates required to complete the project.	
Project Status Report	Provides an overview of project health and important related details.
Delivered after initiation and then regularly throughout the project in a frequency to be determined by the Hyland and Customer Project Managers (e.g., bi-weekly).	
Includes details about the project health, financials (budgeted vs. actuals), critical action items, upcoming key activities, outstanding deliverables, change requests and notable issues/risks.	
Each updated report requires a shared review with Customer and Customer verification for accuracy.	
Software Solution	The Software configuration delivered at the conclusion of the Project, as described in the project scope.
Implementation of the requirements defined in the project scope.	

SCHEDULE 1 – TERMS AND CONDITIONS

1. DEFINED TERMS.

"Professional Services" shall mean the services performed under the Services Proposal within which this Schedule is incorporated.

"Software" means Hyland's proprietary software products for which Customer has obtained a valid license from Hyland or one of its authorized solution providers.

"Specifications" means the definitive, final functional specifications for Work Products, if any, produced by Hyland under the Services Proposal.

"Working Hour" means the services of one (1) person for a period of one (1) hour (or any part thereof) during regular business hours.

"Work Products" means all items in the nature of computer software, including source code, object code, scripts, and any components or elements of the foregoing, or items created using the configuration tools of the Software, together with any and all design documents associated with items in the nature of computer software, in each case which are created, developed, discovered, conceived or introduced by Hyland, working either alone or in conjunction with others, in the performance of services under this Schedule. If applicable, Work Products shall include any pre-configured templates or VBScripts which have been or may be created or otherwise provided by Hyland to Customer as part of the configuration of the advance capture module of the Software.

2. FULFILLMENT. Hyland will provide the Professional Services as mutually agreed under the Services Proposal. Hyland will provide the Professional Services described in this mutually agreed upon Services Proposal at a time and on a schedule that is mutually agreed upon by the parties. If any delays in such Professional Services occur solely as a result of any incorrect information, incorrect assumption or failure of Customer to perform or fulfill its obligations in connection with any Services Proposal, the performance schedule for the applicable project may be extended. Hyland shall have no liability or responsibility for any costs or expenses resulting from such delays. In the event that performance of any milestone set forth in any Services Proposal is not met due to a delay solely caused by Hyland, and provided that such cause is not an event of force majeure, Hyland agrees, at no additional charge to Customer, to commit such additional resources and personnel as shall be necessary to ensure that such delay does not result in the slippage of later milestones or completion of such Professional Services. The parties agree that any Professional Services or Work Products described in the Services Proposal that have been performed or developed, in whole or in part, prior to the execution of this Services Proposal by the parties nevertheless shall be covered by all terms and conditions of this Services Proposal.

3. CHANGES TO SERVICES PROPOSAL. Hyland or Customer may, at any time, reasonably request a change to any Service Proposal. Any requested change that the parties mutually accept (a "Change") will be set forth in a written change order prepared by Hyland and agreed to and signed by both parties that specifically references the relevant Service Proposal. In the event the parties are unable to mutually agree upon a proposed Change or a proposed change order, and such proposed Change relates to a material component of the project that is the subject of the relevant Services Proposal, either party may terminate such Service Proposal upon not less than thirty (30) days advance written notice to the other party.

4. CUSTOMER'S OBLIGATIONS.

4.1 Assistance and Obligations. Customer agrees that it will cooperate with and assist Hyland in the performance of Professional Services under this Services Proposal; will provide the resources specified in the relevant Services Proposal; and will perform or fulfill all obligations required to be performed or fulfilled by Customer under the terms of the Services Proposal. Customer acknowledges that if it fails to provide assistance and perform or fulfill its obligations in accordance with this Section and the Services Proposal, Hyland's ability to provide such Professional Services, meet the performance schedule set forth in such Services Proposal and keep services fees reasonably in line with any estimates given in the Services Proposal may be adversely affected. During any period in which Hyland is performing services hereunder, Customer shall provide to the Hyland project team independent local (onsite) and remote (offsite) access through the use of secure connections such as a network connection, VPN connection or other similar methods and dedicated user accounts with appropriate privileges to the Software, hardware or virtual machines allocated to the Software system. Remote and local access will be granted for all provisioned environments, including production.

4.2 Third Party Software Rights. Notwithstanding any contrary terms, if Customer requests Hyland to perform Professional Services on or with respect to any third party software, Customer represents and warrants to Hyland that Customer has all necessary rights to allow Hyland to do so.

4.3 Protection of Customer's Systems. CUSTOMER UNDERSTANDS THAT IT IS SOLELY RESPONSIBLE TO TAKE APPROPRIATE MEASURES TO ISOLATE AND BACKUP OR OTHERWISE ARCHIVE ITS COMPUTER SYSTEMS, INCLUDING ITS COMPUTER PROGRAMS, DATA AND FILES.

4.4 Safe Work Environment. Customer will be responsible for and shall ensure that while Hyland employees, agents or subcontractors are on Customer's premises, all proper and legal health and safety precautions are in place and fully operational to protect such persons.

5. SERVICES FEES. Except as otherwise provided in the Services Proposal: (a) Hyland will charge services fees to Customer for Professional Services at Hyland's then-current standard list price for the applicable Professional Services; and (b) Hyland shall invoice Customer for Professional Services fees monthly, in arrears, based on the number of Working Hours required to complete the project and the applicable hourly fees; and Customer shall pay in full within thirty (30) days after the invoice date. Any estimates of fees or Working Hours required to complete the project are approximations of the anticipated amount of fees and time needed to complete the project. The actual number of Working Hours may vary.

6. TRAVEL AND EXPENSES. Customer shall be responsible to pay or reimburse Hyland for all customary and reasonable out-of-pocket costs and expenses incurred by Hyland in connection with the performance of services under this Services Proposal (including fees and expenses relating to travel, meals, lodging and third party vendor registration requirements) in accordance with Hyland's applicable internal policy for the reimbursement of costs and expenses to its employees ("Hyland Expense Policy"). Except as otherwise provided in any applicable Services Proposal, Hyland shall

invoice Customer for all reimbursable costs and expenses on a monthly basis, in arrears; and Customer shall pay in full each such invoice in accordance with the General Terms.

7. CERTAIN REMEDIES FOR LATE PAYMENT. All past due amounts shall bear interest at the rate of one and one-half percent (1.5%) per month (or, if lower, the maximum rate lawfully chargeable) from the date due through the date that such past due amounts and such accrued interest are paid in full. In the event of any default by Customer in the payment of any amounts due hereunder, which default continues unremedied for at least ten (10) calendar days after the due date of such payment, Hyland shall have the right to suspend or cease the provision of any services under this Services Proposal unless and until such default has been cured.

All payments under this Services Proposal are exclusive of all applicable taxes and governmental charges (such as duties), all of which shall be paid by Customer (other than taxes on Hyland's income). In the event Customer is required by law to withhold taxes, Customer agrees to furnish Hyland all required receipts and documentation substantiating such payment. If Hyland is required by law to remit any tax or governmental charge on behalf of or for the account of Customer, Customer agrees to reimburse Hyland within thirty (30) days after Hyland notifies Customer in writing of such remittance. Customer agrees to provide Hyland with valid tax exemption certificates in advance of any remittance otherwise required to be made by Hyland on behalf of or for the account of Customer, where such certificates are applicable.

8. WORK PRODUCTS

8.1 Ownership. THIS AGREEMENT IS NOT A WORK-FOR-HIRE AGREEMENT. Hyland or its suppliers retain on an exclusive basis for itself or themselves all right, title and interest in and to any intellectual property developed, discovered, conceived or introduced by Hyland in the performance of the Services Proposal, including, but not limited to, all patents, patent applications, copyrights and other intellectual property rights relating to or associated with the Work Products.

8.2 Work Products License. Customer agrees to take all reasonable steps to protect all Work Products, and any related documentation from unauthorized copying or use. Hyland grants to Customer a limited, non-exclusive and non-assignable license for the duration of the term of the license agreement pursuant to which Customer received the right to use the Software with which the Work Products will be used ("License Agreement"), to use the Work Products only internally, only in connection with Customer's own data and only in connection with Customer's authorized use of the software under the License Agreement. Customer may not: (a) make or authorize the making of copies of any Work Products; (b) remove any Hyland notices in the Work Products; (c) sell, transfer, rent, lease, time share or sublicense the Work Products to any third party; or (d) disassemble, decompile, reverse engineer or otherwise attempt to derive source code from any Work Product for any reason. Customer further agrees that, in connection with any use of the Work Products by Customer, the Work Products shall not be copied and installed on additional servers unless Customer has purchased a license therefore.

8.3 Modification of Work Products.

8.3.1 Form of Delivered Work Products. The form in which Hyland delivers Work Products will be determined by Hyland depending on the purpose and functionality of the Work Product.

8.3.2 Configuration Work Products. If Hyland delivers a Work Product: (a) in the form of (1) source code which is compiled by tools in the Software to machine language form; or (ii) a script; or (b) created using the configuration tools in the Software (a "Configuration Work Product"), then Hyland grants to Customer the limited right to modify the Configuration Work Product, provided such modified Configuration Work Product is used only in compliance with the terms of the limited license to such Work Product granted under this Section.

8.3.3 Independent Work Products. If Hyland delivers a Work Product which is not a Configuration Work Product (an "Independent Work Product"), then, except as otherwise provided in the last sentence of this paragraph, Customer may not alter or modify such Independent Work Product. If Hyland delivers an Independent Work Product, and Customer desires to obtain the right to modify the Independent Work Product, then the parties may mutually agree that Hyland shall deliver to Customer a copy of the format of the Independent Work Product that is necessary to enable the Customer to complete its modifications, subject to and upon the payment by Customer to Hyland of any additional Professional Services fees as Hyland may charge to prepare and deliver such format. In such case, Hyland grants to Customer the right to modify, and if necessary, compile the delivered format of the Independent Work Product, provided such modified Independent Work Product is used only in compliance with the terms of the limited license to such Work Product granted under this Section.

9. LIMITED WARRANTY FOR SERVICES AND WORK PRODUCTS

9.1 Limited Warranty for Professional Services. For a period of sixty (60) days from the date of completion of Professional Services, Hyland warrants to Customer that such Professional Services have been performed in a good and workmanlike manner and substantially according to industry standards. This warranty specifically excludes (a) non-performance issues caused as a result of incorrect data or incorrect procedures used or provided by Customer or a third party or failure of Customer to perform and fulfill its obligations under this Services Proposal; and (b) any Professional Services in the nature of staff augmentation.

9.2 Limited Warranty for Work Products. For a period of sixty (60) days from and including the date that Hyland has delivered a completed Work Product to Customer, Hyland warrants to Customer that such Work Product, when properly installed and properly used, will function in all material respects as described in the Specifications. The terms of this warranty shall not apply to, and Hyland shall have no liability for any non-conformity related to, any Work Product that has been (a) modified or added to by Customer or a third party, (b) used in combination with equipment or software other than that which is consistent with the Specifications, or (c) misused or abused.

9.3 Remedy. Hyland's sole obligation, and Customer's sole and exclusive remedy for any non-conformities to the express limited warranties under Sections 9.1 and 9.2 shall be as follows: provided that, within the applicable sixty (60)-day period, Customer notifies Hyland in writing of the non-conformity, Hyland will use commercially reasonable efforts to re-perform the non-conforming services in an attempt to correct the non-conformity(ies), or, in the case of a Work Product, either repair or replace the non-conforming Work Product, which may include the delivery of a commercially reasonable workaround for the non-conformity. If Hyland is unable to correct such non-conformity(ies) after a reasonable period of time or determines that repair or replacement of the Work Product is not commercially reasonable, Customer's sole and exclusive remedy shall be to terminate the Services Proposal,

in which event Hyland will refund to Customer any portion of the services fees under such Services Proposal relating directly to such non-conforming Professional Services or to the creation and implementation of the non-conforming Work Product, in either case paid prior to the time of such termination.

9.4 Disclaimer of Warranties. Except as expressly set forth above, Hyland makes no warranty or representations regarding any Work Products, information or services provided under this Services Proposal. Hyland disclaims and excludes any and all other express, implied and statutory warranties, including, without limitation, warranties against infringement, the implied warranties of merchantability and fitness for a particular purpose, and warranties that may arise or be deemed to arise from any course of performance, course of dealing or usage of trade. Hyland does not warrant that any services, Work Products provided will satisfy Customer's requirements or are without defect or error, or that the operation of any software provided under this Services Proposal will be uninterrupted. Hyland does not assume any liability whatsoever with respect to any third party hardware, firmware, software or services.

10. TERMINATION.

10.1 By Customer. Customer may terminate the Services Proposal for breach as stated in section 10.2. below or for convenience, upon not less than thirty (30) days advance written notice to Hyland to such effect.

10.2 By Either Party. Either party may terminate the Services Proposal, effective immediately upon written notice to the other party, if the other party has committed a breach of a material provision of this Schedule and has failed to cure the breach within thirty (30) days after the receipt of written notice of the breach given by the non-breaching party.

10.3 Terminating a Services Proposal. In the event of any termination of a Services Proposal, Customer agrees to compensate Hyland for all Professional Services already performed prior to, and including, the date of termination, except to the extent that Hyland has breached its obligations to perform such Professional Services and such breach is the cause of such termination.

11. LIMITATIONS OF LIABILITY.

11.1 HYLAND'S LIABILITY FOR ANY LOSS OR DAMAGES ARISING OUT OF OR IN CONNECTION WITH THE SERVICES PROPOSAL, INCLUDING, BUT NOT LIMITED TO, THE PERFORMANCE OR NON-PERFORMANCE OF SERVICES OR THE USE OR INABILITY TO USE ANY WORK PRODUCTS, SHALL IN NO EVENT EXCEED THE AMOUNT THAT HAS BEEN ACTUALLY PAID BY CUSTOMER TO HYLAND FOR HYLAND'S PERFORMANCE UNDER THIS SERVICES PROPOSAL.

IN NO EVENT WILL HYLAND OR ITS DIRECT OR INDIRECT SUPPLIERS BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL OR PUNITIVE DAMAGES, LOSS OF BUSINESS PROFITS, BUSINESS INTERRUPTION, LOSS OF DATA OR INFORMATION, THE COST OF RECOVERING SUCH DATA OR INFORMATION, OR THE COST OF SUBSTITUTE SERVICES OR WORK PRODUCTS, EVEN IF HYLAND OR SUCH SUPPLIERS HAVE BEEN ADVISED OF THE POSSIBILITIES OF SUCH DAMAGES.

12. GENERAL TERMS

12.1. Force Majeure. No failure, delay or default in performance of any obligation of a party to this Services Proposal (except the payment of money) shall constitute a default or breach to the extent that such failure to perform, delay or default arises out of a cause, existing or future, beyond the control (including, but not limited to: action or inaction of governmental, civil or military authority; fire; strike, lockout or other labor dispute; flood; war; riot; theft; earthquake; natural disaster or acts of God; national emergencies; unavailability of materials or utilities; sabotage; viruses; or the act, negligence or default of the other party) and without negligence or willful misconduct of the party otherwise chargeable with failure, delay or default. Either party desiring to rely upon any of the foregoing as an excuse for failure, default or delay in performance shall, when the cause arises, give to the other party prompt notice in writing of the facts which constitute such cause; and, when the cause ceases to exist, give prompt notice of that fact to the other party. This section shall in no way limit the right of either party to make any claim against third parties for any damages suffered due to said causes. If any performance date under this Services Proposal is postponed or extended pursuant to this section for longer than ninety (90) calendar days, Customer, by written notice given during the postponement or extension, and at least thirty (30) days prior to the effective date of termination, may terminate Hyland's right to render further performance of services after the effective date of termination; provided, that Customer will be responsible for payment for the services provided by Hyland through the effective date of termination in accordance with the terms of this Schedule.

12.2. Governing Law and Jurisdiction. This Services Proposal and any claim, action, suit, proceeding or dispute arising out of this Services Proposal shall in all respects be governed by, and interpreted in accordance with, the substantive laws of the State of Delaware U.S.A. (and not by the 1980 United Nations Convention on Contracts for the International Sale of Goods, as amended), without regard to the conflicts of laws provisions thereof. Venue and jurisdiction for any action, suit or proceeding arising out of this Services Proposal shall vest exclusively in the federal or state courts of general jurisdiction located in Delaware U.S.A.

12.3 Binding Effect and Assignments. This Services Proposal shall be binding upon and shall inure to the benefit of the parties and their respective successors and permitted assigns. Neither party may assign its rights or obligations under this Services Proposal, in whole or in part, to any other person or entity without the prior written consent of the other party. Any change in control resulting from an acquisition, merger or otherwise shall constitute an assignment under the terms of this provision. Any assignment made without compliance with the provisions of this section shall be null and void and of no force or effect.

12.4 Entire Agreement. The Services Proposal (including this Schedule) constitutes the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes all prior and contemporaneous agreements, documents and proposals, oral or written, between the parties with respect thereto. To the extent there is a conflict between this Schedule and the Services Proposal, the terms of this Schedule control.

***** END OF DOCUMENT *****

NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS
GOVERNANCE COMMITTEE
MINUTES

Thursday, February 3, 2022 at 7:00a.m.
Teleconference

1. CALL TO ORDER

2. ROLL CALL

Board: Jody Veenker, Chair; Jean Turner, Treasurer
Staff: Kelli Davis, Chief Executive Officer
Other: None

3. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

3.1 NIHD Bylaws Review

3.1.1 Article VI, Committees, Section 2, Item C, Governance Committee, definition of.

3.1.2 Article VI, Committees, Section 2, Item C, Governance Committee, functions of.

Review and discussion of the definition and functions of Governance Committee as outlined in the current NIHD Board Bylaws. Importance of aligning the Governance Committee role with the adopted NIHD strategic plan was noted. CEO was requested to provide examples of such alignment to Board Chair and Treasurer. Additional discussion took place regarding historical revisions of Bylaws and defining clear processes for Board approved Bylaws revision, formalizing the revisions and facilitation of Board review and access to the most current edition of the Bylaws. CEO will discuss use of current Policy Platform for capturing and tracking revision and finalization processes.

Further discussion will take place at the next Governance Committee Meeting.

3.2 **NIHD Board Policies Review**

3.2.1 Governance Committee review and discussion of the list of Board policies.

Discussion took place regarding expansion of current practices for Board member review/revision of Board owned policies. Further discussion to take place at next Governance Committee meeting. CEO was requested to send all Board policies to Chair and Treasurer prior to next meeting.

3.3 **Board Governance**

3.3.1 Board Self-Assessment Update

Discussion took place regarding the process of and content of 2019 Board Self-Assessment. Outreach to Amber King of ACHD for best practice and additional information on the self-assessment tool provided through ACHD free of charge to members. ACHD currently uses the Walker Group for District self-assessments. CEO will look into availability for Amber King to join next Governance Committee meeting for questions.

3.3.2 Chief Executive Officer Evaluation Update

NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS
GOVERNANCE COMMITTEE
MINUTES

Thursday, February 3, 2022 at 7:00a.m.
Teleconference

Discussion took place regarding the 2020/2021 Interim CEO routine evaluations by the Board. Interim CEO transitioned to CEO in October 2021. 90-day Introductory, annual and more periodic evaluations were discussed including the addition of a standing schedule for routine feedback on a quarterly basis. Discussed Governance Committee oversight wording of the CEO evaluation including "The Committee shall also be responsible for development of a format for the evaluation of the Chief Executive Officer, and for the conduct of a periodic evaluation". Discussed revising to expand the "conduct of a periodic evaluation" to the full Board being involved in this process.

Further discussion will take place at the next Governance Committee Meeting.

3.3.3 Board Education Opportunities

3.3.3.1 Development of Education Calendar

Discussion and review of the sample document took place on the implementation of an annual Board Education Calendar. Utilization of the next Board Self-Assessment to help define educational and structure input from the Board is the next step before developing a calendar. It was noted that a "fluid" calendar should be considered.

3.3.4 Governance Committee Charter Development

Discussion and review of a sample charter document took place. Inclusion of long term oversight and operational support that aligns with a high level governance Board role was recommended. CEO will research and return to the next meeting additional insight into organization best practices on Governance Charters.

4. NEXT MEETING DATE

Tuesday, February 8, 2022, at 7:00 a.m. via teleconference.

5. ADJOURNMENT OF MEETING

Meeting was adjourned at 7:59 a.m.

NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS
GOVERNANCE COMMITTEE
MEETING MINUTES
Date: February 8, 2022, 7:00a.m. Teleconference

1. CALL TO ORDER
7:06am

2. ROLL CALL

Board:	Jody Veenker, Chair; Jean Turner, Treasurer
Staff.	Kelli Davis, CEO; Cori Stearns, Executive Administrative Assistant
Other:	Amber King (ACHD, joined at 7:30)

3. APPROVAL OF MINUTES OF: February 3, 2022
Approved

4. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

4.1 NIHD Board Policies Review
Governance Committee review and discussion of the list of Board policies
16 policies sent for review. These will be reviewed at the next Governance Committee meeting.

4.2 Governance Committee Charter Discussion
Governance Committee review and discussion of best practices for a charter
Industry examples of Governance Charters provided and discussed. Kelli will send these examples to Jody and Jean for consideration.

Further discussion will take place at the next Governance Committee Meeting.

4.3 Board Governance

4.3.1 Board Self-Assessment Discussion
Governance Committee will be joined by guest, Amber King, ACHD, for discussion

- Kelli will send some information to Jody and Jean on self-assessments and education
- Past NIHD Board Self-Assessments were tracked down for 2015, 2018 and 2019. ACHD was utilized for Board Self-Assessments historically. Kelli will send these three years to Jody and Jean. A Governance Gain spreadsheet was attached to each one which may be helpful.
- Amber King joined at 7:30am to discuss:
  Self-Assessment process,
  the tool provided by The Walker Company
  Various ways organizations complete Self-Assessments
  Use of facilitators and recommendations by other organizations
  Options for Districts to share information on the Self-Assessment process; successes and challenges
  Amber will also provide additional information to the Committee on strategic planning resources, governance resources.

NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS
GOVERNANCE COMMITTEE
MEETING MINUTES
Date: February 8, 2022, 7:00a.m. Teleconference

Further discussion will take place in upcoming Governance Committee Meetings.

4.3.2 Chief Executive Officer Evaluation Discussion

Governance Committee will be joined by guest, Amber King, ACHD, for discussion

- NIHD Board has used this tool and posed no questions for Amber at this time.

OTHER

- Governance Day is September 14, 2022. September 14-17 is ACHD Annual Conference
- Learning how other Districts are scheduling annual education would be helpful. Tahoe Forest does a good job of this. Amber will reach out to them. Kelli has researched Tahoe Forest and found them to be a good example to follow.

5. NEXT MEETING DATE

Thursday, March 3, 7am

- Review policies
- Review Charter language
- Discuss possible educational topics for the last ¾ of the year; current data and issues regarding opioids or adolescent health. Discussion on whether this Board would do this or would it be an Educational Committee.

6. ADJOURNMENT OF MEETING

7:58am

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: February 9, 2022

Title: **Northern Inyo Healthcare District Committees with Board Member Participation**

Synopsis: Per the NIHD Board Bylaws, "The Board of Directors may sit as a Committee of the Whole on any and all matters, or may create such Standing Committees, ad hoc Committees, or task force Committees as are deemed appropriate".
The Board has requested a current list of Board attendee Committees. The attached list of NIHD Committees with Board member participation notes the current committee participation by NIHD Board members.

Prepared by: ERIKA HERNANDEZ
Name
Title BOARD CLERK

Approved by: Kelli Davis
Name KELLI DAVIS
Title CEO

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: 2/9/2022 Submitted by: Kelli Davis
Chief Officer

Committee	Chair	Board Member Attendee(s)	Executive Team Attendee(s)
Compliance & Business Ethics Committee	Patty Dickson	Jody Veenker	Kelli Davis, Vinay Behl, Joy Engblade, Allison Partridge
Finance/ROI Committee	Vinay Behl	To Be Assigned by Board	Executive Team
Medical Executive Committee	Sierra Bourne, MD	Mary Mae Kilpatrick	Kelli Davis, Joy Englbade, Allison Partridge
Physician Compensation Committee	Joy Engblade, MD	Topah Spoonhunter & Robert Sharp	Kelli Davis, Joy Englbade, Allison Partridge, Vinay Behl
Quality Council	Joy Engblade, MD	Mary Mae Kilpatrick	Allison Partridge

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: 01/31/2022
Title: **LETTER TO THE WHITE HOUSE REGARDING NURSE STAFFING AGENCIES CONCERNS 01/24/2022**

Synopsis:

Across the United States, health care entities continue to struggle with staffing shortages and in particular, nursing shortages. Northern Inyo Healthcare District has these very same struggles and throughout the pandemic, we have utilized our own Human Resources team and we have enlisted recruiting/contract staffing agencies to span every arena possible, including the use of contracted (traveler) RN's. We have watched the hourly cost of contracted staff increase consistently, double and triple, what we had paid pre-pandemic. Our state peers in healthcare have validated time again in networking meetings, they too, are struggling with the same behaviors from the agencies they are using. Due to the exorbitant costs, rural hospitals cannot afford to pay the escalating costs and at times, must decline the traveler. Hospital leaders throughout the state have worked with the California Hospital Association (CHA), resulting in the attached letter to the Congress of the United States. NIHD has been active in the outcry and ultimately in the signing of an initiative letter requesting congressional advocacy. Attached you will find a follow-up letter supported by our California congressional delegates.

Some additional information: **FEDERAL UPDATE**

Congress: CHA issued an **alert** urging Congress to support hospitals and their staff with additional financial relief during the ongoing COVID-19 pandemic. Members are encouraged to contact their representatives by Jan. 31. In support of this effort, CHA sent a **letter** to the California congressional delegation asking Congress to immediately distribute and replenish the Provider Relief Fund (PRF), provide additional time for repayment of Medicare Accelerated and Advance Payment Program loans, extend the delay in sequestration cuts at least for the duration of the public health emergency, and address workforce shortages with policy solutions and funding.

In the U.S. House of Representatives, 196 members — including 26 members of the California congressional delegation — signed on to a **bipartisan letter** asking the White House to enlist the support of federal agencies to investigate reports of anticompetitive behavior from nurse staffing agencies. The members of the California congressional delegation who signed on include Reps. Speier (CA-14), Bass (CA-37), Swalwell (CA-15), Thompson (CA-5), LaMalfa (CA-1), Costa (CA-16), Aguilar (CA-31), Garamendi (CA-3), Lieu (CA-33), Roybal-Allard (CA-40), McNerney (CA-9), Napolitano (CA-32), Panetta (CA-20), Garcia (CA-25), Chu (CA-27), Gomez (CA-34), Peters (CA-52), Barragan (CA-44), Cardenas (CA-29), Harder (CA-10), Levin (CA-49),Sanchez (CA-38), Schiff (CA-28), Sherman (CA-30), Swalwell (CA-15), and Valadao (CA-21). CHA thanks members for reaching out to their representatives on this important issue.

Prepared & Approved by: Kelli Davis, Chief Executive Officer

Congress of the United States
Washington, DC 20510

January 24, 2022

Mr. Jeffrey Zients
COVID-19 Response Team Coordinator
The White House
1600 Pennsylvania Ave., NW
Washington, D.C. 20500

Dear Mr. Zients:

The current surge in COVID-19 cases fueled by the Omicron variant continues to put incredible strain on our health care system, particularly the supply of desperately needed hospital staff, including nursing staff. The situation has affected every state and every corner of the nation, challenging hospitals' ability to care for their patients due to these dire workforce concerns. The persistent strain of the pandemic has required many hospitals to rely on nurse-staffing agencies to supply urgently needed staff to care for the increasing number of patients.

We are writing because of our concerns that certain nurse-staffing agencies are taking advantage of these difficult circumstances to increase their profits at the expense of patients and the hospitals that treat them. We urge you to enlist one or more of the federal agencies with competition and consumer protection authority to investigate this conduct to determine if it is the product of anticompetitive activity and/or violates consumer protection laws.

The situation is urgent and the reliance on temporary workers has caused normal staffing costs to balloon in all areas of the country. We have received reports that the nurse staffing agencies are vastly inflating price, by two, three or more times pre-pandemic rates, and then taking 40% or more of the amount being charged to the hospitals for themselves in profits. We have heard the amounts charged to hospitals rose precipitously as the newest wave of the COVID-19 crisis swept the nation and the agencies seemingly seized the opportunity to increase their bottom line. But, this is not the first time the agencies have engaged in this sort of conduct. As the first wave of COVID-19 swept the nation in 2020, they similarly inflated their prices to hospitals. Hospitals have no choice but to pay these exorbitant rates because of the dire workforce needs facing hospitals around the country.

Thank you for your attention to the matter, these costs are simply unsustainable for many health systems across the country. We urge you to ensure that this issue gets the attention from the federal government it merits to protect patients in dire need of life-saving health care treatment and prevent conduct that is exacerbating the shortage of nurses and straining the health care system. We look forward to your response.

Sincerely,

PETER WELCH
Member of Congress

H. MORGAN GRIFFITH
Member of Congress

List of Signatories

Robert B. Aderholt
Pete Aguilar
Rick W. Allen
Colin Allred
Mark Amodei
Jake Auchincloss
Don Bacon
Nanette Diaz Barragán
Karen Bass
Joyce Beatty
Cliff Bentz
Sanford D. Bishop, Jr.
Lisa Blunt Rochester
Suzanne Bonamici
Mike Bost
Carolyn Bourdeaux
Brendan F. Boyle
Shontel Brown
Ted Budd
Michael C. Burgess, M.D.
Cheri Bustos
Tony Cárdenas
Mike Carey
Earl L. "Buddy" Carter
Troy A. Carter
Matt Cartwright
Ed Case
Kathy Castor
Liz Cheney
Judy Chu
David N. Cicilline
Katherine Clark
Yvette D. Clarke
Emmanuel Cleaver II
Michael Cloud
Steve Cohen
Tom Cole
Jim Cooper
Jim Costa
Joe Courtney
Eric A. "Rick" Crawford
Charlie Crist
Jason Crow
Henry Cuellar
Sharice L. Davids
Danny K. Davis
Madeleine Dean
Peter A. DeFazio
Rosa DeLauro
Lloyd Doggett
Mike Doyle
Neal P. Dunn, M.D.
Tom Emmer
Veronica Escobar
Dwight Evans
Randy Feenstra
A. Drew Ferguson IV
Brian Fitzpatrick
Lizzie Fletcher
Ruben Gallego
John Garamendi
Andrew R. Garbarino
Mike Garcia
Bob Gibbs
Carlos A. Gimenez
Jared Golden
Jimmy Gomez
Anthony Gonzalez
Vincente Gonzalez
Paul A. Gosar, D.D.S.
Josh Gottheimer
Sam Graves
Al Green
Raul M. Grijalva
Glenn Grothman
Michael Guest
Josh Harder
Jahana Hayes
Brian Higgins
French Hill
Ashley Hinson
Richard Hudson
Ronny L. Jackson, M.D.
Bill Johnson
Eddie Bernice Johnson
Henry C. "Hank" Johnson
John Joyce, M.D.
Marcy Kaptur
John Katko
Fred Keller
Daniel T. Kildee
Andy Kim
Ron Kind
Adam Kinzinger
Raja Krishnamoorthi
Ann McLane Kuster
Doug LaMalfa
James R. Langevin
John B. Larson
Robert E. Latta
Jake LaTurner
Brenda L. Lawrence
Al Lawson
Teresa Leger Fernández
Debbie Lesko
Mike Levin
Ted W. Lieu
Billy Long
Alan Lowenthal
Frank D. Lucas
Blaine Luetkemeyer
Tom Malinowski
Nicole Malliotakis
Lucy McBath
Betty McCollum
A. Donald McEachin
James P. McGovern
David B. McKinley, P.E.
Jerry McNerney
Peter Meijer
Grace Meng
Dan Meuser
Marianette Miller-Meeks, M.D.
Barry Moore
Joseph D. Morelle
Seth Moulton
Markwayne Mullin
Gregory F. Murphy, M.D.
Jerrold Nadler
Grace F. Napolitano
Joe Neguse
Donald Norcross
Tom O'Halleran
Ilhan Omar
Steven M. Palazzo
Jimmy Panetta
Chris Pappas
Bill Pascrell, Jr.
Donald M. Payne, Jr.
Scott H. Peters
Dean Phillips
Chellie Pingree
Ayanna Pressley
Mike Quigley
Jamie Raskin
Kathleen M. Rice
Mike D. Rogers
John Rose
Deborah K. Ross
David Rouzer
Lucille Roybal-Allard
C.A. Dutch Ruppersberger
Bobby L. Rush
Tim Ryan
Maria Elvira Salazar
Linda T. Sánchez
John P. Sarbanes
Mary Gay Scanlon
Adam Schiff
Brad Schneider
Kurt Schrader
Austin Scott
David Scott
Terri A. Sewell
Brad Sherman
Mike Simpson
Albio Sires
Alissa Slotkin
Jackie Speier
Greg Stanton
Elise Stefanik
Thomas R. Suozzi
Eric Swalwell
Claudia Tenney
Glenn "GT" Thompson
Mike Thompson
Dina Titus
Paul Tonko
Lori Trahan
David Trone

Michael R. Turner
David G. Valadao
Jeff Van Drew
Filemon Vela
Ann Wagner
Tim Walberg
Michael Waltz
Bonnie Watson Coleman
Bruce Westerman
Susan Wild
Nikema Williams
Robert J. Wittman
Steve Womack
Don Young

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

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: February 2, 2022
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 (*action item*)
   1. The following practitioners have submitted an application to renew their privileges at Northern Inyo Healthcare District for calendar years 2022-2023 and have been recommended for approval.

	Practitioner	**Title**	**Specialty**	**Category**
1	Ahmed, Farres	MD	Radiology	Courtesy
2	Alim, Muhammad	MD	Pulmonology	Telemedicine
3	Atwal, Danish	MD	Cardiology	Telemedicine
4	Bowersox, Jon	MD	General Surgery	Active
5	Brieske, Timothy	MD	Family Medicine	Active
6	Brown, Stacey	MD	Family Medicine	Active
7	Bryce, Thomas	MD	Radiology	Telemedicine
8	Chan, Brandon	MD	Radiology	Telemedicine
9	Dell, Alissa	FNP	Family Nurse Practitioner	APP
10	Dillon, Michael	MD	Emergency Medicine	Active
11	Ebner, Benjamin	MD	Cardiology	Telemedicine
12	Erogul, John	MD	Radiology	Courtesy
13	Farooki, Aamer	MD	Radiology	Telemedicine
14	Figueroa, Jennifer	PA-C	Family Practice	APP
15	Firer, Daniel	MD	Emergency Medicine	Active
16	Fong, Nancy	FNP	Family Nurse Practitioner	APP
17	Garg, Shilpi	MD	Cardiology	Telemedicine
18	Gaskin, Gregory	MD	Emergency Medicine	Active
19	Graves, Casey	MD	Emergency Medicine	Active
20	Harvey, Carly	MD	Radiology	Courtesy
21	Hathaway, Nickoline	MD	Internal Medicine	Active
22	Hawkins, John (Adam)	DO	Emergency Medicine	Active
23	Hewchuck, Andrew	DPM	Podiatry	Active
24	Jesionek, Adam	MD	Internal Medicine	Active
25	Kamei, Asao	MD	Internal Medicine	Active
26	Khine, Htet	MD	Cardiology	Telemedicine
27	Kim, Martha	MD	OB/GYN	Active
28	Klabacha, Rita	PA-C	Family Practice	APP
29	Loos, Stephen	MD	Radiology	Active
30	Ma, Ruhong	DO	Internal Medicine	Active
31	Majlessi, Azadeh	MD	Rheumatology	Telemedicine

32	Maki, Erik	MD	Radiology	Courtesy
33	Malloy, Sarah	FNP	Family Nurse Practitioner	APP
34	Meredick, Kristin	MD	Pediatrics	Active
35	Meredick, Richard	MD	Orthopedic Surgery	Active
36	Norris, Jennifer	CNM	Nurse Midwife	APP
37	O'Neill, Tammy	PA-C	Family Practice	APP
38	Patel, Nilem	MD	Endocrinology	Telemedicine
39	Peterson, Snow	DO	Sleep Medicine	Telemedicine
40	Pflum, Jeannie	DO	OB/GYN	Courtesy
41	Pillsbury, Kinsey	MD	Radiology	Telemedicine
42	Plank, David	MD	Plastic Surgery	Courtesy
43	Pomeranz, David	MD	Emergency Medicine	Active
44	Quach, Truong	MD	Internal Medicine	Active
45	Reid, Thomas	MD	Ophthalmology	Active
46	Ricci, Lindsey	MD	Pediatrics	Active
47	Rowan, Christopher	MD	Cardiology	Telemedicine
48	Saft, Amy	CRNA	Nurse Anesthesia	APP
49	Schweizer, Curtis	MD	Anesthesia	Active
50	Starosta, Sarah	PA-C	Family Practice	APP
51	Sullivan, Laura	MD	Cardiology	Telemedicine
52	Swackhamer, Robert	MD	Cardiology	Telemedicine
53	Tiernan, Carolyn	MD	Emergency Medicine	Active
54	Tseng, Ian	MD	Radiology	Telemedicine
55	Turner, Gary	MD	Radiology	Courtesy
56	Wakamiya, Anne	MD	Internal Medicine	Active
57	Wasef, Eva	MD	Pathology	Active
58	Wei, Stephen	MD	Radiology	Telemedicine
59	Wilson, Christopher	MD	Cardiology	Telemedicine

B. Medical Staff Appointments (*action item*)
   1. Jennifer Lizcano, MD (*internal medicine*) – active staff
   2. Geoffrey McWilliams, MD (*musculoskeletal radiology*) – telemedicine staff, Tahoe Carson Radiology

C. Medical Staff Appointments – Credentialing by Proxy (*action item*)
   As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Quality Nighthawks's credentialing and privileging decisions.
   1. Ara Kassarjian, MD (*teleradiology, Quality Nighthawk*) – telemedicine staff

D. Medical Staff Resignations (*action item*)
   1. Shabnamzehra Bhojani, MD (*telepsychiatry*) – effective 12/15/2022

E. Policies (*action item*)
   1. *Medical Staff Department Policy – Hospital Medicine*
   2. *Medical Staff Department Policy – Radiology*
   3. *Practitioner Re-Entry Policy*

4. *Scope of Service for the Respiratory Care Department*
5. *Weights for Infant and Pediatric Patients*
6. *Death in the Operating Room*
7. *Medical Students in the OR*
8. *Operating Room Attire*
9. *Standardized Procedure for Registered Nurse First Assistant*
10. *Surgical Procedures that Require Special Consents*

F. New Medical Staff Privilege Forms (*action item*)
    1. General Surgery
    2. Colon & Rectal Surgery
    3. Podiatry
    4. Orthopedic Surgery
    5. Obstetrics & Gynecology

G. Annual Review of Critical Indicators (*action item*)
    1. Neonatal
    2. Pediatric
    3. Anesthesia
    4. Surgery

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

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Hospital Medicine		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Hospitalist Practitioners		
Date Last Modified: 12/17/2021	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/22/2021	

PURPOSE:
To delineate clear expectations for practitioners in the Department of Hospital Medicine at Northern Inyo Healthcare District (NIHD).

POLICY:
All practitioners granted privileges in the Department of Hospital Medicine will adhere to the following procedures.

PROCEDURE:
1. Admissions and Consults
    a. Any admission or consultation called to the Physician will become the responsibility of that Physician. If the admission or consult is called to Physician during the final 60 minutes of their shift AND the admission along with uncompleted work from his/her shift would significantly prevent the Physician from completing their shift in a reasonable amount of time, the Physician may choose to hand-off the admission or other work to the oncoming hospitalist, within reason. This decision must be made in mutual agreement with the Emergency Department (ED) physician AND the Physician must make every effort to not slow throughput in the ED or delay patient care. Exceptions to the hand-off would be if the admission or consultation is an ICU patient, critically ill, requires time sensitive testing or treatment, or there are more than one other pending admission(s) in the ED.
2. Credentialing:
    a. Physician practitioners in the Department of Hospital Medicine must be board certified or board eligible by the American Board of Family Medicine or the American Board of Internal Medicine and are strongly encouraged to be members of the Society of Hospital Medicine.
3. Emergencies/Codes:
    a. Physician shall respond to in-house emergencies in the same manner as other members of the Medical Staff of Northern Inyo Hospital. If physician is not in house, he/she is expected to return to the hospital within 20 minutes.
4. In-House Coverage
    a. Physicians performing Hospitalist Services are not required to be in house at all times however, they are generally expected to be in house from 8 am to 5 pm if not longer for a full census. It is the expectation that day shift hospitalist will be fully prepared (have seen all patients and reviewed all charts) for the morning Multidisciplinary Team meeting and will fully participate in

the discussion of each patient presented. Night shift Physician is encouraged but not required to stay in-house and utilize the hospitalist call room especially if the Emergency Department is busy, the census is full or there is a critically ill or concerning patient(s). If Physician is off-campus, they are still expected to answer all calls, enter their own orders and return to the hospital for patient care within twenty (20) minutes. At any point in time, Hospitalist Director or Chief of Inpatient Medicine may request a revocation of off-campus privileges and may request Physician to provide in-house coverage for the entirety of their 12 hour shift.

5. Response time
    a. Physician shall respond to NIHD Emergency Department or other NIHD staff requests within twenty (20) minutes of call. If the request is for an admission or consultation, a reasonable goal is to see the patient within 20 minutes so as to formulate a plan and disposition. If the Physician is otherwise preoccupied with patient care that takes a higher precedence such as a critically ill patient, Physician will discuss with ED physician or other NIHD staff to let them know when they can reasonably expect to see the patient. Every effort should be made to see the patient, determine disposition and have orders in one (1) hour after admission request.
6. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to complete FPPE as per policy. Hospitalists sign out to each other at the start/end of each shift so multiple charts are reviewed on an ongoing basis. Verbal sign outs are the standard (email sign outs are acceptable but the exception) and feedback is given in real time. Peer review results and Unusual Occurrence Reports are incorporated into FPPE as appropriate.
7. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per medical staff policy. Hospitalists sign out to each other at the start/end of each shift so multiple charts are reviewed on an ongoing basis. Verbal sign outs are the standard (email sign outs are acceptable but the exception) and feedback is given in real time. Peer review results and Unusual Occurrence Reports are incorporated into OPPE as appropriate.
8. Peer Review:
    a. All inpatient charts identified by critical indicators will be peer reviewed by the Chief of Inpatient Medicine or delegated practitioner. Selected cases will be reviewed at the Inpatient Medicine committee at its next scheduled meeting. Records are confidential and will be kept by the Medical Staff Office.
    ~~a. Inpatient charts identified by critical indicators will all be subject to peer review as per the peer review policy.~~
9. Re-Entry:
    a. Hospitalist practitioners may be eligible for re-entry per policy.
10. Services Provided
    a. Physician should address and/or manage, within the scope of their training and responsibility, all internal medicine issues, as requested for all patients admitted to NIHD. Physician should also provide consultation and management services to patients as requested by NIHD Medical Staff members, visiting Specialist Physicians, the Emergency Department, and other departments as appropriate.

REFERENCES:

1. N/A

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

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

Supersedes: v.1 Medical Staff Department Policy - Hospital Medicine

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Radiology		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physicians Privileged in Radiology		
Date Last Modified: 12/01/2021	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To delineate clear expectations for physicians in the Department of Radiology within Northern Inyo Healthcare District (NIHD).

POLICY: All physicians (radiologists) granted privileges in the Department of Radiology will adhere to the following procedures.

PROCEDURE:

1. Patient Care Responsibilities
    a. Patient care services, including call, on-site hours, and procedures are to be provided in accordance with the applicable contract(s) for services.
2. Documentation:
    a. Radiology reports will be completed timely as further outlined in the *DI – Timely Performance Standards – Hospital Based Patients* policy.
    b. The radiologist, or radiologist's designee, shall communicate critical results to the ordering provider within 1 hour of determining the results of the test as per the *DI – Timeliness for Critical Results* policy.
    c. Informed consent is to be obtained by the physician and properly documented for applicable procedures as described in the *Informed Consent – Practitioner's Responsibility* policy.
    d. Verbal and/or phone orders are to be authenticated within 48 hours as per the *Verbal and/or Phone Medical Staff Practitioner Orders* policy.
3. Credentialing:
    a. Physicians in the Department of Radiology must be board certified or board eligible by the American Board of Radiology.
    b. Radiologists applying for privileges in breast imaging must meeting Mammography Quality Standards Act (MQSA) requirements.
4. Meeting Attendance:
    a. Radiologists are to attend meetings of the Medical Staff per Medical Staff Bylaws requirements.
5. Focused Professional Practice Evaluation (FPPE):
    a. Radiologists new to NIHD will be expected to complete FPPE as per policy and as recommended at the time of privileging.
6. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per Medical Staff policy.

7. Peer Review:
    a. Five percent of interpretations will be randomly selected for peer review on an ongoing basis.
    b. All charts identified by critical indicators will be peer reviewed by the Chief of Radiology or designee. Critical indicator lists are reviewed by the Department of Radiology on an annual basis.
    c. Selected cases will be reviewed at the Radiology Services committee at its next scheduled meeting. Records are confidential and will be kept by the Medical Staff Office.
8. Re-Entry:
    a. Applicants to the Department of Radiology may be eligible for Re-entry as per policy.

REFERENCES:

1. N/A

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. *DI – Timely Performance Standards – Hospital Based Patients*
3. *DI – Timeliness for Critical Results*
4. *Informed Consent – Practitioner's Responsibility*
5. *Verbal and/or Phone Medical Staff Practitioner Orders*
6. *Focused and Ongoing Professional Practice Evaluation Policy*
7. *Practitioner Re-Entry Policy*

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Practitioner Re-Entry Policy		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Medical Staff Privileged Practitioners		
Date Last Modified: 12/17/2021	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/18/2020	

PURPOSE:
To enable a practitioner, under certain circumstances, to return to clinical practice after an extended period of clinical inactivity while ensuring the high standard of patient care expected at Northern Inyo Healthcare District (NIHD).

DEFINITIONS:
1. **Full Re-entry:** Defined by the American Medical Association as "return to clinical practice for which one has been trained, certified or licensed after an extended period of clinical inactivity not resulting from discipline or impairment". For the purposes of this policy an extended period is further defined as greater than or equal to 2 years and no more than 5 years.
2. **Partial Re-entry:** Process of resuming a portion of clinical practice for which an actively practicing clinical practitioner has been previously trained, certified or licensed but is not currently able to qualify for privileges due to inactivity in that area of practice.

POLICY FOR FULL RE-ENTRY:
1. To qualify for full re-entry, the applicant must meet the following requirements:
    a. Meet the definition of full re-entry above.
    b. Abide by state medical board re-entry rules or recommendations, if any.
    c. Abide by any re-entry policy of the relevant specialty board(s), if any.
    d. Abide by malpractice insurance policy for practitioner re-entry, if any.
    e. Have evidence of recent continuing medical education in accordance with current medical staff standards.
    f. Be board certified.
    g. Meet all other qualifications for credentialing as per the medical staff bylaws.
2. A potential applicant who has been out of clinical practice for more than 5 years will not qualify for re-entry but may apply for medical staff membership after completion of a full standardized re-entry program or an equivalent program adequate to prove current competency.
3. The full re-entry plan requirements are as follows:
    a. Re-entry plan may include a full standardized re-entry program, re-entry evaluation with a standardized re-entry program, specific skills proctoring at a teaching facility or other appropriate facility (e.g. robotic surgery, Neonatal Intensive Care Unit (NICU) for neonatal care, high volume of deliveries to resume obstetrical privileges, etc.) shadowing/proctoring within our organization, or an appropriate combination thereof at the discretion of the relevant department and/or credentialing committee.

b. The re-entry plan will identify a mentor to oversee the re-entry process. The mentor must have sufficient time and experience and be a member of the medical staff in good standing.
c. The re-entry plan will include a Focused Practice Performance Evaluation (FPPE) for documentation of the re-entry process completed by the identified mentor. The FPPE plan will be individualized to each applicant, but will be no less than the minimum requirements for initial FPPE plans normally used by the department.
d. The re-entry plan will be agreed upon by the applicant, the relevant department(s) and the credentialing committee.
e. The length and scope of the re-entry plan will account for the type of practice/procedures privileges requested, previous level of training/experience, Maintenance of Certification (MOC) status, and any relevant interim activities. The expected length and scope of the re-entry plan will be included in the initial plan but may be extended by the applicant or the department upon recommendation of the mentor if more time is deemed necessary to show competency.
f. Any practitioner who practices in a field in which the volume of patients at NIHD makes re-entry proctoring impractical to complete within a reasonable amount of time will be required to complete a full standardized re-entry program or an equivalent program at the discretion of the relevant department and/or credentialing committee.

POLICY FOR PARTIAL RE-ENTRY:

1. A practitioner who is currently in clinical practice but unable to prove current competency/recent experience for some portion of core privileges may be eligible for a partial re-entry plan.
2. The partial re-entry plan requirements are as follows:
    a. A partial re-entry plan may include specific skills proctoring at a teaching facility or other appropriate facility (e.g. robotic surgery, NICU for neonatal care, high volume of deliveries to resume OB privileges, etc.) shadowing/proctoring within our organization or an appropriate combination thereof at the discretion of the relevant department and/or credentialing committee.
    b. The partial re-entry plan will be agreed upon by the applicant, the relevant department(s) and the credentialing committee.
    c. The length and scope of the partial re-entry plan will account for the type of practice/procedures privileges requested, previous level of training/experience, MOC status, and any relevant interim activities.
    d. The partial re-entry plan will identify a mentor to oversee the re-entry process. The mentor must have sufficient time and experience and be a member of the medical staff in good standing.
    e. The partial re-entry plan will include a FPPE for documentation of the re-entry process completed by the identified mentor.
    f. Once the agreed upon partial reentry plan has been completed the practitioner may be released from FPPE for the appropriate additional clinical privileges.

PROCEDURE:

1. A practitioner who qualifies for full or partial re-entry as stated above may complete an application for medical staff or Advanced Practice Provider staff membership with the medical staff office as per the NIHD bylaws.
2. Once the application is otherwise complete, a re-entry plan will be required in lieu of current competencies/recent experience. An example re-entry plan is included in Attachment 1.

3. The re-entry plan must be agreed upon by the applicant, the relevant department(s) and the credentialing committee before the application process can proceed. NIHD medical staff will attempt to complete this process in a timely manner.
4. If a re-entry plan cannot be agreed upon, the application will be deemed incomplete and can be withdrawn without penalty.
5. The re-entering practitioner will be responsible for any cost incurred from the re-entry plan unless otherwise agreed upon by NIHD administration/ board at the recommendation of the department and or credentialing committee.
6. Once a re-entry plan is agreed upon the application process can proceed as per current bylaws.

REFERENCES:

1. American Medical Association. Resources for physicians returning to clinical practice. https://www.ama-assn.org/practice-management/career-development/resources-physicians-returning-clinical-practice
2. Community Memorial Health System. "Medical Staff Re-entry Plan." Policy and procedure. Revised 10/4/2016.
3. National Association of Medical Staff Services. "Back in the Saddle Again: Credentialing Conundrums Surrounding the Reentry Physician." Educational Conference and Exhibition. 9/20/2016.
4. State Medical Licensure Requirements and Statistics. "Physician Re-entry." 2013.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. N/A

Supersedes: v.1 Practitioner Re-Entry Policy

ATTACHMENT 1

SAMPLE RE-ENTRY TO PRACTICE PLAN

Name: _____

Clinical Experience:

Specialty: _____

Time Spent in Clinical Practice: _____

Date and Location of Last Clinical Practice: _____

Reason for Leaving Clinical Practice: _____

Intended Clinical Practice:

Intended Practice Setting and Location: _____

Special Privileges requested: _____

Description of How I Maintained Competency After Leaving Clinical Practice

_____

_____

_____

_____

_____

_____

Maintenance of Certificate status: _____

Applicable Medical Board status including most recent test date: _____

Continuing Medical Education within last 2 years: _____

Plan for Obtaining Re-entry Education and Clinical Competency

Refresher Course(s)/ Mini-Residency Offered by a Medical School or Other Formal Program:

_____

Mentorship/Preceptorship:

Name/Medical Specialty of Mentor/Preceptor: _____

Number of Work Days/Hours per Week: _____

Total hours of patient care expected: _____

Total number of procedures expected (if applicable): _____

Method of Direct Supervision and Review of Clinical Care: (e.g. The mentor shall participate in the care of each patient to the degree necessary to be personally responsible for the care rendered, to be able to certify to the quality of such care, and to provide prompt meaningful feedback and guidance)_____

_____

_____

_____

_____

Frequency of Written Reports to Department/Credentialing committee: _____

Content of Written Reports to the Department/Credentialing committee: (e.g. Practice activities, hours, workload, functioning, knowledge, skills, general professionalism, any deficiencies, and overall ability to practice safely and competently. Minimum must be equivalent to department FPPE standard):

_____

_____

_____

_____

Signatures: _____ (applicant)

_____ (department chair(s))

_____ (credentials committee)

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Scope of Service for the Respiratory Care Department		
Owner: Cardiopulmonary Manager	Department: Respiratory	
Scope: Respiratory Care Practitioners		
Date Last Modified: 07/06/2021	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The purpose of the Respiratory Care Department at Northern Inyo Hospital is to provide the best possible care to the acute and chronically ill patients of all ages. The scope of practice crosses all patient, client, and resident populations in the acute care setting. Through the direct and indirect patient observation and monitoring of signs, symptoms, reactions, general behavior and general physical response to respiratory care and diagnostic interventions.

POLICY:

The department manager manages the Cardiopulmonary departments whom reports to the Director of Diagnostic Services, whom reports to the Chief Executive Officer (CEO) and consists of licensed Respiratory Care Practitioners whom focus on the utilization of protocols, guidelines, pathways, and policies driven by evidence-based medicine, expert opinion, and standards of practice that are outlined in the Respiratory Care Department's Standards of care procedure. The implementation of Respiratory Therapy procedures, medical technology, and diagnostic procedures necessary for disease prevention and treatment management. The Respiratory Care Practitioners provide patient and family education activities focused on the promotion of cardiopulmonary wellness and prevention that is sustainable.

SCOPE:

The Department of Respiratory Care operates 24 hours a day, 7 days a week. The responsibilities of the Respiratory Care Practitioner include, but are not limited to:

1. Performance and collection of diagnostic information
    a. Pulmonary Function Testing
    b. Non-Invasive and invasive diagnostic procedures
    c. Blood gas and other pertinent laboratory analysis
2. Patient assessment
    a. Physical examination
    b. Diagnostic data interpretation
3. Application of therapeutics to respiratory care
    a. Medical gas therapy
    b. Humidity therapy
    c. Aerosol therapy
    d. Artificial airway insertion, management, and care

    e. Airway clearance
    f. Invasive and non-invasive mechanical ventilation
4. Assessment of therapies
5. Disease management of acute and chronic diseases
6. Collaborative support of hemodynamics
7. Discharge planning and case management
8. Provision of emergency, acute, critical and post-acute care, including
    a. Patient and environmental assessment
    b. Therapeutic interventions

STAFFING:

The Respiratory Care staff provide care to patients of all ages and in all areas of the hospital on a 24 hour a day basis. The highly variable patient population dictates staffing requirements. The Intensive Care Unit (ICU) and Medical/Surgical Unit (Med/Surg) are normally staffed with at least one Respiratory Care Practitioner per unit. The Emergency Services, Post Anesthesia Care Unit, and Perinatal Unit are staffed as needed, usually by the ICU or Med/Surg Respiratory Care Practitioner. This coverage is usually on an "as needed" basis. In the event that more Respiratory Care Practitioners are needed for the increased critical patient census, internal disaster, epidemic, and/or massive trauma the cardiopulmonary manager and/or Respiratory Care staff will call the emergency call list provided in the Respiratory Care Department. Pulmonary Function testing is a pre-scheduled diagnostic event with a Respiratory Care Practitioner staffed to perform the test. Respiratory Care Practitioners also assist the EKG department with Electrocardiograms when they are unable to respond.

REFERENCES:

AARC. (2018). Respiratory Care Scope of Practice. AARC. https://www.aarc.org/wp-content/uploads/2017/03/statement-of-scope-of-practice.pdf

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Weights for Infant and Pediatric Patients*		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: Acute/Subacute Department, Perinatal Department, Clinics		
Date Last Modified: 12/13/2021	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/18/2016	

PURPOSE:
To monitor growth and development, assist physician in diagnosis and assessment of therapeutic effectiveness, and to determine medication dosages.

POLICY:
1. All pediatric inpatients up to age 13 are weighed on admission to hospital and daily unless the physician writes an order to discontinue daily weights. If the child's condition is critical and a weight cannot be obtained, an approximate weight should be obtained from parents and recorded as such. An accurate weight will be obtained within 4 hours of admission.
2. All pediatric outpatients are weighed at each office visit.
3. Pediatric patients are weighed in kilograms using age-appropriate electronic scale.
4. Procedure may be performed by RN or MA (may be CNA in clinic).

Equipment:

1. Infant scale or standing scale
2. Scale paper for infant scale

PROCEDURE:
1. Weighing the infant
    a. Follow procedure in Lippincott "Weight measurement, infant"
    b. Record the weight in kilograms in the electronic record.
    c. For inpatients, place **initial** weight of patient on the appropriate color coded card that matches the Broselow Bag tape and attach at head of bed or foot of crib. If patient is in precautions, place a second color coded card on the door.
2. Weighing the older child
    a. Follow procedure in Lippincott "Weight measurement, child"
    b. Record the weight in kilograms on the Flowsheet tab of the electronic record.
    c. For inpatients, place **initial** weight of patient on the appropriate color coded card that matches the Broselow Bag tape and attach at head of bed or foot of crib. If patients in precautions, place a second color coded card on patient's door.

RECORD RETENTION AND DESTRUCTION:
Medical records are retained and destroyed per NIHD policy under the control of the Medical Records Department.

REFERENCES:

1. Bowden, V. R., & Greenberg, C. S. (2016). *Pediatric nursing procedures* (4th ed.). Wolters Kluwer.
2. The Joint Commission. (2021). Sentinel event alert 39: Preventing pediatric medication errors. Retrieved July 2021 from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-39-ped-med-errors-rev-final-4-14-21.pdf (Level VII)
3. Institute for Safe Medication Practices. (2020). 2020-2021 targeted medication safety best practices for hospitals. Retrieved July 2021 from https://www.ismp.org/sites/default/files/attachments/2020-02/2020-2021%20TMSBP-%20FINAL_1.pdf

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Weight measurement, child. (January, 2016). *Lippincott Procedures.* Retrieved on April 5, 2016 from http://procedures.lww.com
2. Weight measurement, infant. (January, 2016). *Lippincott Procedures.* Retrieved on April 5, 2016 from http://procedures.lww.com

Supersedes: v.1 Weights for Infant and Pediatric Patients*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Death in the Operating Room		
Owner: OP/PACU Manager	Department: Surgery	
Scope: Surgery		
Date Last Modified: 12/03/2021	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 09/1992	

PURPOSE:
To assure that the patient is properly cared for after death and that all pertinent release forms are completed.

POLICY:
All deaths in the operating room are considered A "**CORONERS CASE**", and are to be treated in a manner that does not disturb any possible evidence.

PROCEDURE:
- The surgeon will confirm the patient's death and will sign the death certificate.
- The surgeon will notify the family of the patient's death.
- The circulating nurse will notify the supervisor of the patient's death.
- The circulating nurse will notify the coroner of the patient's death or delegate this task to the House Supervisor.
- The operating room personnel will prepare the body for transfer to the mortuary. **All IV lines, Foley catheters, endotracheal tubes, or any other invasive line must stay intact, these tubes can be tied off or clamped, but may not be removed. Do not clean the body** (example; it could remove powder burns or other forms of evidence.
- **If the patient has a gunshot wound, the entrance and exit wounds are to be left open and not closed. Any evidence such as bullets must be properly labeled, following procedure on transfer of evidence.**
- Incisions may be closed and this usually is done with a one-layer closure.

Moving the Patient:

- Ask the coroner permission to remove the patient from the operating room before moving the patient onto the gurney.
- The operating room personnel will place the patient on a clean gurney and cover him with a clean bath blanket.
- If the family wishes to view the patient, place the patient in a quiet, private environment and stay with the family for support. (**This must be approved by the Coroner**).
- Prepare the family emotionally for the appearance of the patient with tubes in place. Provide emotional support.
- The patient's belongings are to be given to the coroner.

- Document in the medical record exactly what was sent. The clothing may be given to the family only in the presence of the coroner.
- Document the time of death on the operating room record and on the discharge slip (this can be obtained from the supervisor).

Release of Body:

- California Health and Safety Code requires health care facilities to notify the mortuary attendant, prior to removal of the body, if the patient is afflicted with a reportable disease listed in Title 17, California Code of Regulation, Section 2500 (c), such as HIV, Hepatitis, etc., without written authorization of the patient's representative, but the release must be tracked.
- The mortuary attendant will complete the **RELEASE OF BODY TO MORTUARY**. This completed form remains on the medical record of the patient. The **RELEASE OF BODY TO MORTUARY** form is available on the *NIHD Intranet, under Resources (Top of intranet page) > Forms and Templates > HIPAA > PDF's >* HIPAA-43 Release of Body to Mortuary.
- The coroner may request copies of the operating room record and the patient's chart.

DOCUMENTATION

Document in medical record: All documentation regarding the patient's death, the family member that was notified and by whom, the time the body was picked up by the coroner, the tubes left in place and any belongings sent with the body or home with the family.

REFERENCES:

California Health and Safety Code: Title 17 California Code of Regulation, Section 2500 c

RECORD RETENTION AND DESTRUCTION:

Documentation in medical record is maintained per the Medical Record Department at NIHD

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pronouncement of Death
2. Death-Disposition of Body
3. Coroner's Cases
4. Forensic evidence collection, OR https://procedures.lww.com/lnp/view.do?pId=6382911&hits=forensic&a=false&ad=false&q=forensic

Supersedes: v.2 Death in the Operating Room

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Medical Students in the OR		
Owner: MEDICAL STAFF DIRECTOR	Department: Surgery	
Scope: Surgery		
Date Last Modified: 12/03/2021	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/28/2009	

PURPOSE:

To outline the role of the medical student and staff in the Operating Room.

POLICY:

A medical student, who is currently enrolled in a qualified medical school, may assist with surgical procedures providing the attending surgeon has determined that the medical student can provide the type of assistance needed during the specific surgery. The medical student functions under the direct supervision of the attending surgeon. (Physical presence of attending surgeon in the operating room).

The medical student may assist the attending surgeon during a surgical procedure by providing aid in exposure, which will help the surgeon carry out a safe operation with optimal results for the patient.

Medical students must demonstrate knowledge of surgical anatomy and physiology and skill in applying principles of asepsis and infection control.

Medical students must demonstrate the ability to function effectively and harmoniously as a team member and perform effectively in stressful and emergency situations.

The Medical Student may, at the discretion of the attending surgeon:

1. Assist with the surgical positioning and draping of the patient if so directed by the surgeon.
2. Provide retraction at the direction of the attending surgeon.
3. Help the surgeon provide homeostasis.
4. Perform knot tying if qualified in the estimation of surgeon.
5. Perform assistance in the closure of tissue as directed by the surgeon; sutures fascia, subcutaneous tissue and skin.
6. Assist the surgeon at the completion of the surgical procedure by:
    - Affixing and stabilizing all drains.
    - Cleaning the wound and applying the dressings.
    - Assist with applying cast; splints, bulky dressings, abduction devices.
7. The medical student practices within the appropriate limitations and may choose not to perform functions for which he/she has not been prepared or feel capable of performing.
8. The activities outlined are determined based on the experience and education of the medical student. The performance of other activities in the role of the medical student is dependent on the ability of the medical student to safely perform the activities under the direction of the surgeon in a competent manner.

REFERENCES: N/A
RECORD RETENTION AND DESTRUCTION: N/A
CROSS REFERENCE POLICIES / PROCEDURES:

- Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities

Supersedes: v.1 Medical Students in the OR

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Operating Room Attire		
Owner: OP/PACU Manager	Department: Surgery	
Scope: Perioperative Services, Pharmacy, Perinatal, Maintenance		
Date Last Modified: 12/06/2021	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/18/2016	

PURPOSE:
The human body and inanimate surfaces inherent to the surgical environment are major sources of microbial contamination and transmission of microbes; therefore, surgical attire and appropriate personal protective equipment (PPE) are worn to promote worker safety and a high level of cleanliness and hygiene within the perioperative environment.

The purpose of operating room attire is to provide effective barriers that prevent the dissemination of microorganisms to the patient. These barriers coincidentally protect personnel from infected patients. These barriers prohibit contamination of the operative wound and sterile field by direct contact.

POLICY:
The operating rooms are entered from a "Clean" limited access corridor.

Hospital personnel having business with perioperative clerk and Surgery / Sterile Processing Manager may enter the non-restricted area through the Surgery Office to conduct their business without donning surgical attire.

Only personnel necessary for patient care are allowed in the semi-restricted and restricted area and must adhere to the policy / procedure.

All persons who enter the semi-restricted and restricted areas of the surgical suite should be in surgical attire intended for use only within the surgical suite. Identification badges should be secure on the surgical attire top, is visible and be cleaned if it becomes soiled.

PROCEDURE:

1. **Attire:**
   Operating room attire consists of body covers such as two-piece pant suits. Clean, fresh attire is donned each time on arrival at the operating room suite and as necessary when garments become wet or grossly soiled.
   - Surgical attire is to be laundered in the hospital laundry or a health care-accredited laundry facility.
   - Surgical attire that has been penetrated by blood or other potentially infectious materials should be removed immediately or as soon as possible and replaced with freshly laundered, clean surgical attire.

- Surgical attire will be made of materials that meet or exceed the standards of the National Fire Protection Association.
- Surgical attire should be made of low-lint material, provide comfort and promote a professional appearance

2. **Shoes:**
   Dedicated shoes worn only in the operating room should remain in the operating room; if worn outside the operating room, clean shoe covers should be worn over shoes. Upon returning from the outside and before entering the surgical environment, remove shoe covers or replace shoe covers with fresh clean ones.
   - If shoe covers are worn in the OR, they must be changed whenever they become wet, soiled or torn and should be removed before leaving the surgical suite.
   - Waterproof shoe covers should be used when there is a higher risk of becoming contaminated with bodily fluids i.e.; Cesarean Section and Arthroscopic procedures.

3. **Perinatal Staff:**
   RNs from the Perinatal unit may wear the Perinatal scrub uniforms into the OR as long as: the RN has changed into clean Perinatal scrub uniform before providing care ONLY to the patient coming to the OR for a C-section and if the Perinatal scrub uniforms are laundered in the hospital laundry or a health care-accredited laundry facility. Hair and shoe covers should be donned before coming in to the OR corridor.

4. **Respiratory Therapy, Radiology, Pharmacy, and Maintenance Personnel, Clinical Engineering and Laboratory personnel:**
   Disposable coveralls (Bunny Suits), or clean surgical scrub uniforms as well as caps and shoe covers are provided for other personnel entering restricted areas. In emergencies, when maintenance personnel must enter the operating rooms while surgery is in process, regular standards for changing into surgical scrubs will be enforced.

5. **Travelling outside the OR with surgical attire**:
   If staying in the hospital (same building), the surgical scrubs do not have to be changed. Surgical attire is not to be worn outside of the surgical area except to get equipment, food, or attend in-house classes or meetings. If leaving the hospital, by going from one building into another or going outside into the environment, the surgical scrubs will need to be changed completely before entering the surgical environment. Cover apparel can be worn but must be changed and laundered in the same manner scrub uniforms are. (Cover apparel has been found to have little or no effect on reducing contamination of surgical attire).

6. **Warm Up Jackets:**
   When non- scrubbed personnel are wearing warm-up jackets they are to be snapped closed, with the cuffs down to the wrists.
   - Wearing warm-up jackets snapped closed prevents the edges of the front of the jacket from contaminating a skin prep area or the sterile surgical field.
   - Warm up-jackets with wrist-length sleeves decrease the skin squames shedding that occurs from the skin and hair on arms.
   - It is recommended in our facility that all non-scrubbed personnel must wear warm-up jackets especially during a Total Joint Procedure.

7. **Head and Beard Covers:**
   Head and beard covers must cover hair (head and beard) and scalp skin completely in the restricted and semi-restricted areas. They will be clean, lint free and changed daily and/or when soiled or torn.

8. **Masks:**
   Masks are worn at all times in the restricted areas of the operating room suite where sterile supplies are opened and during any surgery.
   - The mask should cover the mouth and nose and be covered in a manner to prevent venting.
   - A fresh clean surgical mask should be worn for every procedure.
   - Masks are worn upon entering the room, during an operation, and during set up.
   - Masks should be changed between cases or at any time they become damp.
   - The filter portion of the mask should not be left dangling around the neck and should only be handled by the ties when removing.
   - Hand hygiene must be performed after removal of masks.

9. **Gloves:**
   Gloves should be selected and worn depending on the tasks to be performed. Sterile gloves will be worn when performing sterile procedures. Unsterile gloves may be worn for other tasks.
   - Gloves should be changed between patient contacts or after contact with contaminated items when task is completed.
   - Hands should be washed after removing gloves.
   - Double gloving is recommended on all surgical procedures.
   - Sterile gloves should be wiped prior to procedure with wet towel or sponge to remove powder, if powdered glove are worn.
   - If a sterile glove is punctured or torn it must be changed immediately.

10. **Sterile Gown:**
    (See the Lippincott Procedure: Surgical Asepsis: Surgical Attire for donning a sterile gown and gloves) A sterile gown is worn over scrub suit to permit wearer to come within the sterile field. The gown must provide a protective barrier from strike through.
    - Although entire gown is sterile, the back is not considered sterile nor is any area below table level once gown is donned.
    - Wraparound gowns that provide sterile coverage to the back by a generous overlap are recommended.

11. **Jewelry:**
    All persons entering the semi-restricted or restricted areas of the surgical suite should have jewelry contained.

12. **Nails:**
    Nail polish and artificial nails should not be worn within the semi-restricted and restricted. Nails should be natural and length should be no more than one quarter inch long and well-manicured.

13. **Badges:**
    - Identification badges should be worn by all personnel in the operating room.
    - Identification badges should be secured on the surgical attire top, be visible, and be cleaned if they become soiled.
    - Badge holders such as lanyards, chains, or beads pose a risk for contamination and may be very difficult to clean.

14. **Fanny Packs:**
    Fanny packs, backpacks and briefcases are discouraged in the semi-restricted and restricted areas of the perioperative suite. These items due to the porous nature of the materials used in the construction may be difficult to clean or disinfect adequately and may harbor pathogens, dust, and bacteria.

PERSONAL PROTECTIVE EQUIPMENT (PPE):

- Eyewear or a face shield is worn to reduce risk of blood or body fluids from patient splashing into the eye of sterile team members. Protective eyewear that becomes contaminated should be discarded or decontaminated as promptly as possible according to manufacturer's recommendation.
- Additional protective attire such as fluid resistant aprons, gowns or shoe covers should be worn when contact with blood or body fluid is unavoidable.
- Lead aprons will be worn under sterile gowns to protect against radiation exposure during procedures performed under fluoroscopy or image intensification.
- Sterile air helmet system will be utilized on all total joint procedures and at physician request on other procedures.
- If CDPH or CDC guidelines are initiated for patient infection or wide spread pandemic, the operating room personnel would be informed and educated for compliance with the guideline.

DOCUMENTATION:

Any known breaks in sterile techniques will be brought to the attention of the surgical team for immediate correction and will be noted in the operating room record under comments. The Surgery / Sterile Processing Manager will be notified and the incident will be tracked on an Unusual Occurrence Report (or currently used quality analysis record).

REFERENCES:

1. TJC: IC.02.05.01
2. AORN Perioperative Standards and Recommended Practices Surgical Attire
3. Lippincott Procedure Surgical Asepsis: Surgical Attire

Supersedes: v.4 Operating Room Attire*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure for Registered Nurse First Assistant		
Owner: DON Perioperative Services	Department: PACU	
Scope: RNFA		
Date Last Modified: 12/03/2021	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The RN First Assistant (RNFA) assists the attending surgeon during a surgical procedure by providing aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.

POLICY

The RNFA practices within the appropriate limitations and may choose not to perform those functions for which she has not been prepared or for which she does not feel capable of performing.

The activities outlined are determined based on the experience and education of the RNFA. The performance of other activities in the role of RNFA is dependent on the ability of the RNFA to safely perform the activities under the direction of the surgeon in a competent manner.

PROCEDURE

1. Experience
    a. Current California RN licensure
    b. Demonstrated proficiency in perioperative nursing practice as both scrub and circulator for at least two years, and currently effectively fulfilling the role of Surgery RN at NIH.
    c. Successful completion of a course in RN First Assisting through an accredited program; one which uses the AORN Core Curriculum for the RNFA as a foundation. (A copy of the certificate of completion will be aced in the RNFA's personnel file.)
    d. Current CNOR (Certified Nurse in the Operating Room), or obtains this within the first year of employment as RNFA.
    e. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that is unique to functioning as an RNFA.
    f. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the RNFA assists.
    g. Demonstrated ability to function effectively and harmoniously as a team member and in stressful and emergency situations.
    h. Able to perform CPR; ACLS/PALS completion.

2. Method of Initial and Continued Evaluation of Competence

a. The attending surgeon has determined that the RNFA can provide the type of assistance needed during the specific surgery.
b. The RNFA will be evaluated for continued competency 90 days after assuming this position and yearly thereafter.
c. The evaluation will be done by means of a written performance evaluation based on the RNFA job description, will be done by the Surgery Nurse Manager, and will contain input from the appropriate attending surgeons based on the protocol section of this standardized procedure, chart review and their observations.

3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RNFAs competent to perform this standardized procedure is maintained with the Chief Nursing Officer and with the Surgery Manager and is updated annually

4. Settings where Standardized Procedure may be performed
    a. The Standardized Procedure for RNFA may take place in the OR

5. Standardized Procedure
   The RNFA will:

    a. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
    b. Provide retraction by:
        - Closely observing the operative field at all times.
        - Demonstrating stamina for sustained retraction.
        - Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
        - Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
        - Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
    c. Provide hemostasis by:
        - Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
        - Sponging and utilizing pressure, as necessary.
        - Utilizing suctioning techniques.
        - Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
        - Placing suture ligatures in the muscle, subcutaneous and skin layer.
        - Placing hemoclips on bleeders, ad directed by the surgeon.
    d. Perform knot tying by:
        - Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
        - Tying knots firmly to avoid slipping.
        - Avoid undue friction to prevent fraying of suture.
        - "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
        - Approximating tissue rather than pulling tightly to prevent tissue necrosis.

e. Perform dissection as directed by the surgeon by:
   - Having knowledge of the anatomy
   - Demonstrating the ability to use the appropriate instrumentation
   - For abdominal surgery: dissection includes all layers to, but not, the peritoneum

f. Provide closure of layers by:
   - Correctly approximating the layers, under direction of the surgeon
   - Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs. continuous; skin sutures vs. staples; subcuticular closure; horizontal mattress
   - Correctly approximating skin edges when utilizing skin staples or suture

g. Assist the surgeon at the completion of the surgical procedure by:
   - Affixing and stabilizing all drains
   - Cleaning the wound and applying the dressing
   - Assist with applying casts; splints, bulky dressings, abduction devices

6. Other specialized circumstances requiring RN to contact physician
   a. None (physician always supervising)

7. Review of Standardized Procedure
   a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

REFERENCES:

Westlaw California Code of Regulations. (2021). Barclays Official California Code of Regulations 17 CA ADC § 35055. Retrieved from https://govt.westlaw.com/calregs/Document/I2599B8C0D60711DE88AEDDE29ED1DC0A?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Surgical Procedures that Require Special Consents		
Owner: DON Perioperative Services	Department: Surgery	
Scope: PACU, Surgery		
Date Last Modified: 12/02/2021	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 1/1/2001	

PURPOSE:
To personally, legally, and morally protect the rights of patients and those rendering care to them.

POLICY:
Patients shall be given the opportunity to provide an informed consent prior to the performance of surgical procedures as stated in the Informed Consent Policy.
The informed consent is the responsibility of the attending physician/surgeon.

PROCEDURE:

1. All surgical procedures require consent signed by the patient and witnessed.
    - The consent must be witnessed by a competent adult of legal age.
    - If the patient is unable to legibly sign his or her name, an "X" is acceptable if there are two witnesses.
    - Non English speaking patients will be provided with language assistance through the hospital's language service program. See policy on Language Services General Policy.
    - Consent must match the surgeon's order, the scheduled procedure, and the history and physical.
2. Any time two surgical procedures are performed by two surgeons simultaneously, a separate consent for each surgery is required, or both surgeries with designated surgeons must be on the same consent. It must be clear on the consent which surgeon is responsible for which surgical procedure.
3. **ABORTION CONSENT:** No special separate consent is required for a therapeutic abortion. Use regular consent form as for any other surgical procedure. Refer to CHA Consent manual for further clarification of abortions.
4. **MISCARRIAGE OR PARTIAL ABORTION**: The "Release from Responsibility for Treatment of Miscarriage or Partial Abortion" form is not required, but it may be useful in those situations where the patient arrives at the hospital in a condition of partial abortion and prudence suggests that the circumstances that led to the condition of partial abortion be established. Refer to CHA Consent Manual page 4.14 for further clarification. A general surgical consent is required.

5. **HYSTERECTOMY**: Consent to Hysterectomy will be completed by physicians in their office and sent to the hospital with the patient prior to the procedure. A general surgical consent is required. The informed consent procedure is not required when the hysterectomy is performed in a life-threatening emergency situation where prior written informed consent is not possible. The surgeon must document this as with any other emergency procedure without consent.

6. **BREAST**: The general surgical consent will be completed. When the surgery or procedure constitutes treatment for breast cancer, the surgeon **must** have given the patient a standardized treatment summary (written by the CDPH) and document this in the patient's medical record. The surgeon **may** add a statement that the patient has been given Breast Cancer Treatment Brochure to the consent.

    - **Mandatory Patient Information:** The summary informs the patient of alternative efficacious methods of treatment that may be medically viable, including surgical, radiological, or chemotherapeutic treatments or combinations thereof, and the advantages, disadvantages, risks and descriptions of the alternative methods of treatment. (**CHA Consent Manual 4.16** for reference to California Law special requirements with respect to the information to be given to a patient who has been diagnosed with breast cancer)
    - The summary may be given prior to the performance of a screening or biopsy for breast cancer upon a patient's request, or at the discretion of the physician in appropriate cases.
    - By Law, the physician may now wait until cancer is actually diagnosed to provide the patient with the brochure.

7. **PROSTATE:** The physician is not required but is urged to provide a written summary of advantages, disadvantages, risks, and descriptions of procedures re: treatment of prostate cancer to the patient when appropriate.

8. **TRANSFUSION CONSENT**: Transfusion consent is required for elective procedures when a patient has been cross matched for blood or a type and screen has been performed.

    a. **PAUL GANN ACT:** Imposes specific obligations upon physicians and podiatrists to provide information concerning transfusions of "autologous blood" to a patient when there is a reasonable possibility that a blood transfusion may be necessary as a result of a medical or surgical procedure. The physician or podiatrist must use the standardized written summary **"A Patient's Guide to Blood Transfusion"** developed by the California Department of Public Health to inform patients.

    b. Any patient that has been cross matched or had a type and screen done needs to be banded with a blood band prior to going to surgery.

9. **STERILIZATION CONSENT**: The regulations apply to elective sterilizations only; that is sterilization for the primary purpose of rendering a person permanently incapable of reproducing.

    - The regulations do not apply to secondary sterilizations; that is, sterilization that is a side effect of an otherwise necessary medical procedure.
    - Will be completed by patient and physician in his office. Check that dates for sterilization are valid with payment source being considered.

- Medical consents must have been completed at least 30 days prior to surgery, but not more than 180 days, unless a documented emergency arises.
- Premature delivery, unexpected date of delivery and emergency abdominal surgery, BUT the consent must have been signed at least 72 hours prior to emergency.
- If private patient, the patient can waive 30-day requirement, but **CANNOT** waive the 72-hour minimum waiting period. This needs to be voluntarily requested in writing.
- Refer to CHA Consent Manual Chapter 4 and Title 22 Regulations 70707.4; 70707.5; 70707.6 for further clarification.

10. **RELEASE OF BODY TO MORTUARY**: Will be completed before release of body and will be a part of the permanent record.

11. **ALLOGRAFT CONSENT**: No special consent is necessary for bone grafting with allograft, it must be a part of the regular consent for procedure. Example of this would be "Right Total Hip Arthroplasty with Allograft". This procedure as with any other is the responsibility of the surgeon to assure the patient has had informed consent. If the patient has any questions about this procedure refer him to his physician for clarification.

12. **PHOTOGRAPHY :** The "Consent to Photograph and Authorization for Use or Disclosure" form should be completed whenever the hospital, an authorized member of the medical staff, or any person not requested to do so by the patient, desires to take a photograph of a patient or any part of the patient's body for purposes **not directly related to the medical treatment of the patient.**

    Consent should be obtained from the Administrator prior to allowing any of this type of photography. Refer to the CHA Consent Manual Chapter 24.

13. **OBSERVATION:** The observation consent is to be signed when a manufacturer representative is to be in the operating room and does not have a signed contract with the hospital. Medical students who are participating from a school that has a contract with the hospital do not need to sign an observation consent. Refer to Observation in the Operating Room.

PROPERLY SIGNED:

An adult patient, 18 years of age or older, with capacity may consent to surgery. "Capacity" means a person's ability to understand the nature and consequences of a decision and to make and communicate a decision. In the case of proposed health care is able to understand the significant benefits, risks, and alternatives.

An emancipated minor may give consent legally without parental involvement. A minor is emancipated if he or she is:

- Married, widowed, or divorced.
- The parent of a child, in which case he or she may also consent for medical care of the child.
- Self-sufficient: Living separate and apart from his or her parents or legal guardians, and is managing his or her own financial affairs.
- A member of the armed forces.

A minor may consent to treatment for:

- Pregnancy or contraceptive care.
- Diagnosis or treatment for communicable (reportable) or sexually transmitted disease.
- A minor 12 years of age or older who is alleged to have been raped may consent to the medical and surgical care and the collection of evidence with regard to the alleged rape.

Anyone under the age of 18 and not an emancipated minor must have the consent form signed by his or her parents or legal guardian.

Next-of-kin may give consent when the patient is not capable of comprehending due to his or her medical condition and therefore is deemed incompetent as documented by the physician in the history of the patient's record. When relaying upon next-of -kin for consent, permission should be obtained in the following order: (1) spouse, (2) children of legal age, (3) parents, (4) siblings of legal age, and (5) grandparents.

EMERGENCY SURGERY:

In the event that surgery is deemed necessary immediately as a life-saving measure and it is not possible to obtain consent from the patient or authorized next -of-kin, treatment may be provided without the patient's consent. The physician will document necessity of procedure in the patient's medical record. This exception applies to minors as well as adult patients.

TELEPHONE CONSENT:

The physician should follow standard protocol for obtaining consent. Hospital personnel should verify consent was obtained with the patient's legal representative and a second hospital employee. Steps to obtain consent by fax, email, or letter should then be obtained when possible.

REFERENCES:

- California Hospital Association Consent Manual (found on NIHD Intranet>Information> Compliance>CHA Manuals>CHA Consent Manual. (2016) Chapters 1, 2, 4, and 11
- TJC: RI.01.03.01
- Title 22 Regulations: 70707.4; 70707.5; 70707.6

RECORD RETENTION AND DESTRUCTION:
Documentation in medical record is maintained per the Medical Record Department at NIHD.

CROSS REFERENCED POLICIES AND PROCEDURES:
Consent for Medical Treatment

Supersedes: v.2 Operative Consents

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

Surgery - General

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	Completion of an ACGME or AOA accredited Residency training program in General Surgery
Certification	Current certification or active participation in the examination process leading to certification in General Surgery by the American Board of Surgery.
Clinical Experience (Initial)	Applicant must provide documentation of provision of surgical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Core Privileges in General Surgery

Description: Diagnosis and preoperative, operative, and postoperative management of patients to correct or treat diseases, disorders and injuries of the alimentary tract, abdomen and its contents, skin and soft tissue and endocrine system.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
	General privileges
☐	Admit to inpatient or appropriate level of care
☐	Perform history and physical examination

☐	Evaluate, diagnose, consult, and provide pre- and post-operative care to patients, to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, and endocrine systems
	Vascular access procedures
☐	Insertion and management of central venous catheter, arterial lines, pulmonary artery catheters, pumps and ports
	Alimentary tract procedures
☐	Esophageal procedures including esophagectomy, esophago-gastrectomy, esophageal bypass procedure, esophageal diverticulectomy and esophageal repair.
☐	Gastric procedures excluding bariatric surgery
☐	Bowel procedures including biopsy; enterolysis; small bowel, colon and rectum resections; anastomosis and stomas; diverticulectomy; appendectomy
☐	Procedures on the anus and rectum including hemorrhoidectomy; rectal prolapse procedures; anal fissures, fistula, abscess incision/drainage and resection/restoration
☐	Abdomino-perineal resection
	Abdominal and pelvic procedures
☐	Biliary tract surgery including cholecystectomy and common duct exploration; biliary enteric anastomosis
☐	Drainage intra-abdominal abscess
☐	Fine needle aspiration
☐	Splenic procedures including splenectomy
☐	Adrenalectomy
☐	Drainage and debridement pancreatic abscess, cyst, necrosis
☐	Pancreaticoduodenectomy
☐	Pancreaticojejunostomy
☐	Abdominal wall hernia repair/abdominoplasty
☐	Retroperitoneal pelvic node dissection
☐	Repair of diaphragmatic hiatal hernia
☐	Inguinal hernia repair
	Liver procedures
☐	Drainage liver abscess
☐	Liver biopsy and excision
	Skin/soft tissue procedures
☐	Head and neck surgery including thyroidectomy; parathyroidectomy; tracheostomy; excision of thyroglossal duct and branchial cleft cysts; neck dissection; removal of salivary gland tumors and repair and biopsy of tongue and oral mucosal lesions.
☐	Skin biopsy, excision, soft tissue repair, treatment of burns, muscle biopsy and graft placement
☐	Lymphatic excisions including cervical, supraclavicular, axillary, retroperitoneal and extremities
	Additional thoracic procedures available to the general surgeon
☐	Thoracotomy, thoracostomy and insertion of chest tubes.
☐	Thoracentesis

☐	Thymectomy
☐	Sympathectomy
☐	Vagotomy
	Laparoscopy
☐	Basic laparoscopic procedures, including appendectomy, cholecystectomy, bile duct, closure of intestinal perforations; biopsy; and hernia repair
☐	Performance of advanced or complex laparoscopic or minimally invasive technique/approach in a procedural area not separately delineated where the applicant is a concurrent privilege holder.
	Incidental procedures
☐	Incidental kidney, bladder and ureteral surgery including repair and complete excision.
☐	Incidental hysterectomy, salphingo-oopherectomy and drainage of abscess of genitalia
☐	Incidental cholecystectomy or common duct exploration
☐	Repair or excision of the spleen incidental to a surgical procedure.
☐	Repair or excision of the liver incidental to a surgical procedure.

FPPE (Department Chief to select)	
☐	Concurrent observation of one major operative procedure
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries.
☐	Evaluation from the OR Supervisor

Privilege Cluster: Endoscopic Procedures

Description: Use of an endoscope to look inside the body to make a diagnosis or to treat abnormalities. The endoscope has a tiny camera on the tip of a long tube that is passed through an opening, such as the mouth or anus, or through a small incision in the abdomen or joint. Various kinds of endoscopy include laparoscopy for the abdomen, colonoscopy for the large intestine, bronchoscopy for the lungs and cystoscopy for the urinary system.

Qualifications

Additional Qualifications Must qualify for and be granted primary privileges in general surgery

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Laryngoscopy
☐	Diagnostic bronchoscopy, biopsy and foreign body removal.
☐	Esophago-gastro-duodenoscopy (EGD) including biopsy
☐	Sclerotherapy/banding esophageal varices
☐	Sigmoidoscopy with biopsy and polypectomy
☐	Colonoscopy with/without biopsy/polypectomy

☐	Percutaneous endoscopic gastrostomy (PEG)
☐	ERCP including sphincterotomy, stent placement, stone removal and stricture dilation
☐	Thoracoscopy, VATS

FPPE (Department Chief to select)	
☐	Concurrent observation of one invasive procedure.
☐	Retrospective evaluation of 2 endoscopic procedures.

Privilege Cluster: Colon and Rectal Surgery

Description: Evaluate, diagnose, provide consultation, treat and medically and surgically manage patients with various diseases of the intestinal tract (and other organs and tissues such as the liver, urinary, and female reproductive system involved with primary intestinal disease), colon, rectum, anal canal, and perianal area.

Qualifications

Additional Qualifications Must qualify for and be granted primary privileges in general surgery

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
	Endoscopy
☐	Diagnostic sigmoidoscopy including biopsy
☐	Therapeutic sigmoidoscopy including fulguration; detorsion or decompression of volvulus, stricture or pseudo-obstruction
☐	Diagnostic colonoscopy including biopsy and removal of polyp
☐	Therapeutic colonoscopy including fulguration; detorsion or decompression of volvulus, stricture or pseudo-obstruction
	Anus and rectum
☐	Incision and drainage of abscess
☐	Sphincterotomy, botox injection, fissurectomy, advancement flap
☐	Perianal and transanal excision and ablation of benign and malignant anorectal lesions and cysts
☐	Hemorroidectomy
☐	Fistula repair, including fistula plug
☐	Stapled hemorrhoidopexy (PPH)
	Pilonidal procedures
☐	Excision, cystotomy, cystectomy, flap closure
	Prolapse procedures (laparoscopic or open)
☐	Perineal procedure for rectal prolapse
☐	Resection or fixation of rectal prolapse or intussusception

	Bowel procedures (laparoscopic or open)
☐	Colectomy, proctectomy, colon procedures
☐	Small bowel resection, small bowel procedures
☐	Creation, revision, relocation or closure of colostomy or cecostomy
☐	Creation, revision, relocation or closure of ileostomy
☐	Lysis of adhesions

FPPE (Department Chief to select)	
☐	Concurrent observation of one major operative procedure
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 2 major surgeries
☐	Evaluation from the OR Supervisor

Privilege Cluster: Breast Disease and Surgical Privileges

Description: Diagnosis and preoperative, operative, and postoperative management of patients with diseases, injuries, and disorders of the breast. Evaluate and manage arm lymphedema and side effect of breast cancer treatment.

Qualifications

Additional Qualifications Must qualify for and be granted primary privileges in general surgery

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Evaluate, treat and manage patients, including interdisciplinary treatment planning with multiple disciplines (radiology, plastic and reconstructive surgery, medical oncology, radiation oncology and pathology).
	Procedures
☐	Lymph node dissection
☐	Major lymphadenectomy
☐	Sentinel node biopsy
☐	Breast biopsies, including stereotactic core breast biopsy, percutaneous core biopsy
☐	Duct excision
☐	Simple (total) mastectomy, subcutaneous mastectomy, skin-sparing mastectomy, modified radical and radical mastectomy
☐	Ultrasound-guided breast cryotherapy
☐	Ultrasound-guided breast procedures including placement of localizing wires, clips, and irradiation catheters
☐	Ultrasound-guided vacuum-assisted rotational cutting biopsy
☐	Breast reconstruction

☐	Chest wall resection

FPPE (Department Chief to select)	
☐	Concurrent observation of one complex breast surgery.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 2 major breast surgeries.
☐	Evaluation from the OR Supervisor.

Privilege Cluster: Surgical Oncology Privileges

Description: Diagnosis and preoperative, operative, and postoperative management of patients with benign and/or malignant tumors within the esophagus, chest, abdomen, ano-rectal, alimentary or renal systems.

Qualifications

Additional Qualifications Must qualify for and be granted primary privileges in general surgery

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Kidney and ureteral surgery including repair and complete excision
☐	Sentinel lymph node biopsy
☐	Bladder surgery including repair,excision and suprapubic cystostomy
☐	Hysterectomy, salphingo-oopherectomy, vaginectomy and vulvectomy
☐	Surgery of the scrotum including orchiectomy and testis biopsy
☐	Reconstructive procedures to repair surgical defects including grafts, flaps and implants

FPPE (Department Chief to select)	
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 2 major surgeries.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the surgeon

Privilege Cluster: Surgical Critical Care (Trauma) Privileges

Description: Management and treatment of the critically ill and postoperative patient, particularly the trauma victim, and treating and supporting patients with multiple organ dysfunction, hemodynamic instability, and complex coexisting medical problems.

Qualifications

Additional Qualifications Must qualify for and be granted primary privileges in general surgery

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Evaluate, diagnose, treat and provide consultation to patients presenting with multiple organ dysfunction and in need of surgical critical care for life threatening disorders
	Procedures (other procedures that are extensions of the same techniques and skills may also be performed)
☐	Intubation and ventilator management -- all modes
☐	Surgical treatment (repair or excision) of penetrating or crush injuries where soft tissue, musculo-skeletal or organ trauma has occurred in the chest, head, neck, abdomen, pelvis and extremities -- open or minimally invasive
☐	Drainage sub/extradural hematoma
☐	Emergent vascular repair
☐	Reimplantation
☐	Investigational or focused ultrasound (FAST)
☐	Temporary transvenous pacemaker insertion

FPPE (Department Chief to select)

☐	Retrospective evaluation to incloude pre-operative work-up, surgical plan and post-operative course of events of 2 major surgeries.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the surgeon

Privilege Cluster: Vascular Procedures

Description: Management of patients to correct or treat diseases, disorders and injuries of the arterial, venous, and lymphatic circulatory systems, exclusive of those circulatory vessels intrinsic to the heart and intracranial vessels.

Qualifications

Additional Qualifications Must qualify for and be granted primary privileges in general surgery

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Dialysis access
☐	A-V fistula formation and management

☐	Portosystemic shunts
☐	Peritoneal dialysis catheter placement
☐	Peripheral vascular procedures

FPPE (Department Chief to select)	
☐	Retrospective evaluation of 2 vascular procedures.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the surgeon

Fluoroscopy

Description: Fluoroscopy privileges for non-radiologists

Qualifications

Certification Current California fluoroscopy permit from the Radiologic Health Branch is required.

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Introduction of radiologic contrast materials in conjunction with operative procedure or assessment of trauma or other anatomic problems

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

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).

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Moderate Sedation (Must perform 6 every 2 Years)

FPPE (Department Chief to select)	
☐	Retrospective review of 3 cases of administration of moderate sedation
☐	Feedback from involved clinical or administrative personnel

Robotic Assisted Surgery

Description: Minimally invasive surgery assisted by a fully robotic surgery platform (daVinci).

Qualifications

Education/Training	Completion of an ACGME or AOA accredited residency or fellowship training program which included robotic surgery training (must submit letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device). **OR** Certification of delineated training from Intuitive Surgical (i.e., completion of Internet training module, Overview/Didactic session, and Skills Lab at the ISI Training Center).
Clinical Experience (Initial)	Applicant must provide documentation of performance of at least 10 robotic procedures representative of the scope of privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	A minimum of 10 cases performed successfully (may be reviewed by the appropriate Department Chief or Committee) during the previous 24-month period without a proctor present. If fewer than 10 cases, refer to Medical Staff policy.
Additional Qualifications	Surgeon must have clinical privileges for the corresponding open and laparoscopic procedures that will be performed robotically.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Use of the robotic platform in a procedure where the physician is a concurrent privilege holder in laparoscopic or minimally invasive approach (Must perform 10 every 2 Years)

FPPE (Department Chief to select)	
☐	Concurrent proctoring of 1 case within 180 days for surgeons with prior da Vinci experience
☐	Concurrent proctoring of 3 cases and 5 observed cases within 180 days for surgeons without prior da Vinci experience

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

Department 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

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

Colon and Rectal Surgery

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	Completion of an ACGME accredited Residency in Surgery (General Surgery) or AOA equivalent. **AND** Completion of an ACGME accredited Fellowship training program in Colon & Rectal Surgery.
Certification	Current certification in General Surgery by the American Board of Surgery. **AND** Current certification in Colon and Rectal Surgery by the American Board of Colon and Rectal Surgery.
Clinical Experience (Initial)	Applicant must provide documentation of provision of colon and rectal surgery services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.

Core Privileges in Colon and Rectal Surgery	
Description: Evaluate, diagnose, provide consultation, treat and medically and surgically manage patients with various diseases of the intestinal tract (and other organs and tissues such as the liver, urinary, and female reproductive system involved with primary intestinal disease), colon, rectum, anal canal, and perianal area.	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Admit to inpatient or appropriate level of care.
☐	Perform history and physical examination.

☐	Evaluation, diagnosis and treatment of patients presenting with diseases, injuries, and disorders of the intestinal tract, colon, rectum, anal canal and perianal areas by medical means including intestinal disease involvement of the liver, urinary, and female reproductive systems.
	Procedures
	Endoscopy
☐	Diagnostic sigmoidoscopy including biopsy
☐	Therapeutic sigmoidoscopy including fulguration; detorsion or decompression of volvulus, stricture or pseudo-obstruction
☐	Diagnostic colonoscopy including biopsy and removal of polyp
☐	Therapeutic colonoscopy including fulguration; detorsion or decompression of volvulus, stricture or pseudo-obstruction
	Anus and rectum
☐	Incision and drainage of abscess
☐	Sphincterotomy, botox injection, fissurectomy, advancement flap
☐	Anoplasty for stricture or ectropion
☐	Perianal and transanal excision and ablation of benign and malignant anorectal lesions and cysts
☐	Anal sphincteroplasty
☐	Hemorroidectomy
☐	Fistula repair, including fistula plug
☐	Stapled hemorrhoidolpexy (PPH)
☐	Endorectal flap procedure for vaginal/ano/perineal fistula
	Pilonidal procedures
☐	Excision, cystotomy, cystectomy, flap closure
	Prolapse procedures (laparoscopic or open)
☐	Perineal procedure for rectal prolapse
☐	Resection or fixation of rectal prolapse or intussusception
	Bowel and other incidental procedures (laparoscopic or open)
☐	Colectomy, proctectomy, colon procedures
☐	Small bowel resection, small bowel procedures
☐	Creation, revision, relocation or closure of colostomy or cecostomy
☐	Creation, revision, relocation or closure of ileostomy
☐	Ileo-anal pull through procedure and other pouch procedures
☐	Appendectomy
☐	Lymph node and sentinel node biopsy
☐	Lysis of adhesions
☐	Kidney, bladder and ureteral surgery including repair and complete excision incidental to a colon and rectal surgery procedure
☐	Hysterectomy, salphingo-oopherectomy and drainage of abscess of genitalia incidental to a colon and rectal surgery procedure
☐	Cholecystectomy or common duct exploration incidental to a colon and rectal surgery procedure.

☐	Repair or excision of the spleen incidental to a colon and rectal surgery procedure.
☐	Repair or excision of the liver incidental to a colon and rectal surgery procedure.
☐	Performance of advanced or complex laparoscopic or minimally invasive technique/approach in a procedural area not previously listed where the applicant is a concurrent privilege holder.

FPPE (Department Chief to select)	
☐	Concurrent observation of one major operative procedure (proctor may be colon and rectal surgeon or general surgeon)
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries
☐	Evaluation from the OR Supervisor

Privilege Cluster: Neuromodulation for Bowel Control (InterStim)

Description: Use of sacral neuromodulation device for fecal incontinence.

Qualifications

Education/Training	Documentation of training and supervised experience during residency/fellowship. **OR** Documentation of completion of manufacturers on line training module is required for each privilege that included or was followed by manufacturer sponsored simulator/cadaver training or supervised training on human subjects. **OR** If training occurred greater than 24 months ago the applicant must provide documentation of ongoing clinical practice.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months (waived if training was completed within the previous 2 years).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity 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.
☐	Endorectal ultrasound
☐	Ultrasound guided needle placement/injection
☐	Surgical placement of neuromodulation device

FPPE (Department Chief to select)	
☐	Concurrent review of initial case.

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

Department 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

Northern Inyo Healthcare District
One Team. One Goal. Your Health.

Podiatry

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	Successful completion of a 24 month or 36 month residency program in podiatric medicine and surgery (post completion of a four year college/school of podiatric medicine) in a program approved by the Council on Podiatric Medical Education (CPME).
Certification	Current certification in foot surgery by the American Board of Foot and Ankle Surgery (ABFAS).
Clinical Experience (Initial)	Applicant must provide documentation of provision of podiatric services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the past 24 months.

Core Privileges in Podiatry

Description: Evaluation, diagnosis and treatment of diseases, disorders, and injuries of the foot and ankle, by medical, biomechanical, and surgical means.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Co-admit to inpatient or appropriate level of care
☐	Perform history and physical examination
☐	Evaluate, diagnose, provide consultation to patients and treat diseases, injuries and complaints involving the foot.
	Foot and Ankle
☐	Wound debridement, treatment of deep wound infections, osteomyelitis
☐	Incision and drainage
☐	Local infiltration anesthetic injection including basic blocks
☐	Amputation and ray resection

☐	Excision of soft tissue lesions and masses
☐	Excision of osseous tumors and ossicles
☐	Neurectomy, neurolysis, and nerve decompression
☐	Plantar fasciotomy
☐	Digital surgery including fusion, arthroplasty, syndactyly
☐	Hallux valgus/bunion repair
☐	Tendon and ligament repair
☐	Tendon lengthening
☐	Tendon transfers of the forefoot and midfoot
☐	Tenodesis of the forefoot and midfoot
☐	Ostectomy
☐	Osteotomy of the forefoot and midfoot
☐	Fusion of the forefoot and midfoot
☐	Open/closed reduction of forefoot fracture and midfoot fractures/dislocations

FPPE (Department Chief to select)	
☐	Concurrent observation of one major surgical procedure.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 3 surgical procedures representative of the scope of privileges.
☐	Feedback from involved clinician or administrative person who is knowledgeable about the services performed by the physician

Privilege Cluster: Reconstructive Rearfoot and Ankle Surgical Privileges	
Description: Reconstructive rearfoot and ankle surgery procedures	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Tendon transfers of the rearfoot and ankle
☐	Osteotomies of the rearfoot and ankle
☐	Subtalar fusion
☐	Tibiocalcaneal fusion
☐	Ankle fusion
☐	Open/closed reduction of fractures of the rearfoot and ankle
☐	Diagnostic arthroscopy
☐	Therapeutic arthroscopy including debridement and soft tissue repair

FPPE (Department Chief to select)	

☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 2 surgical procedures representative of the scope of privileges.
☐	Concurrent review of one case representative of the complexity of privileges requested.

Fluoroscopy

Description: Fluoroscopy privileges for non-radiologists

Qualifications

Certification Current California fluoroscopy permit from the Radiologic Health Branch is required.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Introduction of radiologic contrast materials in conjunction with operative procedure or assessment of trauma or other anatomic problems

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

Department 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

Orthopedic Surgery

Delineation of Privileges

Applicant's Name: ,

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Orthopaedic Surgery.
Certification	Current certification or active participation in the examination process leading to certification in Orthopaedic Surgery by the American Board of Orthopaedic Surgery or AOA equivalent.
Certification - Other	Current California Fluoroscopy Permit required.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications	Complex device-related privileges require documentation of completion of manufacturer designated training followed by supervised cases on human subjects or ongoing clinical practice if training occurred greater than 24 months ago.

Core Privileges in Orthopedic Surgery	
Description: Evaluate, diagnose, provide consultation, treat and medically and surgically manage patients with congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the skeleton including joints, spine and hand. An orthopedic surgeon is also concerned with primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system.	
Request	Request all privileges listed below.
☐	Admit to inpatient or appropriate level of care
☐	Perform history and physical examination
☐	Evaluate, diagnose, treat and provide consultation to correct or treat various conditions and injuries of the extremities, spine, and associated structures by medical and physical means.
	Procedures
☐	Acute and secondary muscle and tendon repair including tendon grafts
☐	Amputation surgery including immediate prosthetic fitting in the operating room
☐	Arthrocentesis and joint injection
☐	Arthrodesis, osteotomy (non-spine)
☐	Arthroplasty excluding total replacement
☐	Bone grafts and allografts

☐	Diagnostic and therapeutic arthroscopy
☐	Debridement, excision and biopsy of soft tissue and bony masses or lesions related to a musculoskeletal lesion; open or closed
☐	Incision and drainage of infection and mass
☐	Ligament reconstruction
☐	Management of infectious and inflammations of bones, joints and tendon sheaths
☐	Metastatic malignancy and benign lesion of the bone including resection
☐	Open and closed reduction and internal/external fixation of fractures and dislocations of the skeleton including use of instrumentation
☐	Reconstruction of nonspinal congenital musculoskeletal anomalies
☐	Simple hand surgery procedures including repair of lacerations; superficial/deep infection; digital tip injuries; skin grafts; amputations; trigger finger (DeQuervain's disease); carpal tunnel decompression; fractured metacarpals, phalanges and wrist; ganglion (palm or wrist, flexor sheath); arthrodesis (metacarpophalangeal, interphalangeal); foreign body removal.
☐	Tenotomy

FPPE	
☐	Concurrent observation of three major surgical procedures.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries.
☐	Evaluation from the OR Supervisor.

Joint Replacement and Revision

Description: Replace joints and subsequent revisional surgery including use of open and minimally invasive technique.

Qualifications

Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services in the specific privileges requested during the previous 24 months (waived for applicants who completed fellowship training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services in the specific privileges requested during the previous 24 months.

Request	Request all privileges listed below.
	Procedures
☐	Shoulder
☐	Hip
☐	Knee
☐	Ankle
☐	Elbow

FPPE	
☐	Concurrent observation of one major surgical procedure.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events for 3 major surgeries encompassing each operative area where privileges have been granted.
☐	Evaluation from the OR Supervisor

Orthopedic Surgery of the Spine Privileges - Simple

Description: Surgically manage patients with spinal column diseases, disorders, and injuries.

Qualifications

Education/Training	Completion of an ACGME residency training program in Orthopedic Surgery which included surgery of the spine. **AND** Letter of reference from program director or attending surgeon attesting to training and competency.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications for Use of a Navigational Device	Documentation of completion of manufacturer designated training in the device to be utilized.

Request	Request all privileges listed below.
	Procedures
☐	Lumbar puncture
☐	Laminectomy or laminotomy; with or without discectomy
☐	Spinal fusion, posterior approach without instrumentation
☐	Anterior cervical fusion with or without instrumentation

FPPE	
☐	Concurrent observation of one major surgical procedure.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries.
☐	Evaluation from the OR Supervisor

Orthopedic Surgery of the Spine Privileges - Complex

Description: Surgically manage patients with spinal column diseases, disorders, and injuries.

Qualifications

Education/Training	Completion of an ACGME Fellowship training program in Orthopedic Surgery of the Spine
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications for Use of a Navigational Device	Documentation of completion of manufacturer designated training in the device to be utilized.

Request	Request all privileges listed below.
	Procedures
☐	Anterior spinal procedures such as eradication of infection and grafting; body excisions; fusions with and without instrumentation
☐	Kyphoplasty or vertebroplasty (with cement)
☐	Vertebroplasty using spacer decompression system
☐	Spinal cord surgery for decompression of spinal cord or spinal canal, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord or other congenital anomalies
☐	Treatment of scoliosis and kyphosis with instrumentation with or without occipital fusion on adult patients
☐	Treatment of traumatic injuries of the spine with or without instrumentation
☐	Impantation of artificial disc and allograft injection for degenerative disc
☐	Implantation of spinal cord stimulator
☐	Percutaneous radiofrequency ablation of the basivertebral nerve
☐	Endoscopic intervention including percutaneous lumbar discectomy or scoliosis correction
☐	Video assisted thoroscopic spinal surgery
☐	Halo application
☐	Adjunctive use of a navigational device in the performance of a privileged procedure in spine surgery

FPPE

☐	Concurrent observation of one major surgical procedure.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries.
☐	Evaluation from the OR Supervisor

Musculoskeletal Oncology Privileges

Description: Evaluate, diagnose, provide consultation, treat and medically and surgically manage patients with benign and primary tumors of bone and connective soft tissues. Includes palliative management of patients with metastatic malignancy to the bone.

Qualifications

Education/Training	Completion of an ACGME Fellowship training program in Musculoskeletal Oncology.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.

Request	Request all privileges listed below.
	Procedures
☐	Primary bone tumor and soft tissue resection
☐	Limb salvage procedure
☐	Surgically address tumors of the hand

FPPE

☐	Concurrent observation of one major surgical procedure.
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries.
☐	Evaluation from the OR Supervisor.

Surgery of the Hand and Wrist

Description: Evaluate, diagnose, provide consultation, treat and medically and surgically manage patients with congenital and acquired defects of the hand and wrist that compromise the function of the hand.

Qualifications

Education/Training	Completion of an ACGME or AOA accredited Fellowship training program in Surgery of the Hand.

Request	Request all privileges listed below.
	Procedures
☐	Complex amputation requiring tendon transfer or reconstruction
☐	Arthroscopy
☐	Arthroplasty
☐	Joint implants

☐	Complex bone grafts, including vascularized
☐	Tendon reconstruction including tendon grafts, complex tenolysis, pulley reconstruction, and tendon transfer
☐	Foot to hand transfer
☐	Nerve repair, including major and digital, graft, neurolysis, surgical treatment of neuroma, transpositions, and tendon decompressions
☐	Reconstruction of or surgically address congenital and acquired deformities of the hand and wrist
☐	Replantation, revascularization
☐	Skin repair, including grafts and flaps, multiple tissue flaps, free microscopic tissue transfers, and insertion of tissue expanders
☐	Open surgery for Dupuytren's contracture
☐	Surgical treatment of complex bone and soft tissue tumors

FPPE	
☐	Concurrent observation of one major operative procedure (proctor may be surgeon in the same specialty or anesthesiologist).
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 major surgeries.
☐	Evaluation from the OR Supervisor

Moderate (Procedural) Sedation

Description: Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

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).

Request	
	Request all privileges listed below.
☐	Moderate Sedation (Must perform 6 every 2 Years)

FPPE	
☐	Retrospective review of 3 cases of administration of moderate sedation

☐	Feedback from involved clinical or administrative personnel

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Demo Hospital 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

Department Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

Privilege	Condition/Modification/Deletion/Explanation

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

Obstetrics and Gynecology

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	Completion of an ACGME or AOA accredited Residency training program in Obstetrics and Gynecology.
Certification	Current certification or active participation in the examination process leading to certification in Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of obstetrics and/or gynecology services as applicable representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of obstetrics and/or gynecology services as applicable representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications	All practitioners requesting privileges to manage and attend births in Labor and Deliver at Northern Inyo Hospital will complete the appropriate BETA (Quest for Zero: Excellence in OB) requirements and will comply with approved terminology in the OB setting **AND** Current BLS or ACLS certification required.

Core Privileges in Obstetrics and Gynecology

Description: Evaluate, diagnose, provide consultation, treat and provide surgical and non-surgical management of reproductive health and pregnancy of female patients.

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

☐	Admit to inpatient care or other level of care
☐	Perform history and physical examination
☐	Evaluate, diagnose, treat and medically manage reproductive health, pregnancy, and medical diseases or problems that are complicating factors in pregnancy.
	Procedures
☐	3rd trimester amniocentesis
☐	OB Ultrasound
☐	Cervical cerclage
☐	Local anesthesia, pudendal and paracervical blocks
☐	Normal labor and delivery with/without episiotomy
☐	Management and delivery of multiple pregnancy
☐	Operative delivery including the use of forceps and vacuum
☐	Augmentation of labor
☐	Version and extraction
☐	Repair or vaginal, cervical, perineal lacerations
☐	Post vaginal delivery tubal ligation
☐	Cesarean section including hysterectomy and tubal sterilization
☐	Elective termination of pregnancy (1st trimester)
☐	Circumcision (newborn)
	Specialized Obstetrical Procedures
☐	Amnioinfusion for abortion
☐	Delivery of fetal demise

FPPE (Department Chief to select)	
☐	Concurrent observation of one C-section
☐	Retrospective review of 5 vaginal deliveries.
☐	Evaluation from the OR Supervisor, the Nursing Supervisor, Obstetrics Unit/Floor and one Anesthesiologist

Primary Privileges in Gynecology	
Description: Evaluate, diagnose, provide consultation, treat and provide both surgical and non-surgical management of the reproductive and genitourinary health of female patients.	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Admit to inpatient care or other level of care
☐	Perform history and physical examination

☐	Evaluate, diagnose, provide consultation, and non-operative management of reproductive health and genitourinary system. Including non-surgical treatment of injuries and disorders of the mammary glands.
	Procedures
☐	Paracervical or pudendal block
☐	Marsupialization or excision of Bartholin cyst or abscess
☐	Soft tissue biopsy of the genital-urinary tract or incidental biopsy of other lesions encountered in the course of a gynecologic procedure
☐	Excision or ablation (excluding laser) of lesion on the external genitalia, vagina or cervix
☐	Simple vulvectomy
☐	Hymenotomy
☐	Dilatation and curettage
☐	Cold-knife conization of the cervix
☐	Colpotomy, culdocentesis
☐	Colpocleisis
☐	Colposcopy
☐	Colpectomy, partial or complete
☐	Hysterectomy, abdominal, total or subtotal with or without BSO
☐	Hysterectomy, vaginal, with or without BSO
☐	Myomectomy via laparotomy
☐	Salpingectomy, salpingo-oophorectomy, salpingostomy, oophorectomy and/or resection of ovarian cyst
☐	Amputation of cervix with colporrhaphy (Manchester Procedure)
☐	Colporrhaphy for urethrocele, cystocele, or rectocele
☐	Repair of enterocele
☐	Suprapubic catheter placement
☐	Abdominal retropubic urethropexy (Burch; Marshall-Marchetti-Krantz, etc.)
☐	Elective termination of pregnancy (1st trimester)
☐	Cystoscopy as part of a gynecologic procedure
☐	Laparoscopy (diagnostic)
☐	Hysteroscopy (diagnostic)
☐	Basic Operative Laparoscopy including treatment of endometriosis; assisted vaginal hysterectomy of uteri anticipated to be less than 12 weeks gestational size); salpingectomy; salpingostomy; salpingo-oopherectomy; lysis of adhesions; myomectomy (pedunculated myoma); and ovarian cystectomy.
☐	Basic Operative Hysteroscopy including polypectomy; removal of IUD, incision of mild type 1 adhesions; resection of submucous myomas; resectoscopic endometrial ablation; global endometrial ablation; and hysteroscopic tubal sterilization.
☐	Incidental appendectomy
☐	Incidental bladder repair
☐	Incidental hernia repair (umbilical, incisional, ventral)
☐	Abdominal paracentesis
	Advanced Laparoscopy and Hysteroscopy

☐	Advanced Operative Laparoscopy including urethropexy (e.g. Burch); enterocele repair; vaginal vault suspension (sacrocolpopexy, utero-sacral ligament fixation); subtotal hysterectomy; assisted vaginal hysterectomy of uteri anticipated to be greater than 12 weeks gestational size; myomectomy (intramural, subserosal); presacral neurectomy; and tubal reanastomosis.
☐	Advanced Operative Hysteroscopy including the following procedures and other procedures that are extensions of the same techniques and skills: incision of uterine septum; incision of moderate to severe (type 2-3) intrauterine adhesions.

FPPE (Department Chief to select)	
☐	Retrospective evaluation to include pre-operative work-up, surgical plan and post-operative course of events of 5 surgeries representative of the scope and complexity of privileges granted.
☐	Concurrent observation of 3 cases representative of the scope of privileges granted.
☐	Evaluation from the OR Supervisor, the Nursing Supervisor, Obstetrics Unit/Floor and one Anesthesiologist

Privilege Cluster: Maternal-Fetal Medicine

Description: Evaluation, treatment, consultation and care of women with complicated pregnancies. This cluster includes privileges specific to Maternal-Fetal Medicine that were not previously referenced in the cluster for Primary privileges in Obstetrics.

Qualifications

Education/Training	Completion of a Fellowship program in Maternal-Fetal Medicine approved by the American Board of Obstetrics and Gynecology (ABOG), ACGME or by the AOA.
Certification	Current certification in Maternal-Fetal Medicine by the ABOG or AOBOG.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed fellowship training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the past 24 months.
Additional Qualifications	Applicant must be granted primary privileges in obstetrics gynecology.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Evaluate, diagnose, treat and provide consultation regarding genetic, or possibly genetically linked diseases or disorders or birth defects
☐	Provide genetic counseling for commonly recognized disorders
	Procedures
☐	Amniocentesis, genetic
☐	Ultrasound examination, all types and at all stages of pregnancy
☐	Chorionic villi sampling
☐	Intrauterine transfusion

☐	Intrauterine fetal therapy (fetal thoracentesis, paracentesis and administration of fetal medications, intrauterine umbilical vessel aspiration or injection)
☐	Fetal exit surgery in conjunction with a pediatric surgeon with privileges in fetal exit surgery. (Privilege requires further delineation regarding precisely what procedures are being authorized.)

FPPE (Department Chief to select)	
☐	Five retrospective case reviews chosen to represent a diversity of major surgical procedures and management challenges.

Robotic Assisted Surgery

Description: Minimally invasive surgery assisted by a fully robotic surgery platform (daVinci).

Qualifications

Education/Training	Completion of an ACGME or AOA accredited residency or fellowship training program which included robotic surgery training (must submit letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device). **OR** Certification of delineated training from Intuitive Surgical (i.e., completion of Internet training module, Overview/Didactic session, and Skills Lab at the ISI Training Center).
Clinical Experience (Initial)	Applicant must provide documentation of performance of at least 10 robotic procedures representative of the scope of privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	A minimum of 10 cases performed successfully (may be reviewed by the appropriate Department Chief or Committee) during the previous 24-month period without a proctor present. If fewer than 10 cases, refer to Medical Staff policy.
Additional Qualifications	Surgeon must have clinical privileges for the corresponding open and laparoscopic procedures that will be performed robotically.

Request	
	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Use of the robotic platform in a procedure where the physician is a concurrent privilege holder in laparoscopic or minimally invasive approach (Must perform 10 every 2 Years)

FPPE (Department Chief to select)	
☐	Concurrent proctoring of 1 case within 180 days for surgeons with prior da Vinci experience
☐	Concurrent proctoring of 3 cases and 5 observed cases within 180 days for surgeons without prior da Vinci experience

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

Department 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

Neonatal Critical Indicators

2022

1. APGAR score less than 7 at 5 minutes
2. Neonatal resuscitation (PPV or beyond)
3. Infant in Neonatal Peds status
4. Birthweight less than ~~2000g~~2500g
5. Infant of a diabetic mother
6. Gestation less than 36 weeks
7. Infant re-admitted within 48 hours of discharge
8. Transfer to NICU
9. Pediatrician attended delivery
10. Any chart brought forward by staff due to concerns

Approved:

Peri-Peds Committee: 01/25/2022
Medical Executive Committee: 02/01/2022
Board of Directors:

Pediatric Critical Indicators

2022

1. Patient transfer to a higher level of care or referral center
2. Readmission to the hospital within 30 days for the same or related diagnosis
3. Respiratory or cardiac arrest (Apnea >15 seconds)
4. Death
5. Abuse
6. Dehydration requiring Intravenous Fluid
7. Neonates < 28 days, admitted to the Acute/Sub Acute Services
8. Length of stay exceeding 48 hours
9. IV/IM antibiotics
10. Nursing concerns

Approved:

Peri-Peds Committee: 01/25/2022
Medical Executive Committee: 02/01/2022
Board of Directors:

Anesthesia Critical Indicators

2022

Adopted from 'MACRA Ready' Adverse Events Reporting Form

Cardiovascular

1. Dysrythmia requiring intervention
2. Cardiac arrest (unplanned)
3. Unexpected death
4. Stroke, CVA, or coma
5. Myocardial ischemia
6. Myocardial infarction
7. Vascular access injury (arterial/pneumothorax)
8. Uncontrolled HTN

Respiratory

9. Aspiration
10. Pneumothorax (related to anesthesia)

Regional

11. Failed Regional Anesthetic
12. Systemic local anesthetic toxicity
13. Post-dural puncture headache
14. Epidural hematoma after spinal/epidural
15. Epidural abscess after spinal/epidural
16. Peripheral nerve injury following regional
17. Infection following peripheral nerve block

PACU

18. Temperature <95.9° F or <35.5° C
19. Inadequate Reversal
20. Reintubation (planned trial extubation documented)
21. Reintubation (no planned trial extubation)

Medication

22. Medication administration error
23. Adverse transfusion reaction
24. Anaphylaxis

Process

25. Wrong site surgery
26. Wrong patient
27. Difficult airway
28. Unplanned hospital admission
29. Unplanned ICU admission
30. Wrong surgical procedure

Miscellaneous

31. Dental trauma
32. Visual loss
33. Malignant Hypothermia
34. Awareness under GA
35. Equipment malfunction
36. Fire in OR
37. Airway fire in OR
38. Corneal abrasion
39. Fall in OR
40. Other

Approvals:

Surgery/Tissue/Transfusion/Anesthesia: 01/26/22
Medical Executive Committee: 02/01/22
Board of Directors:

Surgical Critical Indicators

2022

1. Death within 30 days of a surgical or anesthetic procedure.
2. Unanticipated admission to the Intensive Care Unit from a lower level of care.
3. Unanticipated return to the Operating Room.
4. Unanticipated readmission to the hospital within 30 days following a surgical procedure.
5. Unanticipated return to the hospital following surgery.
6. Unanticipated removal or repair of tissue not considered to be a common outcome of the procedure.
7. Unanticipated patient retention of foreign material.
8. Complication consequent to implantation of prosthetic devices or their malfunction or failure.
9. Documented significant postoperative complication within 30 days. These will include ventilator failure, myocardial infarction, stroke, renal failure, pulmonary embolus or deep vein thromboembolic disease, sepsis, or impairment of body function to a level less than that present prior to a surgical or anesthetic procedure, and less than commonly expected as a result of the operative procedure.
10. Airway management for moderate sedation (oral airway or bagging patient).
11. Wrong-site surgery.

Approvals:

Surgery/Tissue/Transfusion/Anesthesia: 01/26/22
Medical Executive Committee: 02/01/22
Board of Directors:

RESOLUTION NO. 22-03

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT MAKING THE LEGALLY REQUIRED FINDINGS TO CONTINUE TO AUTHORIZE THE CONDUCT OF REMOTE "TELEPHONIC" MEETINGS DURING THE STATE OF EMERGENCY

WHEREAS, on March 4, 2020, pursuant to California Gov. Code Section 8625, the Governor declared a state of emergency stemming from the COVID-19 pandemic ("Emergency"); and

WHEREAS, on September 17, 2021, Governor Newsom signed AB 361, which bill went into immediate effect as urgency legislation; and

WHEREAS, AB 361 added subsection (e) to Government Code Section 54953 to authorize legislative bodies to conduct remote meetings provided the legislative body makes specified findings; and

WHEREAS, as of September 19, 2021, the COVID-19 pandemic has killed more than 67,612 Californians; and

WHEREAS, social distancing measures decrease the chance of spread of COVID-19; and

WHEREAS, this legislative body previously adopted a resolution to authorize this legislative body to conduct remote "telephonic" meetings; and

WHEREAS, Government Code 54953(e)(3) authorizes this legislative body to continue to conduct remote "telephonic" meetings provided that it has timely made the findings specified therein.

NOW, THEREFORE, IT IS RESOLVED by the Board of Directors of Northern Inyo Healthcare District as follows:

1. This legislative body declares that it has reconsidered the circumstances of the state of emergency declared by the Governor and at least one of the following is true: (a) the state of emergency, continues to directly impact the ability of the members of this legislative body to meet safely in person; and/or (2) state or local officials continue to impose or recommend measures to promote social distancing.

PASSED, APPROVED AND ADOPTED this 16th day of February, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Jody Veenker, Chair
Board of Directors

ATTEST:

_____
Name: Erika Hernandez
Title: Board Clerk

CALL TO ORDER	The meeting was called to order at 5:30 pm by Jody Veenker, District Board Chair.
PRESENT	Jody Veenker, Chair Mary Mae Kilpatrick, Vice Chair Topah Spoonhunter, Secretary Jean Turner, Treasurer Robert Sharp, Member-at-Large Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer Vinay Behl, Interim Chief Financial Officer Joy Engblade MD, Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer Keith Collins, General Legal Counsel (Jones & Mayer)
ABSENT	Sierra Bourne MD, Chief of Staff
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Veenker 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 Public Comments were heard.
NEW BUSINESS	
RE- ORDERING OF MEETING AGENDA	Ms. Veenker requested that the agenda item 3F, *Discussion of existing Board Committee's,* be re-ordered to become item 3E under *New Business* section. The re-ordering of the agenda was requested in order to allow a board discussion to take place prior to appointing a Board Member to the *Compliance and Business Ethics Committee.*
COVID 19 COMMUNITY UPDATE	Chief Medical Officer, Joy Engblade and Chief Nursing Officer, Allison Partridge provided a community update regarding COVID 19 and clarified question for the Board.

APPROVAL OF THE RENEWAL AGREEMENT BETWEEN NOTHERN INYO HEALTHCARE DISTRICT AND EASTERN SIERRA EMERGENCY PHYSICIANS	Chief Executive Officer, Kelli Davis introduced Northern Inyo Healthcare District (NIHD) Emergency Physician, Adam Hawkins, DO. Doctor Hawkins called attention to the proposed renewal agreement between NIHD and Eastern Sierra Emergency Physicians. It was moved by Robert Sharp, seconded by Jean Turner, and unanimously passed to approve the renewal agreement between NIHD and Eastern Sierra Emergency Physicians as presented.
APPROVAL OF DISTRICT BOARD RESOLUTION 22-01, NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM	Interim Chief Financial Officer, Vinay Behl called attention to the proposed District Board Resolution 22-01, Nondesignated Public Hospital Bridge Loan Program. It was moved by Mr. Sharp, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the Board District Resolution 22-01, Nondesignated Public Hospital Bridge Loan Program as presented.
POLICY AND PROCEDURE APPROVAL, CHARGE CAPTURE POLICY AND PROCEDURE	Ms. Davis called attention to the revised NIHD Policy and Procedure titled; *Charge Capture Policy and Procedure*. It was moved by Ms. Kilpatrick, seconded by Topah Spoonhunter, and unanimously passed to approve the revised NIHD Policy and Procedure titled: *Charge Capture Policy and Procedure* as presented.
DISCUSSION OF EXISITING BOARD COMMITTEE'S	Ms. Veenker opened discussion on the subject of existing Board Committees. Director Turner and Director Veenker were appointment to the Governance Committee. Additional Board participant committees will be discussed at the next Regular Board Meeting.
RECOMMENDATION TO APPOINT A BOARD MEMBER TO THE COMPLIANCE AND BUSINESS ETHICS COMMITTEE	Ms. Davis called attention to the need to select a NIHD Board Member to serve on the Compliance and Ethics Committee. A discussion took place, the Board then proposed to have Ms. Veenker continue to serve on this committee. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve to appoint Ms. Veenker to serve on the Compliance and Business Ethics Committee as requested by the Board of Directors. No objections were heard.
NORTHERN INYO HEALTHCARE DISITRICT ORTHOPEDIC SERVICES DECEMBER HIGHLIGHT	Ms. Davis provided a brief overview of the Healthy Lifestyle talk "Sports Medicine & You: Helping athletes stay in the game" provided by NIHD Orthopedic physician Dr. Loy that took place December 16 2021.

CHIEF OF STAFF REPORT

On behalf of Chief of Staff Sierra Bourne, MD, Joy Engblade, MD, Chief Medical Officer reported following review and consideration the Medical Executive Committee recommends approval of the following Radiology Privilege Form.

RADIOLOGY PRIVILEDGE FORM

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve the Radiology Privilege form as requested.

MEDICAL EXECUTIVE COMMITTEE REPORT

Doctor Engblade provided a report on the Medical Executive Committee meeting and clarified questions.

_____.

CONSENT AGENDA

Ms. Veenker called attention to the Consent Agenda for this meeting which contained the following items:

1. *Approval of District Board Resolution 22-02, to continue to allow Board meetings to be held virtually.*
2. *Approval of minutes of the December 15, 2021 Regular Board Meeting*
3. *Approval of minutes of the December 29, 2021 Special Board Meeting*
4. *Operating Room Flooring Replacement Update*
5. *Chief Executive Officer Report*
6. *Chief Medical Officer Report*
7. *Chief Nursing Officer Report*
8. *Financials and Statistical reports as of November 30, 2021*
9. *Approval of Policies and Procedures*
   A. *Identity Theft Red Flags Rule Policy*

Ms. Davis introduced NIHD Maintenance Manager, Jason Moxley who provided an updated on the Operating Room Flooring Project and clarified questions for the Board.

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve all nine (9) Consent Agenda items as presented.

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Ms. Veenker additionally asked if any members of the Board of Directors wished to report on any items of interest. No reports were provided.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Ms. Veenker announced that at this time persons in the audience may speak only on items listed on the closed session portion of this meeting. No public comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 6:42 pm Ms. Veenker announced the meeting would adjourn to Closed Session for

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 LAFCO and NIHD v. SNHD, Case No 3-2015-8002247-CY-WM-GDS-Sacramento County.

Ms. Veenker additionally noted that it was not anticipated that an action would be reported out following the conclusion of Closed Session.

RETURN TO OPEN SESSION AND REPORT OF ANY ACTION TAKEN

At 7:08 pm, the meeting returned to Open Session. Ms. Veenker reported that the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 7:09 pm.

_____
Jody Veenker, Chair

Attest: _____
Topah Spoonhunter, Secretary

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: 02/04/2022

Title: **OR FLOORING**

Synopsis: UPDATE

The installation of the flooring in phase 2 is complete. OR 2 will be terminally cleaned during the early morning of 2/7/22. Restocking and re commissioning of OR 2 will take place during the week of 2/7/22. We are expecting to have OR back in service for emergent surgeries by 2/8/22.

Vendors will be back onsite during the week of 2/7/22 to move infection control walls and remove equipment from OR 3 in preparation of phase 3 which will start 2/15/22. We expect the installation of phase 3 to take place during the week of 2/15/22. When phase 3 is complete will start the final phase 4.

Prepared by: Scott Hooker Director of Facilities

Approved by: Kelli Davis, Chief Executive Officer

Pioneer Home Health Care, Inc. (PHHC)

2021 Year End Summary Report for NIHD

Dear NIHD Board Members –

Please see the attached summary of the services we provided in 2021.

1. Admission Analysis by referral source for Home Health services.
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. Personal Care Program (PCP) hours

PROGRAM REPORTS

Home Health Program

Statistics through 12/31/21
226 admits
1,597 visits
26,580 total miles traveled – average 16.64 miles per HH visit
Number of active patients on December 31, 2021 = 20

Patient/visit numbers are down compared to 2020 due to less referrals, this is most likely related to the adjustment to COVID, change of Northern Inyo Hospitals' (NIH) Electronic Medical Record (EMR) called Athena, to the new one called Cerner. This change occurred in May of last year, and because many providers did not know how to send a referral it greatly impacted us. To cope with this situation a concerted effort by NIH employees; Dr. Engblade, Jannalyn Lawrence, the Rural Health Clinic Care Coordination team, NIH IT and others was made to orient the providers on how to send out Home Health orders. Ilah Cavanaugh, Therapy Supervisor and Ruby Allen, Administrator, provided a short presentation to the hospitalists on what is specifically needed for a home health referral, and which type of patients would most benefit from our services. Since then we have seen an increase in the referrals from NIH. We also are working with case management at NIH, on receiving a detailed verbal report from the discharging nurse on each patient being referred to us. This will build better communication between our hospital partners and help to improve continuity of care for our patients. We have been working closely with Rural Health Clinic (RHC) Care Coordination team to provide the best service to our shared patients, as well as aide in the transition from hospital to home. By working with the RHC Care Coordination team we have been able to help a number of patients that have been living on the "fringes" by utilizing creativity and our entire team of skilled nurses, therapists and medical social worker to meet their care needs.

As planned, we have started integrating SHP (our new Oasis scrubber/ analytic assessment tool for home health services) into our current EMR NDoc. Home Health Gold our previous product is still in use until we fully integrate into SHP.

Start of Care admission/educational packets are still being revised and updated, with all clinical team members participating. We have changed our presentation packet utilizing more color, bold captions, less wording, more pictures, and a more "user friendly" version in order to capture the patients' interest. The hopes of our new look will be to gain patient participation, involvement, and compliance which should translate into less ER visits and re-hospitalizations, more home health goals being met, and improved functionality, with better survey results.

Value Based Purchasing (VBP) will be implemented by CMS in 2023, and will be an "add on" to the Patient Driven Grouping Model (PDGM) reimbursement system. It will result in either additions or deficits up to 5% of our reimbursement based on if the patient has made progress, has or hasn't had ER visits, re-hospitalizations, and our survey results. In order to improve participation in the survey, we are completing after discharge phone calls to our patients, in order to assess our services, ask for recommendations on how to improve services, and to encourage completion of the survey.

We are currently preparing for both Home Health and Hospice surveys as they were both last completed in 2019. Survey prep education of all staff members is in process. Our plan is to focus on infection control, and updating our care plans.

Hospice Program

Statistics through 12/31/21

We have served 35 hospice patients and provided 343 home visits this past year
Average length of stay (LOS) = 30.43 days
4,674 total miles traveled – average miles traveled per HOS visit = 12.03
Present number of patients = 3

We are planning to present 2-3 Community Grief Groups for this year. We were able to present two groups last year, along with a "How to Cope with Grief during the Holidays" presentation, as well as our annual Light Up a Life event. With fundraising we are hoping to extend the length of each grief group from 6 to 8 weeks.

Volunteers are still needed to augment the Hospice program. Fundraising will continue to focus on providing more volunteer classes, and volunteer oversight and support. Marga Foote RN has been heading up the volunteers, and assisting in the clerical duties that come with hospice care, bereavement support and volunteer training.

Dr. Boo, one of our hospice medical directors, states he has changed his work schedule, and will now have more time to be involved in Hospice, and we are looking forward to him joining our every other week Interdisciplinary Group (IDG) hospice patient care meetings.

Personal Care Program (PCP)

Statistics through 12/31/21

Present number of active clients is 21
Staffing: currently have 11 caregivers
11,847 hours of caregiving have been given to community members in 2021

The coordinator job hours were reduced from 40 hours a week to 30 hours in an effort to reduce the program overhead.

We have implemented the increased hourly fee for our PCP services; $26/hr, and are now billing for mileage and travel time based on the location of the client. So far so good, as clients have still signed on to this service despite this fee increase.

We are working on a backup system on all PCP billing to ensure accuracy, by having the Billing Coordinator Grace Tanksley double check all outgoing bills for PCP.

The program currently is in need of caregivers, so we continue to advertise using Facebook, the local Inyo Register newspaper, community outreach at Cerro Coso Community College, and word of mouth etc. We have also reached out to Mammoth Hospital and an employment service agency and TIHP.

We continue to receive PCP work through an IMACA grant, and we are now starting to see Kern Regional clients as well through First Choice Solutions.

BENEFITS

Regarding the 401K retirement program; we will be working with Bruce Fox from Fox and Fox who are our retirement fund managers to address the new California state law which requires that all employers offer a retirement plan for all employees. The State has offered a program called Cal Savers, however we plan to do something different by opening up the opportunity to participate in our current 401K plan. We have until June 2022 to put together our plan.

There is a yearly management fee based on the dollar amount which we as a company have put into the 401K. Therefore, it is beneficial to keep only current employees in the 401K plan. How we transition out past employees legally, will be arranged with Bruce Fox. The goal is to reduce our administrative fees for this particular employee benefit where we can.

Workers Comp evaluation by ICW Group: Pioneer was found to be in compliance with all of their recommendations to reduce employee injuries. In the evaluation ICW reported they had nothing to add to our current Illness and Injury Prevention (IIP) program, which is presented to all employees on a quarterly basis. They applauded us for our good workers' comp record, and our efforts to keep all of our employees safe. Additional resources were provided to us to further augment our IIP program.

HUMAN RESOURCE REPORT

Marianne Rogers retired after 30 plus years! She spent the last 6 months of her employment preparing for when she leaves, creating a template of her job, tying up loose ends, and training Holly Mullanix to replace her. We are thankful that Marianne will continue on as a contractor, in order that we may use her on an "as needed" basis. We will celebrate her on her last day, 2/2/22.

We have a new coordinator for the Personal Care Program: Panda Bourelle, CNA. She is very experienced in the home care field, has worked as a PCP attendant herself, and has extensive experience from her employment at Bishop Care Center. We are proud to be working with her in this capacity.

Our Employee Manuel has been updated and all employees have a copy. We are looking at positions that previously were part time and converting them to Per Diem if appropriate. This status change allows the employee to continue to accrue sick time but not PTO or vacation time if they are only available on a limited basis. The concern is that if a part time employee is available only limited hours of the day, or refuses frequent opportunities for work, they should be in the Per Diem work category vs Part Time.

All job descriptions will be reviewed for updates, changes, or additions as time allows.

Will continue with the search for a Clinical Supervisor or Case Manager to round out Nursing.

MISCELLANEOUS FINANCIALS

CARES monies in the amount of $46,966.30 were forgiven, no longer a liability.

Fundraising: $15,040.97 was raised via various yard & bake sales, annual Spring Silent Auction/Breakfast event, Dolly Browns' estate sale, Polar Express movie viewing at Bishop Twin Theater, the Christmas Gift Tree raffle and our annual Light up a Life event. Other miscellaneous donations were received as well.

Charity Care has been updated to include both post and pre-care situations. We have created an application with criteria that must be met in order to be eligible for charity care. This past year, $3,163.67 was expensed to home health charity care.

Saved costs: Marianne's' retirement, no further expenditures are expected on the Employee Manual, and we are looking at increasing the amount employees pay for health insurance benefits for dependents by 10%.

Respectfully submitted by Ruby Allen, Administrator

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

for period ending 12/31/21

	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						1							1
Clinic - Mammoth Lakes Fam Med		2				1							3
Clinic - Rural Health NIH	1	5	2	2	2		4			2	1	2	21
Clinic - SIH				1									1
Clinic - Toiyabe						1				3	1	1	6
Family / Friend / Self								1					1
Hospital - Carson/Tahoe				1	1					1		1	4
Hospital - Glendale Adventist										1			1
Hospital - Loma Linda													0
Hospital - Mammoth Lakes	1	1	2	1		1	1					1	8
Hospital - Northern Inyo	9	6	10	13	8	5	9	8	8	7	8	7	98
Hospital - Renown Medical Center	2	3	3	3	3	4	1	2	2	3	2		28
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - St. Mary's							1						1
Hospital - UCLA Medical Center	1												1
Hospital - USC / Keck Med			1		1				1				3
Hospital - VA													0
Hospital - Other	1	1	1	1	4	1			2	1	1	1	14
Other													0
Physicians' Office Local	2		1					6	1		1		11
Physicians' Office Out-of-Counties	1												1
SNF - Bishop Care Center	2		2	3	1	1	2	1	2			2	16
SNF - Southern Inyo						1							1
SNF - Other	1	1			1					1	1		5
Another HH Agency													0
Workers Comp Insurance													0
Totals	21	19	23	25	21	16	18	18	16	19	15	15	226

S:\PHHC Secure Documents\EFINANCE\Referrals\Referrals 2021.xlsx

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

for period ending 12/31/21

	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				3		1	1	1			2	1	9
Clinic - SIH													0
Clinic - Toiyabe						1	1				1	1	4
Family / Friend / Self													0
Hospital - Carson/Tahoe													0
Hospital - Glendale Adventist													0
Hospital - Loma Linda													0
Hospital - Mammoth Lakes													0
Hospital - Northern Inyo		1			2								3
Hospital - Renown Medical Center			1					1					2
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										1			1
Physicians' Office Local		3			4	1	1		3		1		13
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	3	6	3	3	2	3	1	4	2	34

Pioneer Home Health Care
2021 Home Health Visit Totals

Home Health Visits
through December 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	53	56	29	49	45	50	57	35	41	590
PT	59	62	58	91	61	68	56	58	61	49	67	46	736
OT	10	7	13	15	14	12	19	30	28	15	6	22	191
ST	2	3	2	0	0	4	2	2	4	4	2	0	25
MSW	4	10	7	8	2	3	7	2	3	4	4	1	55
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**141**	**143**	**128**	**167**	**133**	**116**	**133**	**137**	**146**	**129**	**114**	**110**	**1597**
													1597
								Average visits per month =			**133**		
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 December 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	22	21	22	17	24	12	11	25	25	212
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	1	4	2	2	0	0	0	0	0	0	0	9
MSW	0	3	2	4	2	2	3	3	3	1	4	3	30
Aide	0	0	0	0	0	0	0	0	0	0	1	0	1
Chaplain	0	2	10	9	4	9	7	6	7	4	19	14	91
Bereavement	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**3**	**16**	**36**	**37**	**29**	**33**	**27**	**33**	**22**	**16**	**49**	**42**	**343**

Average visits per month = **28.0**

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**

Hospice Volunteer Visits

	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
	1	2	4	5	1	0	0	1	1	4	8	0	27

Hospice Visits - Volunteers

2020	3	2	3	0	4								12
2019	1	0	2	1	1	5	5						**15**
2018	1	4	3	4	3	6	4	7	2	0			34

Pioneer Home Health Care
Personal Care Program Hours

For period ending December 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 @$25.00	469.75	432.92	454.00	486.00	572.00	516.00	539.75	608.50	603.25	611.43	570.59	597.66
PCA Billable Chgs @$25.00	11743.75	10823.00	11350.00	12150.00	14300.00	12900.00	13493.75	15212.50	15081.25	15285.75	14264.75	14941.50

	15-Jul	31-Jul	15-Aug	31-Aug	15-Sep	30-Sep	15-Oct	31-Oct	15-Nov	30-Nov	15-Dec	31-Dec	Annual Totals
PCA Billable Hours @$25.00	574.32	570.25	534.98	571.99	483.32	529.75	512.42	391.00	335.08	288.50	242.50	242.50	**11738.46**
PCA Billable Hours @$26.00									22.33	21.00	32.00	33.00	**108.33**
Total Hours	**574.32**	**570.25**	**534.98**	**571.99**	**483.32**	**529.75**	**512.42**	**391.00**	**357.41**	**309.50**	**274.50**	**275.50**	**11846.79**
PCA Billable Chgs @$25.00	14358.00	14256.25	13374.50	14299.75	12083.00	13243.75	12810.50	9775.00	9137.58	7998.50	6062.50	6062.50	**$ 295,008.08**
PCA Billable Chgs @$26.00											832.00	858.00	**$ 1,690.00**
Total Charges	**14358.00**	**14256.25**	**13374.50**	**14299.75**	**12083.00**	**13243.75**	**12810.50**	**9775.00**	**9137.58**	**7998.50**	**6894.50**	**6920.50**	**$ 296,698.08**

Hours by Month:

January	902.67
February	940.00
March	1088.00
April	1148.25
May	1214.68
June	1168.25
July	1144.57
August	1106.97
September	1013.07
October	903.42
November	666.91
December	550.00
	11846.79

FY2022

Unit of Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Cash, CDs & LAIF Investments	51,541,102	51,660,613	51,218,981	44,626,386	48,069,372	48,192,815
Days Cash on Hand	194	192	192	158	176	174
Gross Accounts Receivable	40,330,632	39,434,879	38,647,332	45,621,898	45,730,808	48,011,063
Average Daily Revenue	497,169	478,408	485,427	486,248	490,359	490,220
Gross Days in AR	81.12	82.43	79.62	93.82	83.82	88.66
Key Statistics						
Acute Census Days	215	170	196	254	306	188
ICU Census Days	0	7	33	11	7	0
Swing Bed Census Days	24	0	0	0	0	0
Total Inpatient Utilization	239	177	229	265	313	188
Avg. Daily Inpatient Census	7.7	5.7	7.6	8.8	10.4	6.1
Emergency Room Visits	783	745	674	766	687	706
Emergency Room Visits Per Day	25	24	22	25	23	23
Observation Days	67	54	56	56	56	67
Operating Room Inpatients	24	23	14	16	21	17
Operating Room Outpatient Cases	107	89	89	82	98	126
Observation Visits	64	54	50	51	45	60
RHC Clinic Visits	2,297	2,743	2,775	3,030	2,707	2,722
NIA Clinic Visits	1,679	1,614	1,699	1,726	1,744	1,557
Outpatient Hospital Visits	8,690	9,250	8,980	9,162	8,728	8,630
Hospital Operations						
Inpatient Revenue	2,774,294	2,563,061	3,193,923	3,361,605	3,958,181	2,404,683
Outpatient Revenue	11,563,898	10,530,380	10,677,079	10,581,296	10,120,970	11,882,529
Clinic (RHC) Revenue	1,074,051	1,155,594	1,126,962	1,206,362	1,137,285	1,136,568
Total Revenue	15,412,242	14,249,034	14,997,964	15,149,263	15,216,437	15,175,508
Revenue Per Day	497,169	459,646	499,932	488,686	507,215	489,533
% Change (Month to Month)		-7.55%	8.76%	-2.25%	3.79%	13.15%
Salaries	2,138,510	2,212,918	2,099,073	2,131,194	2,303,918	2,726,796
PTO Expenses	68,403	67,782	201,732	161,627	383,062	434,307
Total Salaries Expense	2,206,912	2,280,700	2,300,804	2,292,821	2,686,980	3,161,102
Expense Per Day	71,191	73,571	76,693	73,962	89,566	105,370
% Change		3.34%	4.24%	-3.56%	21.10%	8.80%
Operating Expenses	6,882,843	7,013,237	7,294,767	7,804,027	7,724,749	8,310,179
Operating Expenses Per Day	222,027	226,233	243,159	251,743	257,492	268,070
Capital Expenses	36,416	3,000	-	104,159	9,546	403,591
Capital Expenses Per Day	1,175	97	-	3,360	318	13,019
Total Expenses	8,511,732	8,533,790	8,636,587	9,124,560	9,203,811	10,127,813
Total Expenses Per Day	274,572	275,284	287,886	294,341	306,794	341,809
Gross Margin	1,732,096	(81,114)	645,366	(132,062)	(11,789)	(660,853)
Debt Compliance						
Current Ratio (ca/cl) > 1.50	2.13	2.10	2.84	2.78	2.54	2.70
Quick Ratio (Cash + Net AR/cl) > 1.33	1.80	1.73	2.29	2.17	2.07	2.22
Days Cash on Hand > 75	194	192	192	158	176	174

NIHD - Income Statement

FY 2022	FY 2020	FY 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD 2022
Total Net Patient Revenue	76,229,126	86,844,620	8,614,939	6,932,123	7,940,133	7,671,965	7,712,959	7,649,326	46,521,445
IGT Revenues	13,729,686	20,295,927	394,000	1,106,255	530,242	394,000	394,000	2,780,184	5,598,681
Total Patient Revenue	89,958,812	107,140,547	9,008,939	8,038,378	8,470,376	8,065,965	8,106,959	10,429,510	52,120,126
Cost of Services									
Salaries & Wages	26,275,799	27,016,877	2,138,510	2,212,918	2,099,073	2,131,194	2,303,918	2,726,796	13,612,408
Benefits	18,316,171	22,382,407	1,618,760	1,635,349	1,795,655	1,801,576	2,059,894	2,085,215	10,996,448
Professional Fees	19,573,242	22,565,034	1,871,274	1,896,180	1,978,664	2,293,527	1,790,435	1,823,508	11,653,589
Pharmacy	3,105,981	4,035,279	274,517	354,714	344,942	405,802	392,006	380,870	2,152,851
Medical Supplies	4,199,962	4,136,111	277,812	255,157	358,049	369,855	451,788	497,972	2,210,633
Hospice Operations	505,000	-	-	-	-	-	-	-	-
Athena EHR System	1,164,797	1,480,088	112,267	114,869	132,491	112,342	108,392	115,958	696,318
Other Direct Costs	4,813,483	5,810,258	589,703	544,051	585,893	689,732	618,316	679,861	3,707,556
Total Direct Costs	77,954,434	87,426,053	6,882,843	7,013,237	7,294,767	7,804,027	7,724,749	8,310,179	45,029,802
Gross Margin	12,004,378	19,714,494	1,732,096	(81,114)	645,366	(132,062)	(11,789)	(660,853)	1,491,643
Gross Margin %	13.34%	18.40%	20.11%	-1.17%	8.13%	-1.72%	-0.15%	-8.64%	3.21%
									-
General and Administrative Overhead									-
Salaries & Wages	4,681,985	3,906,499	319,290	323,708	319,740	305,823	355,039	412,400	2,036,001
Benefits	4,150,743	3,754,395	283,420	299,665	312,500	243,511	322,152	382,695	1,843,944
Professional Fees	2,337,874	3,978,605	421,033	420,876	222,237	282,805	300,113	462,506	2,109,571
Depreciation and Amortization	4,275,662	4,094,658	370,335	358,995	347,178	358,655	347,192	369,148	2,151,503
Other Administrative Costs	1,412,451	1,396,332	234,811	117,308	140,164	129,739	154,566	190,884	967,472
Total General and Administrative Overhea	16,858,715	17,130,488	1,628,889	1,520,552	1,341,820	1,320,533	1,479,063	1,817,634	9,108,490
Net Margin	(18,584,023)	(17,711,920)	103,207	(1,601,666)	(696,454)	(1,452,595)	(1,490,852)	(2,478,487)	(7,616,847)
Net Margin %	-24.38%	-20.39%	1.20%	-23.10%	-8.77%	-18.93%	-19.33%	-32.40%	-16.37%
Financing Expense	2,362,880	1,413,155	179,672	179,585	176,035	143,658	136,649	101,007	916,606
Financing Income	2,372,608	1,755,654	173,785	173,785	173,785	173,785	173,785	173,785	1,042,708
Investment Income	600,420	387,349	23,766	16,876	20,534	20,443	16,045	27,865	125,528
Miscellaneous Income	1712917.01	1361183.52	172,440	66,574	9,045,548	57,016	80,081	(460)	9,421,199
Net Surplus	(2,531,273)	4,675,038	687,526	(417,762)	8,897,620	(951,010)	(963,590)	401,879	7,654,663