Northern Inyo Healthcare District

Board Packets

November 16, 2022 - Regular Board Meeting

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

November 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 Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom:

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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. Reports from Board Members (*Board will provide this information*)
4. New Business:
   A. Chief Financial Officer Report

   a. Introduction of Northern Inyo Healthcare District Controller, Andrea Mossman *(Board will receive introduction information from Chief Financial Officer)*
   b. Financial Presentation (*Board will receive and consider accepting this report*)

B. Eastern Sierra Emergency Physician Quarterly Report (*Board will receive and consider accepting this report*)

C. New NIHD Foundation Board Member Approval *(Board will consider the approval of a new board member)*

D. NIHD and Pioneer Home Health Care Component Relationship *(Board will discuss historical and future role with Pioneer Home Health Care*

E. Appointment of the CEO Search ADHOC Committee (*Board will consider appointment and approval of the ADHOC Committee*)

5. Chief of Staff Report, Sierra Bourne MD:

   A. Policies (*Board will consider approval of these policies*)
      1. *340B Contract Pharmacy Policy and Procedure*
      2. *340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedure*
      3. *Admission, Documentation, Assessment, Discharge and Transfer of Swing-Bed Patients*
      4. *Admission Procedure of Pediatric Patient*
      5. *Age Related and Population Specific Care*
      6. *Compliance with Information Blocking Rule*
      7. *Death and disposition of Body*
      8. *De-escalation Team*
      9. *Departments That Deliver Nursing Care to Patients*
      10. *Diagnostic Imaging – Patient Priority*
      11. *Education of Patient and Family*
      12. *Evaluation and Assessment of Patients' Nutritional Needs*
      13. *Nursing Care Plan*
      14. *Patient Safety Attendant or 1:1 Staffing Guidelines*
      15. *Recognizing and Reporting Swing Bed Resident Abuse/Neglect*
      16. *Standardized Protocol – Physician Assistant in the Operating Room*
      17. *Swing Bed Patient Restraints*
   B. Medical Executive Committee Meeting Report *(Board will receive this report)*

Consent Agenda

All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.

6. Approval of District Board Resolution 22-17, to continue to allow Board meetings to be held virtually *(Board will consider the adoption of this District Board Resolution)*

7. Approval of minutes of the October 19, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
8. Approval of minutes of the November 3, 2022 Special Board Meeting *(Board will consider the approval of these minutes)*
9. Chief Executive Officer Report (*Board will consider accepting this report*)
10. Chief Nursing Officer Report (*Board will consider accepting this report*)
11. Chief Medical Officer Report (*Board will consider accepting this report*)
12. Compliance Department Quarterly Report (*Board will consider accepting this report*)
13. Pioneer Home Health Quarterly Report *(Board will consider accepting this report)*
14. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*
    A. Automatic and Manual Transfer Switch Testing
    B. Development, Review and Revision P&P

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15. Public comments on closed session items.
16. Adjournment to Closed Session to/for:

    A. Conference with Labor Negotiators; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6)
17. Return to open session and report on any actions taken in closed session.
18. 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
REPORT TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: 10/28/2022

Title: **INTRODUCTION OF NORTHERN INYO HEALTHCARE DISTRICT CONTROLLER, ANDREA MOSSMAN**

Synopsis: The Chief Financial Officer, Stephen DelRossi, will introduce the new NIHD Controller, Andrea Mossman.

Prepared by:

Autumn Tyerman on behalf of CFO, Stephen DelRossi

Title: Board Clerk

Honorable Board Member and Public,

I am honored to introduce Andrea Mossman, CPA, as financial controller for the district. Andrea comes to us from the Healthcare Company of America (HCA), the world's largest for-profit acute care health system, where she was the Associate Chief Financial Officer of two hospitals. Andrea spent 13 years in total with HCA working in Physician Practices and Acute Care hospitals. Andrea is an MBA who holds a Certified Public Accountant (CPA) certificate. Andrea is also a Certified Training Manager – she spent 3 years in a training manager role recruiting and managing accountants, and writing and leading technical accounting training manuals for a department of 150 accountants. We are privileged to have her as part of the district.

Respectfully,

Stephen DelRossi, CFO, MSA

Financial Presentation

Management's Responsibility

Management is responsible for compliance with federal, state, and regional statutes, regulations, and other terms and conditions.

The CFO

The CFO in the senior financial expert of a company. As such, the CFO is responsible for cash flow, financial & strategic planning, analyses, record keeping, purchasing, billing, and other vital financial operations. As the senior executive of finance, the position carries non-delegable responsibilities: chief among these are open and honest conversations with the CEO and Board of Directors; failure to inform either party constitutes gross negligence and renders the aforementioned parties incapable of making the best informed decisions. Further, failure of the CFO to act upon discrepancies and material issues jeopardizes the short and long-term viability of the company, in this case, the district. Unfortunately, Kelli Davis, CEO, & the Board of Directors were placed in this position due to a lack of communications and a failure to act by the former CFO. The following conversation highlights issues that have been discovered since my, Stephen DelRossi, arrival – unfortunately, this list is neither complete nor exhaustive as issues are discovered no less than weekly.

Internal Control

A process effected by those charged with governance, management, and other personnel that is designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations. Internal control over safeguarding of assets against unauthorized acquisition, use, or disposition may include controls relating to financial reporting and operations objectives. (AICPA AU-C Section 315 publication compiled from *Auditing Standards Board Statement on Auditing Standards (SAS) #122, #128, #130, #134, #135, #142*)

A ***deficiency in internal control*** exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. (*Eide Bailly*)

A ***material weakness*** is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements **will not be prevented** or detected and corrected on a timely basis. We consider the deficiencies described in…item 2021-001 to be a material weakness. (*Eide Bailly*)

A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies described in…items 2021-002, 2021-003, and 2021-004, to be significant deficiencies. (*Eide Bailly*)

Audit Material or Significant Findings 2021:

- 2021-001 (also 2020-002): Balance sheet reconciliations (not mitigated prior to September, 2022)
- 2021-002 (also2020-008): Pension administration (not mitigated prior to September, 2022)
- 2021-003 (also 2020-009): Reconciliation of time keeping system with payroll processor (not mitigated prior to September, 2022)
- 2021-004: Timely submittal of Medicare Patient Credit Reports (not mitigated prior to September, 2022)
- 2021-005: Federal award findings and questioned costs (not mitigated prior to September, 2022)
    - *Material Weakness in Internal Control Over Compliance in Activities Allowed or Unallowed and Allowable Costs/Cost Principles*
    - *Material Weakness in Internal Control Over Compliance in Reporting and Material Instances of Noncompliance in Reporting* (*Eide Bailly*)

Generally Accepted Accounting Principles (U.S. GAAP)

"Generally Accepted Accounting Principles (GAAP or US GAAP) are a collection of commonly-followed accounting rules and standards for financial reporting. The specifications of GAAP, which is the standard adopted by the U.S. Securities and Exchange Commission (SEC), include definitions of concepts and principles, as well as industry-specific rules. The purpose of GAAP is to ensure that financial reporting is transparent and consistent… Although its principles work to improve the transparency in financial statements, they do not provide any guarantee that a company's financial statements are free from errors or omissions that are intended to mislead..." *(https://www.cfainstitute.org*)

Significant Accounting Estimates

"Accounting estimates in historical financial statements measure the effects of past business transactions or events, or the present status of an asset or liability. Examples of accounting estimates include net realizable values of inventory and accounts receivable…Accounting estimates in historical financial statements measure the effects of past business transactions or events, or the present status of an asset or liability. Examples of accounting estimates include net realizable values of inventory and accounts receivable. Management is responsible for establishing a process for preparing accounting estimates. Although the process may not be documented or formally applied, it normally consists of [the following]:

a. Identifying situations for which accounting estimates are required;

b. Identifying the relevant factors that may affect the accounting estimate;

c. Accumulating relevant, sufficient, and reliable data on which to base the estimate;

d. Developing assumptions that represent management's judgment of the most likely circumstances and events with respect to the relevant factors;

e. Determining the estimated amount based on the assumptions and other relevant factors;

f. Determining that the accounting estimate is presented in conformity with applicable accounting principles and that disclosure is adequate.

The risk of material misstatement of accounting estimates normally varies with the complexity and subjectivity associated with the process, the availability and reliability of relevant data, the number and significance of assumptions that are made, and the degree of uncertainty associated with the assumptions." (*AU-C Section 342: SAS #57, SAS #113*). "Significant accounting estimates are estimates used for the preparation of the financial statements where accurate, historic amounts and/or information are not available. Financial statements include various estimates, from rather straightforward estimates of the useful lives and residual values of property, plant, and equipment, or the allowance for doubtful debts to complex issues like the fair value of financial instruments or derivatives not traded publicly. Management is responsible for preparing accounting estimates and properly disclosing them, and for maintaining a system of internal control to support reasonable calculations." (*Study.com*)

The methodology used in calculating contractual allowances (amount not allowed via payor for services rendered) and bad debt consists of reviewing accounts determined to be closed. When determining the open or closed status of an account, management established a threshold of $250 – accounts with a balance of less than $250 were used in the calculation for contractual allowances and bad debt allowances. Prior to September, 2022, the last historical lookback was conducted April, 2021; historical lookbacks should be completed no less than twice yearly with the CFO's expectation of quarterly.

Revenue and Expense Recognition

"Accounting Standards Codification (ASC) 606: On May 28, 2014, the Financial Accounting Standards Board (FASB) and International Accounting Standards Board (IASB) jointly issued Accounting Standards Codification (ASC) 606, regarding revenue… ASC 606 provides a uniform framework for recognizing revenue… The old guidance was industry-specific, which created a system of fragmented policies. The updated revenue recognition standard is industry-neutral and, therefore, more transparent. It allows for improved comparability of financial statements with standardized revenue recognition practices across multiple industries. There are five steps needed to satisfy the updated revenue recognition principle:

- Identify the contract with the customer.
- Identify contractual performance obligations.
- Determine the amount of consideration/price for the transaction.
- Allocate the determined amount of consideration/price to the contractual obligations.
- Recognize revenue when the performing party satisfies the performance obligation.

Financial Restatement

The Financial Accounting Standards Board (FASB) defines a restatement as a revision of a previously issued financial statement to correct an error. Restatements are required when it is determined that a previous statement

contains [a] “material” inaccuracy. However, FASB offers minimal guidance in defining materiality. Accountants are responsible for determining whether a past error is “material” enough to need a restatement. The Securities and Exchange Commission (SEC) suggests companies and auditors conduct quantitative and qualitative analysis to identify any errors in prior financial statements. Often, “material” inaccuracies stem from accounting mistakes, noncompliance with generally accepted accounting principles (GAAP) or other frameworks, fraud, misrepresentation or clerical errors. A “material” error affecting part or all of a financial statement often triggers a restatement. Some leading causes for restatements include:

- Recognition errors.
- Income statement and balance sheet misclassifications.
- Complex rules related to acquisitions, investments, revenue recognition and tax accounting. (*BakerTilly.com*)

FY 2022 Restatement

Northern Inyo Healthcare District		
Fiscal Year 2022		
	6/30/20	2022 YTD
Gross Patient Service Revenue		
Inpatient Patient Revenue	2,987,037	38,125,673
Outpatient Revenue	11,789,931	129,361,046
Clinic Revenue	1,292,210	14,406,706
Gross Patient Service Revenue	16,069,178	181,893,425
Deductions from Revenue		
Contractual Adjustments	(7,152,019)	(81,362,648)
Bad Debt	(1,712,866)	(9,582,273)
A/R Writeoffs	(314,527)	(3,036,147)
Other Deductions from Revenue	(4,765,617)	10,295,825
Deductions from Revenue	(13,945,029)	(83,685,243)
Other Patient Revenue		
Incentive Income	0	1,974
Other Oper Rev - Rehab Thera Serv	10,364	148,629
Medical Office Net Revenue	0	0
Other Revenue	10,364	150,603
Net Patient Service Revenue	2,134,512	98,358,785
Cost of Services - Direct		
Salaries and Wages	2,130,467	26,955,174
Benefits	2,118,991	22,309,661
Professional Fees	3,204,545	27,029,033
Pharmacy	499,818	4,294,421
Medical Supplies	809,222	4,323,064
Hospice Operations	0	0
EHR System Expense	218,098	1,543,602
Other Direct Expenses	1,167,346	7,839,306
Total Cost of Services - Direct	10,148,486	94,294,261
General and Administrative Overhead		
Salaries and Wages	300,827	4,097,538
Benefits	3,623,272	7,133,574
Professional Fees	334,404	4,063,113
Depreciation and Amortization	346,201	4,134,640
Other Administative Expenses	411,544	2,209,730
Total General and Administrative Overhead	5,016,248	21,638,594
Total Expenses	15,164,734	115,932,855
Financing Expense	358,369	2,602,830
Financing Income	1,313,294	3,199,828
Investment Income	8,101	185,770
Miscellaneous Income	3,680,946	13,556,981
Net Income	(8,386,250)	(3,234,321)

FY 2023 Restatement

Northern Inyo Healthcare District				
Fiscal Year 2023				
	7/31/2022	8/31/2022	9/30/2022	2023 YTD
Gross Patient Service Revenue				
Inpatient Patient Revenue	3,986,305	3,395,933	1,938,350	9,320,588
Outpatient Revenue	11,474,649	12,619,549	11,643,340	35,737,538
Clinic Revenue	1,112,050	1,281,637	1,298,041	3,691,727
Gross Patient Service Revenue	16,573,004	17,297,119	14,879,730	48,749,853
Deductions from Revenue				
Contractual Adjustments	(9,974,707)	(7,321,894)	(6,081,406)	(23,378,008)
Bad Debt	(1,834,762)	(2,292,073)	110,396	(4,016,438)
A/R Writeoffs	(378,045)	(717,468)	(739,907)	(1,835,419)
Other Deductions from Revenue	492,000	(492,000)	72,943	72,943
Deductions from Revenue	(11,695,514)	(10,823,435)	(6,637,974)	(29,156,923)
Other Patient Revenue				
Incentive Income	0	0	0	0
Other Oper Rev - Rehab Thera Serv	5,303	4,367	4,346	14,015
Medical Office Net Revenue	0	0	0	0
Other Revenue	5,303	4,367	4,346	14,015
Net Patient Service Revenue	4,882,793	6,478,050	8,246,101	19,606,944
Cost of Services - Direct				
Salaries and Wages	2,175,027	2,269,022	2,195,439	6,639,487
Benefits	2,008,070	1,759,698	1,801,034	5,568,802
Professional Fees	2,373,943	2,061,702	3,102,063	7,537,708
Pharmacy	211,326	671,932	54,166	937,424
Medical Supplies	315,752	290,221	578,033	1,184,006
Hospice Operations	0	0	0	0
EHR System Expense	107,979	220,753	220,408	549,140
Other Direct Expenses	546,374	667,228	808,934	2,022,536
Total Cost of Services - Direct	7,738,472	7,940,556	8,760,076	24,439,104
General and Administrative Overhead				
Salaries and Wages	360,265	365,276	370,478	1,096,019
Benefits	356,264	312,157	316,570	984,991
Professional Fees	565,435	242,300	410,987	1,218,722
Depreciation and Amortization	318,087	332,153	334,828	985,068
Other Administative Expenses	79,314	164,310	199,143	442,767
Total General and Administrative Overhead	1,679,363	1,416,196	1,632,007	4,727,566
Total Expenses	9,417,836	9,356,752	10,392,082	29,166,670
Financing Expense	183,196	182,350	180,796	546,342
Financing Income	64,203	431,229	247,716	743,147
Investment Income	74,115	23,389	(18,154)	79,351
Miscellaneous Income	59,508	60,051	73,544	193,103
Net Income	(4,520,413)	(2,546,383)	(2,023,671)	(9,090,467)

Balance Sheet

Balance Sheet FY 2023				
	Prior Year Balances	**July 2022**	**August 2022**	**Sept 2022**
Assets				
Current Assets				
Cash and Liquid Capital	9,223,997	8,260,905	9,033,146	7,095,805
Short Term Investments	26,808,421	24,254,218	24,248,339	21,741,818
PMA Partnership	-	-	-	-
Accounts Receivable, Net of Allowance	24,367,758	21,409,786	19,693,748	20,999,337
Other Receivables	127,648	653,090	824,130	1,887,427
Inventory	3,145,539	3,116,641	3,111,028	3,075,988
Prepaid Expenses	1,318,137	1,842,961	1,808,098	1,708,822
Total Current Assets	64,991,500	59,537,601	58,718,490	56,509,196
Assets Limited as to Use				
Internally Designated for Capital Acquisitions	-	-	-	-
Short Term - Restricted	1,953,496	2,044,212	2,044,299	2,044,383
Limited Use Assets				
LAIF - DC Pension Board Restricted	639,041	747,613	753,493	760,014
DB Pension	14,044,924	14,044,924	14,044,924	14,044,924
PEPRA - Deferred Outflows	-	-	-	-
PEPRA Pension	-	-	-	-
Total Limited Use Assets	14,683,965	14,792,537	14,798,417	14,804,938
Revenue Bonds Held by a Trustee	1,111,723	1,105,984	1,100,247	1,090,633
Total Assets Limited as to Use	17,749,184	17,942,733	17,942,963	17,939,954
Long Term Assets				
Long Term Investment	2,274,315	2,274,959	2,777,201	2,741,517
Fixed Assets, Net of Depreciation	77,253,188	76,967,404	76,801,899	77,108,738
Total Long Term Assets	79,527,504	79,242,363	79,579,100	79,850,255
Total Assets	162,268,187	156,722,697	156,240,553	154,299,405
Liabilities				
Current Liabilities				
Current Maturities of Long-Term Debt	2,606,169	2,575,534	2,549,958	2,524,301
Accounts Payable	4,848,604	3,993,933	5,404,967	5,504,922
Accrued Payroll and Related	4,977,342	5,908,449	6,822,949	6,615,701
Accrued Interest and Sales Tax	99,832	145,639	252,061	321,777
Notes Payable	2,133,708	2,133,708	2,133,708	2,133,708
Unearned Revenue	2,534,074	1,299,762	607,290	607,290
Due to 3rd Party Payors	-	-	-	-
Due to Specific Purpose Funds	-	-	-	-
Other Deferred Credits - Pension	2,146,080	2,146,080	2,146,080	2,146,080
Total Current Liabilities	19,345,808	18,203,104	19,917,013	19,853,780
Long Term Liabilities				
Long Term Debt	33,455,947	33,455,947	33,455,947	33,455,947
Bond Premium	240,908	237,771	234,634	231,497
Accreted Interest	16,725,130	16,820,264	16,915,399	17,010,533
Other Non-Current Liability - Pension	47,950,740	47,950,740	47,950,740	47,950,740
Total Long Term Liabilities	98,372,724	98,464,722	98,556,720	98,648,717
Suspense Liabilities	-	-	-	-
Uncategorized Liabilities	425,933	451,476	709,722	763,396
Total Liabilities	118,144,465	117,119,302	119,183,454	119,265,892
Fund Balance				
Fund Balance	44,848,874	41,614,553	41,614,553	41,614,553
Temporarily Restricted	2,509,169	2,509,255	2,509,342	2,509,426
Net Income	(3,234,321)	(4,520,413)	(7,066,796)	(9,090,467)
Total Fund Balance	44,123,722	39,603,395	37,057,099	35,033,513
Liabilities + Fund Balance	162,268,187	156,722,697	156,240,553	154,299,405

	FYE 2022	Jul-22	Aug-22	Sep-22	FYE 2023	Total
Net Income prior to adjustments	**5,455,430**	**(3,624,839)**	**(1,431,081)**	**(7,756,271)**	**(12,812,191)**	**(7,356,761)**
Provider Relief Claim	3,065,371				-	
IGT reduction (correction of AR)	(8,371,430)				-	
Bad Debt Entry Error		(1,379,208)			(1,379,208)	
Medicaid Contractual Rate Correction				4,544,349	4,544,349	
Other AR Adjustments	85,347				-	
Pension True-up to Actuary Report	(3,346,115)				-	
Other Expense Accrual Adjustments	(122,924)	483,634	(1,115,302)	1,188,646	556,979	
Total Adjustments	**(8,689,751)**	**(895,574)**	**(1,115,302)**	**5,732,995**	**3,722,120**	**(4,967,631)**
Adjusted Net Income	**(3,234,321)**	**(4,520,413)**	**(2,546,383)**	**(2,023,276)**	**(9,090,071)**	**(12,324,392)**

*credits are unfavorable (reduce) to net income

NIHD Statistics	Jul Totals		Aug Totals		Sept Totals	
	Total	**Total w/o NB**	**Total**	**Total w/o NB**	**Total**	**Total w/o NB**
Inpatient Days						
Total Patient Days	**246**	**220**	**207**	**178**	**139**	**130**
Total Admits	**93**	**77**	**76**	**62**	**62**	**56**
Total Discharges	**90**	**76**	**81**	**66**	**60**	**54**
ADC (average daily census)	8	7	7	6	5	4
Inpatient Hospital Gross Revenue		3,986,305		3,395,933		1,938,350
Outpatient Hospital Gross Revenue		11,474,649		12,619,549		11,643,340
Total Gross Hospital Revenue		15,460,954		16,015,482		13,581,690
OP (Outpatient) Factor		4		5		7
Adjusted Admissions		299		292		392
Adjusted Patient Days		853		839		911
Adjusted ADC		28		27		30
Patient Days by Financial Class						
Blue Cross	53	49	60	41	24	19
Commercial	18	17	8	8	8	7
Medicaid	5	5	5	5	3	3
Medi-Cal	34	24	2	2	9	9
Medi-Cal Managed Care	46	35	21	14	32	29
Medicare	86	86	105	105	58	58
Medicare Advantage	-	-	3	3	-	-
Self Pay	4	4	3	-	5	5
Veterans Administration	-	-	-	-	-	-
Worker's Compensation	-	-	-	-	-	-
Admissions by Financial Class						
Blue Cross	16	13	26	17	14	11
Commercial	7	6	4	4	3	2
Medicaid	2	2	2	2	2	2
Medi-Cal	16	11	2	2	3	3
Medi-Cal Managed Care	23	16	12	8	18	16
Medicare	28	28	27	27	20	20
Medicare Advantage	-	-	2	2	-	-
Self Pay	1	1	1	-	2	2
Veterans Administration	-	-	-	-	-	-
Worker's Compensation	-	-	-	-	-	-
Discharges by Financial Class						
Blue Cross	15	13	28	18	14	11
Commercial	7	6	3	3	4	3
Medicaid	2	2	1	1	2	2
Medi-Cal	13	9	5	4	2	2
Medi-Cal Managed Care	24	17	12	8	16	15
Medicare	28	28	30	30	20	20
Medicare Advantage	-	-	2	2	-	-
Self Pay	1	1	-	-	2	1
Veterans Administration	-	-	-	-	-	-
Worker's Compensation	-	-	-	-	-	-
Surgery						
Surgeries - IP	**29**		**30**		**6**	
Surgeries - OP	**105**		**97**		**74**	
Total Surgeries	**134**		**127**		**80**	

Surgery Minutes - IP	**1,788**	**1,424**	**418**
Surgery Minutes - OP	**3,890**	**4,076**	**2,882**
C-Section Deliveries	**7**	**7**	**2**
Anesthesia Minutes - IP	**2,854**	**2,433**	**674**
Anesthesia Minutes - OP	**6,144**	**6,373**	**4,765**
Outpatient Visits **OP Visits Include: (Includes Observation, Imaging, Rehab, ED, Clinic)			
Total Outpatient Visits	**8,185**	**8,966**	**8,422**
Blue Cross	2,690	2,882	2,728
Charity	-	-	-
Client	105	108	98
Commercial	524	563	494
Indian Beneficiary	-	-	-
Medicaid	46	53	48
Medi-Cal	321	286	354
Medi-Cal Managed Care	1,248	1,395	1,327
Medicare	2,752	3,168	2,862
Medicare Advantage	122	144	140
Other	11	10	3
Self Pay	231	208	214
Veterans Administration	19	14	24
Worker's Compensation	116	135	130
Clinic Visits			
Rural Health Clinic Visits	**2,249**	**2,562**	**2,431**
Blue Cross	837	921	871
Charity		-	-
Commercial	177	189	158
Medicaid	10	9	12
Medi-Cal	102	89	124
Medi-Cal Managed Care	348	476	448
Medicare	645	745	687
Medicare Advantage	25	39	22
Other		-	1
Self Pay	84	72	79
Veterans Administration	5	3	5
Worker's Compensation	16	19	24
Total NIA Clinic Visits	**1,493**	**1,693**	**1,623**
Bronco Clinic Visits	-	4	40
Internal Medicine Clinic Visits	358	436	389
Orthopedic Clinic Visits	301	346	322
Pediatric & Allergy Clinic Visits	456	528	528
Specialty Clinic Visits	235	237	271
Surgery Clinic Visits	100	109	39
Virtual Care Clinic Visits	43	33	34
Total Clinics	**3,742**	**4,255**	**4,054**
DI Exams			
Bone Density	40	46	51
Computed Tomography	381	380	368
General Diagnostic	879	935	896
Magnetic Resonance Imaging	101	166	134
Mammography	131	195	157
Nuclear Cardiac	15	20	11
Nuclear Medicine	12	8	11
Ultrasound	343	347	363

Vascular Ultrasound	58		62		54	
Total Exams	**1,960**		**2,159**		**2,045**	
ED Visits						
ED Visits per day	29		25		26	
ED Visits - OP	841		739		727	
ED Visits - Admitted to IP	57		46		47	
ED Left W/O Being Seen	11		5		5	
Total ED Visits	**898**		**785**		**774**	
Blue Cross	229		155		170	
Charity	-		-		-	
Commercial	94		58		69	
Medicaid	20		18		13	
Medi-Cal	88		58		70	
Medi-Cal Managed Care	189		189		173	
Medicare	181		204		185	
Medicare Advantage	20		15		18	
Other	-		-		1	
Self Pay	58		54		53	
Veterans Administration	3		3		4	
Worker's Compensation	16		31		18	
Outpatient Nursing Visits						
Infusion	157		180		123	
Injection	54		57		53	
Multiple Services	1					
Wound Care	49		62		68	
Total OP Nursing Visits	**261**		**299**		**244**	
Rehab Visits						
Occupational Therapy	89		89		70	
Physical Therapy	561		561		585	
Speech Therapy	88		88		57	
Total Rehab Visits	**738**		**738**		**712**	
Other Hospital Statistics						
Observation Days	**71**		**73**		**79**	
Observation Visits	**78**		**75**		**67**	
Observation Hours	**1,707.19**		**1,755.72**		**1,897.05**	
Blue Cross	224.96		370.95		287.56	
Charity	-		-		-	
Commercial	246.03		75.74		235.78	
Medicaid	64.20		64.23		90.36	
Medi-Cal	129.91		27.12		37.02	
Medi-Cal Managed Care	220.79		284.51		270.47	
Medicare	798.26		716.53		930.81	
Medicare Advantage	23.04		162.83		45.04	
Other	-				-	
Self Pay	-		53.81		-	
Veterans Administration	-		-		-	
Worker's Compensation	-		-		-	
Hours of Inservice Nursing Ed						
Meals Served - Cafeteria	**6,794**		**6,296**		**6,570**	
Employee GL Ending Balance						
Visitor GL Ending Balance						
Meals Served - Dietary	**915**		**1,073**		**793**	
Meals Served - Total	**7,709**		**7,369**		**7,363**	

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

Date: October 30th, 2022

Title: **Quarterly Report: Eastern Sierra Emergency Physicians (ESEP)**

Synopsis: The purpose of this report is to provide the Northern Inyo Healthcare District Board of Directors with an update on the clinical and operational activity of Eastern Sierra Emergency Physicians. A brief outline of the report is listed below. The report will be presented by Dr. Adam Hawkins in person at the scheduled board meeting on November 16th.

Recruitment: The Hospitalist and Emergency Medicine Departments remain fully staffed at this time. The Emergency Department has welcomed a few new faces since the last quarterly report. Dr. Hawkins will provide an update on the current staffing levels and physician recruitment.

Hospitalist Program: Dr. Hawkins will provide a brief update on clinical areas of focus within the Hospitalist Department. These include: improving the medication reconciliation process, as well as implementing an initiative to improve pneumococcal and influenza vaccination rates offered to our inpatients. Additionally, Dr. Atashi Mandal has taken over as Chair of the Pharmacy and Therapeutic Committee. This committee has broad oversight and oversees complex protocols across a wide-range of interdisciplinary departments. Dr. Mandal takes over this role from Dr. Hathaway who served as the chair of the P&T committee for many years. These are big shoes to fill but Dr. Mandal has hit the ground running. ESEP is very proud of the job she is doing and we look forward to continued leadership from this committee.

Hospital Medicine Clinic: The Hospitalist Medicine Clinic continues to operate with a dynamic eye towards how it can function to best serve the needs of The District. Dr. Hawkins to provide a brief update on newly adopted workflow and interdisciplinary partnerships as it pertains to the HMC.

Medication-Assisted Treatment (MAT) Program: Dr. Anne Goshgarian continues to spearhead an essential program to provide harm reduction and vital resources to a particularly vulnerable patient population within our community. Dr. Hawkins to provide a brief update on the latest initiatives and areas of emphasis at the Medication-Assisted Treatment Program.

Emergency Medicine Program: Dr. Hawkins will provide a brief update on clinical areas of focus within the Emergency Department. These include continued monitoring of sepsis management and procedural sedation. Additionally, the physician leadership within the ER has worked with an interdisciplinary leadership panel at NIH to advocate for the reintroduction of a medication called Droperidol to our hospitals formulary.

Prepared, Reviewed and Approved by:

J. Adam Hawkins, DO
Chief, Chair Emergency Department Northern Inyo Hospital
President, Eastern Sierra Emergency Physicians

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

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

Date: 09/26/2022

Title: **NEW FOUNDATION BOARD MEMBER APPROVAL**
(Carry over item)

Synopsis: It is recommended that the Board of Directors vote to approve a new Foundation board member nominated by the current membership of the Foundation board. Please review her background sheet for insight into her credentials to serve on the Foundation.

Prepared by: Greg Bissonette, Foundation Executive Director

Approved by: Kelli Davis
Kelli Davis, CEO

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

Date: October 31, 2022

Title: **NORTHERN INYO HEALTHCARE DISTRICT (NIHD) AND PIONEER HOME HEALTH CARE (PHHC) COMPONENT RELATIONSHIP RESTRUCTURE – REQUEST FOR THE FORMATION OF AN AD HOC COMMITTEE**

Synopsis: In 2018, NIHD became the sole corporate member in PHHC. As community health care partners, 4-years of support through peer engagement and resource stabilization has proven successful to date for PHHC.
PHHC Board of Directors and Administration is requesting consideration of dissolution of the NIHD sole corporate member role and a return to PHHC's pre-2018 structure.

Request: Approval of the formation of an Ad Hoc Board Committee to work with NIHD Administration and legal (BBK Law). This Committee will review and consider necessary changes and make a recommendation to the NIHD Board.

Prepared by: _____
Kelli Davis
CEO

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

Date: 11/9/2022

Title: **CEO SEARCH ADHOC COMMITTEE FORMATION AND DESIGNATION**

Synopsis: It is recommended that the Board of Directors approve the formation of and designate members of the CEO Search ADHOC Committee.

Prepared by: _____
Marjorie Routt
Human Resources Manger

Approved by: _____
Name
Title

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: November 1, 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. Policies (*action item*)
   1. *340B Contract Pharmacy Policy and Procedure*
   2. *340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedure*
   3. *Admission, Documentation, Assessment, Discharge and Transfer of Swing-Bed Patients*
   4. *Admission Procedure of Pediatric Patient*
   5. *Age Related and Population Specific Care*
   6. *Compliance with Information Blocking Rule*
   7. *Death and disposition of Body*
   8. *De-escalation Team*
   9. *Departments That Deliver Nursing Care to Patients*
   10. *Diagnostic Imaging – Patient Priority*
   11. *Education of Patient and Family*
   12. *Evaluation and Assessment of Patients' Nutritional Needs*
   13. *Nursing Care Plan*
   14. *Patient Safety Attendant or 1:1 Staffing Guidelines*
   15. *Recognizing and Reporting Swing Bed Resident Abuse/Neglect*
   16. *Standardized Protocol – Physician Assistant in the Operating Room*
   17. *Swing Bed Patient Restraints*

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

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: 340B Contract Pharmacy Policy and Procedure		
Owner: Acting Director of Pharmacy	Department: Pharmacy	
Scope: Pharmacy, Finance Department		
Date Last Modified: 05/06/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/19/2016	

PURPOSE:
This policy is intended to ensure that Northern Inyo Healthcare District (NIHD), which participates in the HRSA 340B Drug Pricing Program Contract Pharmacy Services, remains compliant with applicable 340B Federal laws and regulations. As such, this policy should not be interpreted or implemented in a manner that would contradict any such law.

BACKGROUND:
Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign a pharmaceutical pricing agreement (PPA) with the Secretary of Health and Human Services. This agreement limits the price that manufacturers may charge certain covered entities for covered outpatient drugs. The 340B Program is administered by the Federal Health Resources and Services Administration (HRSA) in the Department of Health and Human Services (DHHS). Upon registration on the HRSA/OPAIS 340B Database as a participant in the 340B Program, the entity: Agrees to abide by specific statutory requirements and prohibitions and may access 340B drugs.

POLICY:
This policy is intended to ensure that Northern Inyo Healthcare District (NIHD), which participates in the HRSA 340B Drug Pricing Program Contract Pharmacy Services, remains compliant with applicable 340B Federal laws and regulations.

DEFINITIONS:
340B Eligible Provider: A Healthcare Professional who is either employed by the covered entity or provides healthcare under contractual or other arrangement, such as a referral for consultation for instance (e.g., a physician specialty practice)
340B Eligible Location: An onsite or offsite service area or facility (location) that is an integral part of a 340B hospital covered entity, as evidenced by the fact that it has reimbursable outpatient revenue and expense allocated to the hospital's Medicare Cost report.

- New locations that are not yet registered with OPA, but that are either (i) listed on the CE's most recently-filed Medicare cost report with reimbursable outpatient costs and charges or (ii) will be listed with such on the next filed MCR, are 340B Eligible Locations where 340B drugs can be purchased and/or used.
- Offsite 340B Eligible Locations shall be registered with OPA as soon as possible once listed on the hospital's MCR. All clinics/services of an offsite 340B Eligible Location must be registered as a child site, regardless of whether they are in the same offsite building.

- Expanded care delivery location at same physical address of CE's registered location (parent hospital) will be considered 340B eligible. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion of emergency departments into parking lots.
- Expanded care delivery location of a hospital child-site location of CE will be considered 340B eligible if the care delivered represents an expansion of the currently registered services, falling on the same Medicare Cost Report Line and Trial Balance department code. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion of emergency departments into parking lots.
- An expanded care delivery location might also include mobile delivery care units which have cost and revenue on a reimbursable line of the cost report.

Contract Pharmacy: A pharmacy other than the covered entity's inpatient pharmacy with which the covered entity has contracted to provide comprehensive pharmacy services to 340B eligible patients utilizing covered outpatient drugs purchased under the 340B Drug Pricing Program.

Contract Pharmacy Arrangement: An agreement with a pharmacy other than the covered entity's inpatient pharmacy with which the covered entity has contracted to provide comprehensive pharmacy services to 340B eligible patients utilizing 340B purchased covered outpatient drugs.

Covered Entity: A hospital or other facility enrolled in the 340B Drug Pricing Program and eligible to purchase covered outpatient drugs for 340B eligible patients through the program at 340B prices.

Diversion Prohibition: The prohibition against the resale or transfer of covered outpatient drugs purchased under the 340B Pricing Program to anyone other than a 340B eligible patient of a Covered Entity.

Duplicate Discount Prohibition: The prohibition against subjecting a manufacturer to providing both a drug at a discounted price under the 340B Pricing Program and also to providing a rebate for the drug under Title XIX of the Social Security Act (Medicaid).

Healthcare Professional: Physicians, mid-level practitioners (e.g., advance nurse practitioner, physician assistants), nurses, pharmacists, respiratory therapists, and other licensed professionals who are trained to provide healthcare to patients.

Health Resources Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services that is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated or medically vulnerable.

In-House Pharmacy: A pharmacy that is owned by, and a legal part of, the 340B entity. Typically, in-house pharmacies are listed as shipping addresses of the entity and the entity owns the pharmacy license.

Office of Pharmacy Affairs (OPA): The component within HRSA that administers the 340B Drug Pricing Program. The Office of Pharmacy Affairs is located within HRSA's Special Programs Bureau.

PROVISIONS:

1. As a covered entity participating in the 340B Drug Pricing Program, NIHD will adhere to all applicable federal, state, and local laws and requirements.
2. NIHD uses any savings generated from 340B in accordance with 340B Program intent.
3. Contract Pharmacy Arrangement: NIHD will establish a contract pharmacy arrangement with each contract pharmacy and will provide comprehensive pharmacy services to 340B eligible patients of NIHD.

3.1. Each contract pharmacy arrangement will include a current written agreement between the covered entity and the one or more applicable contract pharmacies that includes HRSA's suggested contract provisions and that specifies the responsibilities/duties of each party with respect to the provisions of this procedure and the comprehensive pharmacy services provided by the contract pharmacy.

3.2. Covered Entity will maintain auditable records demonstrating compliance.

3.3. Covered entity will register each contract pharmacy arrangement on-line during open registration and attest that each arrangement is active during each recertification period.

4. NIHD will remain responsible for all 340B covered outpatient drugs purchased through a contract pharmacy and for adhering to the 340B Contract Pharmacy Policy and Procedure and corresponding 340B Auditing Guide to ensure that at least the following requirements are met:

4.1. Diversion prohibition: only 340B eligible patients of the NIHD will receive 340B purchased drugs from a contract pharmacy.

4.2. Duplicate discount prohibition: manufacturers will not be subjected to duplicate discounts for 340B purchased drugs.

4.3. Contract Pharmacy with multiple covered entities: If a contract pharmacy has more than one different covered entity that it has contracted with, appropriate steps will be taken to ensure duplicate 340B processing does not occur.

5. Procurement/drug shipping and billing: a "ship to, bill to" process will be used for providing 340B purchased drugs to each contract pharmacy. Under this process, NIHD will purchase covered outpatient drugs at 340B prices from manufacturers/wholesalers. Each manufacturer/wholesaler will bill NIHD for the 340B purchased but ship the drugs directly to the contract pharmacy.

5.1. In accordance with its written contract with NIHD, the contract pharmacy will compare all shipments of 340B purchased drugs received by the contract pharmacy to orders for the drugs and inform NIHD of any discrepancies.

6. To ensure ongoing compliance with the provisions set forth in this policy and the 340B Contract Pharmacy Procedure, NIHD will perform regularly scheduled audits.

7. NIHD will remain aware of, and adhere to, anti-kickback provisions of the Medicare and Medicaid Anti-Kickback statute.

8. Diversion prohibition: NIHD will collaborate with each contract pharmacy to ensure that 340B purchased drugs are not provided to patients who are not 340B Eligible Patients (diversion). This collaboration will include:

8.1. NIHD and the contract pharmacy establishing a verification system for qualifying hospital/clinic claims.

8.2. The contract pharmacy regularly provides NIHD with auditable customary business records. The contract pharmacy, with the assistance of the covered entity will establish and maintain a tracking system that is suitable for auditing for diversion, as set forth below.

8.3. NIHD and the contract pharmacy establishing a tracking system and utilizing the tracking system and/or contract pharmacy's customary business records to periodically audit for diversion, in accordance with the 340B Audit Guide, by comparing prescribing records of the covered entity with dispensing records of the contract pharmacy to identify any irregularities.

9. Duplicate Discount:

9.1. NIHD will collaborate with each contract pharmacy to ensure that manufacturers are not be subjected to duplicate discounts for 340B purchased drugs. This collaboration will include establishing a system for

carving-out Medicaid claims to ensure that 340B purchased drugs are not dispensed when Medicaid is a payer unless the covered entity, HRSA, and the state have an arrangement to prevent duplicate discounts.

9.2. NIHD utilizes the tracking system and/or contract pharmacy's customary business records to periodically audit for duplicate discounts, in accordance with the 340B Audit Guide.

10. Inventory Management:

10.1. A replenishment model using an 11-digit to 11-digit NDC match is used by each contract pharmacy.

REFERENCES:

1. Apexus: https://www.apexus.com/home/
2. Section 340B of the Public Health Service Act ("PHSA"), Section 602 of the Veterans Health Care Act of 1992
3. Federal Register, Vol. 75, No. 43, Friday, March 5, 2010
4. Medicare and Medicaid Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b)
5. Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, Office of Pharmacy Affairs (OPA): *http://www.hrsa.gov/opa/index.html*
6. HRSA's Final Notice Regarding Manufacturer Audit Guideline and Dispute Resolution Process, 61 Fed. Reg. (Dec. 12, 1996), page 65407: *https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/disputeresolutionprocess121296.pdf*

CROSS REFERENCED POLICIES AND PROCEDURES:

1. 340B Hospital and Outpatient Clinic Administered Drugs Policy and Procedure

RECORD RETENTION AND DESTRUCTION:

Contract Pharmacy Agreement must be maintained for the life of the agreement, plus fifteen (15) years.
340B records must be maintained for a minimum of three (3) years.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: 340B Hospital/Outpatient Clinic Administered Drugs Policy and Procedure		
Owner: Acting Director of Pharmacy	Department: Pharmacy	
Scope: Pharmacy, Compliance, Fiscal		
Date Last Modified: 05/09/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/19/2016	

PURPOSE:

This policy and procedure is intended to ensure that Northern Inyo Healthcare District (NIHD), which participates in the HRSA 340B Drug Pricing Program, remains compliant with all applicable 340B federal laws and regulations. As such, this policy and procedure should not be interpreted or implemented in a manner that would contradict any such law. Furthermore, the purpose is to define a systematic approach to protect the integrity of and adherence to the rules and regulations of the Health Resources and Services Administration (HRSA) 340B Drug Pricing Program (340B Program).

SCOPE:

This policy and procedure is applicable to Northern Inyo Healthcare District's participation in the 340B drug pricing program, which provides 340B covered outpatient drugs to its outpatients. This document includes guidelines for managing 340B drug purchasing and compliance at NIHD.

DEFINITIONS:

340B Drug Pricing Program: The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. Participation in the Program can result in significant savings on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients, and providing more comprehensive services.

340B Eligible Patient: A patient of a covered entity that meets HRSA's definition of a patient. A 340B Eligible Patient may receive 340B purchased covered outpatient drugs while admitted as an outpatient of a covered entity and/or after receiving treatment and being discharged from the covered entity.

HRSA's definition of a patient requires that (1) the hospital establishes a relationship with the individual, such that the covered entity maintains records of the individual's healthcare; and (2) the individual receives healthcare services from a healthcare professional who is either employed by the covered entity or provides healthcare under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the hospital.

340B Price: The maximum price for a covered outpatient drug that manufacturers can charge covered entities participating in the 340B drug pricing program.

340B Eligible Provider: A Healthcare Professional who is either employed by the covered entity or provides healthcare under contractual or other arrangement, such as a referral for consultation for instance (e.g., a physician specialty practice).
340B Purchased Drugs: Covered outpatient drugs purchased by a covered entity under the 340B Drug Pricing Program.
340B Eligible Location: An onsite or offsite service area or facility (location) that is an integral part of a 340B hospital covered entity, as evidenced by the fact that it has reimbursable outpatient revenue and expense allocated to the hospital's Medicare Cost report.

- New locations that are not yet registered with OPA, but that are either (i) listed on the CE's most recently-filed Medicare cost report with reimbursable outpatient costs and charges or (ii) will be listed with such on the next filed MCR, are 340B Eligible Locations where 340B drugs can be purchased and/or used.
- Offsite 340B Eligible Locations shall be registered with OPA as soon as possible once listed on the hospital's MCR. All clinics/services of an offsite 340B Eligible Location must be registered as a child site, regardless of whether they are in the same offsite building.
- Expanded care delivery location at same physical address of CE's registered location (parent hospital) will be considered 340B eligible. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion of emergency departments into parking lots.
- Expanded care delivery location of a hospital child-site location of CE will be considered 340B eligible if the care delivered represents an expansion of the currently registered services, falling on the same Medicare Cost Report Line and Trial Balance department code. Examples may include but are not limited to conversion of non-clinical areas to patient care areas and expansion of emergency departments into parking lots.
- An expanded care delivery location might also include mobile delivery care units which have cost and revenue on a reimbursable line of the cost report.

Contract Pharmacy: A pharmacy that is not owned by the covered entity with which the covered entity has a written contract to provide services to the covered entity's patients, including the service of dispensing covered entity-owned 340B drugs.
Contract Pharmacy Arrangement: An arrangement in which a 340B covered entity signs a contract with a contract pharmacy to provide pharmacy services.
Covered Entity: A hospital or other facility enrolled in the 340B Drug Pricing Program and eligible to purchase covered outpatient drugs for 340B eligible patients through the program at 340B prices.
Covered Outpatient Drug: A drug defined in Section 1927(k) of the Social Security Act (42 USC § 1396r–8(k) that may be purchased, with certain possible exceptions, by covered entities under the 340B Drug Pricing Program.
Diversion Prohibition: The prohibition against the resale or transfer of covered outpatient drugs purchased under the 340B Pricing Program to anyone other than a 340B eligible patient of a Covered Entity.
Duplicate Discount Prohibition: The prohibition against subjecting a manufacturer to providing both a drug at a discounted price under the 340B Pricing Program and also to providing a rebate for the drug under Title XIX of the Social Security Act (Medicaid).
Healthcare Professional: Physician, Nurse Practitioner, Physician assistant, Registered Nurse, Pharmacist, Respiratory Therapists and other licensed professionals who are trained to provide healthcare to patients.
Group Purchasing Organization (GPO): An organization that represents and organizes a group of hospitals to evaluate and select pharmaceutical products. Using the purchasing power of the entire group, the GPO negotiates contracts that are more favorable than a single organization could achieve.
Health Resources Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services that is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated or medically vulnerable.

Medicaid Exclusion File: Covered entities are required to designate in the application process whether 340B drugs will be utilized for Medicaid patients. HRSA maintains this information in the Medicaid Exclusion File which is available to state Medicaid programs. The purpose of this file is to exclude 340B drugs from Medicaid rebate requests. This prevents drug manufacturers from providing duplicate discounts – upfront as the 340B drug price and then later as the Medicaid rebate.
Office of Pharmacy Affairs (OPA): The component within HRSA that administers the 340B Drug Pricing Program. The Office of Pharmacy Affairs is located within HRSA's Special Programs Bureau.
Orphan Drug: Those drugs granted a designation by the Food and Drug Administration (FDA) to treat a rare disease or condition, which the law defines as any disease or condition that affects fewer than 200,000 people in the United States or affects more than 200,000 people but drug sales would not cover the costs of developing the drug.

POLICY:

1. Northern Inyo Healthcare District, which is participating in the 340B Drug Pricing Program as a covered entity, will adhere to all applicable 340B federal laws and regulations.

2. Northern Inyo Healthcare District will be responsible for implementing a procedure to ensure compliance with all applicable federal 340B laws and regulations and to ensure that at least the following requirements are met:

2.1. Annual 340B recertification by Northern Inyo Healthcare District is kept current.

2.2. Only 340B Eligible Patients receive 340B purchased drugs to avoid diversion.

2.3. Manufacturers are not subjected to duplicate discounts for 340B drugs purchased by Northern Inyo Healthcare District under the 340B Drug Pricing Program.

2.4. Any drug purchasing restrictions applicable to Northern Inyo Healthcare District are followed. These purchasing restrictions may vary depending on which 340B pricing program Northern Inyo Healthcare District is enrolled under.

2.5. Northern Inyo Healthcare District uses any savings generated from 340B in accordance with 340B Program intent.

2.6. Northern Inyo Healthcare District has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

2.7. Northern Inyo Healthcare District maintains auditable records demonstrating compliance with the 340B Program.

2.7.1. 340B Program related records and transactions are maintained for a period of three years in a readily retrievable and auditable format.

2.7.2. These records are reviewed monthly as part of its 340B oversight and compliance program.

2.7.3. Northern Inyo Healthcare District engages an independent organization to perform audits of its contract pharmacies. Efforts are made to schedule such audits annually, or as close to annually as is reasonably possible.

2.7.4. The 340B Specialist will be responsible for ensuring compliance with the 340B program. Periodic audits of 340B transactions will be conducted by NIHD.

2.8. Northern Inyo Healthcare District will implement a 340B Oversight Team, for oversight and audit response. The Oversight Team will meet on a quarterly basis to assess the covered entity's overall compliance, address and resolve any lapses in compliance, and otherwise oversee the covered entity's participation in the 340B program.

2.8.1. The 340B Oversight Team will include those staff listed in the procedure below.

2.8.2. The team will also include, either as regularly scheduled participants or ad hoc participants, other employees that are identified as being available to respond to a 340B audit from HRSA/OPA or a drug manufacturer (e.g., compliance staff, legal staff, information technology staff).

PROCEDURE:

1. **340B Eligibility**: Northern Inyo Healthcare District is eligible to participate in the 340B Drug Purchasing Program by meeting the following three criteria for inclusion:
   - **1.1.1.** Private non-profit corporation which maintains contract(s) with state or local government for provision of patient services.
   - **1.1.2.** Sole Community Hospital (SCH), Critical Access Hospital (CAH), and Rural Referral Center (RRC) must meet eligibility requirements under 42 USC 256b(a)(4)(L)(i). SCHs and RRCs must also have a disproportionate share adjustment percentage equal to or greater than 8% on the most-recently filed Medicare cost report.

   1.2. 340B eligible clinic/departments of NIHD have cost and revenue allocated to a reimbursable line of the Medicare cost report, to be eligible for 340B purchasing.

   1.3. Orphan Drugs: Certain hospitals, including SCHs, CAHs, and RRCs cannot purchase orphan drugs at a 340B price. However, manufacturers may voluntarily provide discounted pricing for their orphan drugs to SCHs, CAHs, and RRCs.

   1.4. Northern Inyo Healthcare District complies with the following process to review or add new 340B services areas or facilities (locations) in the 340B Drug Purchasing Program:
   - **1.4.1.** Northern Inyo Healthcare District's 340B Authorizing Official evaluates a new service area or facility (location) to determine if the location is 340B eligible. If cost and revenue are allocated to a reimbursable line of the cost report 340B drug may begin to be used at the new hospital outpatient department. Once the Authorizing Official or Primary Contact validates that the location appears as reimbursable on NIHD's most recent Medicare Cost Report, the location will be registered on OPAIS.
   - **1.4.2.** Northern Inyo Healthcare District location eligibility is validated annually with collaboration of Legal, Finance, and Pharmacy. This is accomplished at the time the Medicare Cost Report is finalized and filed.
   - **1.4.3.** The registration of Northern Inyo Healthcare District and its child site locations on the 340B Office of Pharmacy Affairs Information System (OPAIS) is reviewed annually in conjunction with the facility eligibility review. All data on OPAIS is reviewed for accuracy and compliance with guidelines for registration.
   - **1.4.4.** Northern Inyo Healthcare District's Authorizing Official and Primary Contact are responsible for completing the OPAIS online registration during open registration periods only.

2. **Recertification:** Annual 340B recertification by Northern Inyo Healthcare District is kept current.

   2.1. Northern Inyo Healthcare District's Authorizing Official completes the annual recertification by following the directions in the recertification email sent from HRSA to the Authorizing Official prior to the stated deadline.

   2.2. Northern Inyo Healthcare District submits specific recertification questions to 340b.recertification@hrsa.gov.

3. **Patient/Prescriber Eligibility Compliance:**

   3.1. An individual is considered a 340B Eligible Patient of Northern Inyo Healthcare District if:
   - **3.1.1.** NIHD has established a relationship with the individual, which includes maintaining records of the individual's healthcare.
   - **3.1.2.** The individual receives healthcare services from a healthcare professional that is either employed by NIHD or provides healthcare under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the individual's care remains with NIHD.

   3.2. An individual is not considered a 340B Eligible Patient of NIHD if the sole healthcare service rendered is the dispensing or prescribing of a drug for self-administration.

   3.3. NIHD establishes such relationships with 340B Eligible Patients and provides healthcare services by healthcare professionals (e.g., while onsite and/or remotely via telemedicine services) such that it remains

responsible for their care during patient encounters (e.g., in-person and/or remotely via telemedicine services) at a NIHD 340B eligible location(s).

3.4. A 340B Eligible Patient of NIHD is considered qualified for a 340B drug in the following cases:

3.4.1. The patient is a 340B Eligible Patient treated at a 340B Eligible Location and has a legal drug order written by a prescriber employed by, under contract or referral relationship (e.g., physician specialty practice) with NIHD.

3.4.2. The patient is an outpatient at the date/time the drug is administered. Observation patients are classified as outpatients of NIHD.

3.4.3. When a patient's status changes to inpatient, then drugs are not accumulated to the 340B account and are then accumulated to the GPO account.

3.4.4. Retrospective changes to patient status are not taken into account in either direction (i.e., outpatient to inpatient OR inpatient to outpatient).

4. Compliance with Duplicate Discount Prohibition:

4.1. NIHD has mechanisms in place to prevent duplicate discounts by ensuring manufacturers are not subjected to Medicaid rebates for 340B purchased drugs.

4.2. NIHD ensures that its information on OPAIS and the HRSA Medicaid Exclusion File (MEF) is consistent with actual practice. NIHD informs OPA immediately of any changes to its information on OPAIS/MEF.

4.3. Carve-Out: NIHD does not bill Medicaid payers for 340B purchased drugs.

4.3.1. NIHD has answered "no" to the question, "Will the covered entity dispense 340B purchased drugs to Medicaid patients AND subsequently bill Medicaid for those dispensed 340B drugs?" on the HRSA 340B Database.

5. Inventory and Procurement:

5.1. Neutral Inventory:

5.1.1. A virtual GPO-based mixed-use drug inventory is maintained by the hospital pharmacy. Inventory is replenished based on 340B or GPO accumulations processed by NIHD's automated split-billing software system. In operation, patient-specific administered drug charges are sent to the software system daily to be processed. The neutral inventory is replenished on an 11-digit NDC basis with drug order purchases made based on available 340B or GPO accumulations.

5.1.2. Once individual accumulations are used, they are decremented from the bank of available accumulations.

5.1.3. In exceptional circumstances when 11-digit NDC replenishment is not possible (e.g., NDC availability, inner vs. outer NDC packaging), 9-digit NDC level replenishment may be used.

5.1.4. Dispensing staff are not required to make any determinations regarding the drug inventory stock to be utilized when dispensing.

5.2. Direct Purchases:

5.2.1. Covered outpatient drugs not available from the pharmacy wholesaler may be purchased from the manufacturer using a direct account.

5.2.2. Separate 340B accounts can be maintained with each manufacturer to purchase 340B drugs.

5.2.3. For mixed use areas, a GPO account and 340B account (when possible) is established with each source.

5.2.4. Direct purchases will be decremented from the accumulator.

5.3. Crediting and Rebilling:

5.3.1. Credits of purchased drugs and subsequent rebills may be processed in the event a 340B account is utilized for a drug purchase that should have been purchased on a non-340B purchasing account.

5.3.2. NIHD may petition the manufacturer, via the distributor, to credit the non-340B purchasing account and rebill the 340B account. The manufacturer may or may not accept NIHD's request.

5.4. Borrow/Lend:

5.4.1. To minimize complexity and compliance risk, NIHD follows a process of borrowing/lending 340B purchased drugs only in emergent situations and not as part of its normal process for inventory replenishment.

5.4.2. NIHD may borrow from or loan medications to nearby facilities in emergent situations. The transaction will be logged and the same product NDC will be returned by the borrower.

5.5. Returns/Waste:

5.5.1. Patient-Specific Waste: Waste associated with a dosage form of a drug provided (e.g., dispensed, administered) to a patient may be documented and allocated for accumulation and/or purchase based on the patient's eligibility status.

5.5.2. Inventory Waste: Drug inventory which is wasted/disposed may be documented and allocated for re-accumulation and/or purchased based on applicable pricing and purchase history.

6. 340B Oversight:

6.1. The oversight of the 340B Drug Pricing Program is the responsibility of the 340B Oversight Team, which is comprised of the following individuals:

6.1.1. Pharmacy Director

6.1.2. Authorizing Official

6.1.3. Additional staff: Compliance Officer, Executive Team, and 340B Analyst

6.2. The 340B Oversight Group has the following responsibilities:

6.2.1. Setting the general direction and policy for 340B drug purchasing and compliance.

6.2.2. Establishing a 340B program audit plan for NIHD.

6.2.2.1. Ensure that internal and external self-audits are conducted on a regular basis in accordance with the 340B program audit plan.

6.2.3. Meets on a quarterly to review reports, trends and audit results.

6.2.4. Maintaining information on current best practices by sending key NIHD personnel to related conferences and/or training programs (e.g., webinars, teleconferences).

6.2.5. Providing compliance and oversight direction.

6.2.6. Providing appropriate resources.

6.2.7. Determining needed modifications or expansion.

6.2.8. Communication to hospital leadership of potential changes/trends to the 340B program that will impact the institution.

6.2.9. Assessing discrepancy response, including determining whether or not a material breach has occurred.

6.3. Discrepancies:

6.3.1. NIHD acknowledges that it may be liable to an individual manufacturer of a covered outpatient drug that is the subject of a discrepancy, and depending upon the circumstances, may be subject to repayment.

6.3.1.1. **Material Breach:** Discrepancies that are considered material are self-reported to HRSA as a material breach. A material breach is defined as a discrepancy that results in an impact of more than 5% of the total pharmacy spend in a fiscal year and does not self-correct within six (6) months.

7. Competency:

7.1. Pharmacy staff with 340B procurement responsibilities are provided comprehensive training on the 340B Program and the compliance requirements of this program. This training is completed by pharmacy procurement staff initially upon hire and competency is also verified annually.

REFERENCES:

1. Apexus: https://www.apexus.com/home/

2. Section 340B of the Public Health Service Act ("PHSA"), Section 602 of the Veterans Health Care Act of 1992
3. Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, Office of Pharmacy Affairs (OPA): http://www.hrsa.gov/opa/index.html
4. HRSA's Final Notice Regarding Manufacturer Audit Guideline and Dispute Resolution Process, 61 Fed. Reg. (Dec. 12, 1996), page 65407: *https://www.hrsa.gov/sites/default/files/opa/programrequirements/federalregisternotices/disputeresolutionprocess121296.pdf*

CROSS REFERENCED POLICIES AND PROCEDURES:

1. 340B Contract Pharmacy Policy and Procedure

RECORD RETENTION AND DESTRUCTION:

340B records must be maintained for a minimum of three (3) years.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients*		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: Acute/Subacute Unit		
Date Last Modified: 07/21/2022	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHDD Board of Directors	Original Approval Date:	

PURPOSE:

To identify the admission, documentation, assessment, discharge and transfer process for Swing Bed Residents.

POLICY:

1. NIHD has adopted the Medicare concept to allow Critical Access Hospitals (CAH) to interchangeably use acute care beds with subacute care beds called swing bed.
2. NIHD is licensed for 15 swing beds.
3. Medicare reimbursement requires a 3-day qualifying stay in a hospital bed prior to admission to a swing bed. The swing bed stay must fall within the same spell of illness as the qualifying stay.
4. The acute care patient that meets admission criteria to subacute care (swing bed status) is to be discharged from acute care and admitted to swing bed.
5. Priority for admission to swing bed will be given to NIHD acute care patients.
   a. External transfers of Inyo County residents will be considered for admissions based on current swing patient census.
   b. Case Management in collaboration with the House Supervisor and Hospitalist will approve external transfers.

PROCEDURE:

1. Case Management will work with the patient's physician and with the House Supervisor (HS) to determine whether a Medicare patient is eligible for swing bed status. If there is a difference of opinion, the Utilization Review Committee Chairman (or the Chief of Staff) and the CEO will be consulted.
   a. Patients who benefit from the swing bed program are individuals recovering from surgery or illness who require skilled care. The goal of skilled nursing care is to help improve a patient's condition or to maintain their current condition and prevent it from getting worse.
   b. To be admitted to a swing bed, Medicare patients must have a 3-day qualifying stay, have Medicare Part A, and a physician order for swing bed admission.
   c. A Medicare patient is allowed up to 100 days per benefit period for swing bed, as long as criteria are being met.
   d. The patient does not have to physically move to a different bed from the acute setting rather the "swing" process is more of an accounting function that indicates a different level of care.
2. When a Medicare patient has been approved for swing bed admission, the physician will enter discharge orders from acute care and an admission order to swing bed status. Both the acute care admission and

the swing admission must have all aspects of a completed charts including H&P, admission orders, appropriate orders for patient care, discharge orders and a discharge summary.
3. The acute care paper chart will be sent to Medical Records for processing and coding, and a new swing bed chart will be initiated (new visit # will be generated).
4. The admitting office shall be notified by nursing that the patient is to be discharged from acute care and admitted to swing status.
5. Admitting will assign a new visit ID and will complete a swing bed admission packet with the patient or the patient's legal representative.
6. Admitting will obtain signatures on ABN's if indicated.
    a. The primary RN will review Resident's Rights with the patient/family.
7. The Department Clerk notifies the Activities Coordinator of the patient's admission to swing bed status.

Assessment:

1. Physicians will visit swing bed Residents at least every 7 days. The physician will write a progress note at the time of each visit.
2. In addition to the Initial Nursing Assessment, the RN will conduct an initial and periodic comprehensive assessment of each resident's functional capacity within 12 hours of admission.
    a. The periodic assessment will be repeated within 14 days after a significant change in the resident's physical or mental condition and not less often than once every 12 months.
3. The interdisciplinary team meets every day to discuss the swing bed resident's care goals and recommends appropriate interventions/referrals.
    a. Families and/or significant others are included in the care planning and family conferences are held as needed.

Documentation:

1. Nursing will utilize the NIHD electronic record for documentation, and a daily assessment will be completed every twelve hour shift.
2. Medications will be administered and documented according to the current NIHD policy.
3. Advance Directives for swing bed patients will be maintained according to the NIHD hospital policy.

Discharge/Transfer:

1. Swing bed residents at NIHD are transferred or discharged based on patient progress toward goals.
    a. Patient/conservator notices of transfer/discharge is documented on the Swing Bed Transfer/Notification form.
    b. Patient or their guardians have the right to request transfer or discharge at any time, but NIHD only initiates transfers or discharge when appropriate regulatory criteria are met.
2. When a swing bed resident is discharged/transferred, the physician completes a discharge summary and documents the reasons for the discharge/transfer in the progress notes.
3. The post-discharge plan of care is developed with the participation of the resident and his or her family.
4. The NIHD non-emergent transfer form will be used for transfers.
5. The swing bed chart will be sent to Medical Records for processing and coding.
    a. The swing bed chart will remain separate from the acute care medical record.
6. If a patient is being transferred to a SNF, a "Notice of Medicare provider for Non-coverage" will be completed by Admitting.

REFERENCES:

1. State Operations Manual: Appendix W – Special Requirements for CAH Providers of Long–Term Care Services.

2. The Joint Commission CAMCAH Manual, 2022

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Advance Directives
2. Medical Records Requirements of Swing Bed Admission/Discharge
3. Standards of Care for the Swing Bed Resident
4. Scope of Service Swing Bed
5. Rights of Swing Bed Patients

Supersedes: v.5 Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Admission Procedure of Pediatric Patient		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: Acute/Subacute Unit		
Date Last Modified: 08/18/2022	Last Review Date: No Review Date	Version: 8
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To prepare the pediatric patient and their legal guardian for the hospital stay; establish a friendly, therapeutic relationship between the patient, parents, and hospital staff by thoroughly orienting them to the department, explaining procedures and equipment involved, obtaining necessary information about the patient, as well as obtaining consents for special treatments or surgery.

POLICY:

All patients will be assigned an appropriate room utilizing diagnosis and age specific considerations. A "Quick Check" of each patient will be completed within 30 minutes of arrival. The time of admission is the time that the patient arrives on the department.

PROCEDURE:

1. Prior to admission:
   - A. Get "Room Ready" by obtaining:
     - a. Age appropriate crib or bed
     - b. Age appropriate scale for admission weight
     - c. Measuring tape for head circumference measurement (As Needed)
     - d. Pediatric blood pressure cuff
     - e. Patient labeled pediatric stethoscope
     - f. Age and size appropriate apparel
2. Upon Admission:
   - A. Greet parents and patient in a friendly manner using AIDET.
   - B. Complete a quick check.
   - C. Obtain a complete set of vital signs including a blood pressure.
   - D. Obtain height and weight
     - a. Obtain the correct colored square paper that corresponds to the Broselow Pediatric Emergency Tape and write the weight on this colored square.
       - i. Attach the colored square to the head of the bed or the foot of the crib
       - ii. Place a colored square on door
       - iii. Inform parents the importance of the colored paper
       - iv. Make a copy of the appropriate color Broselow Emergency Tape (front and back) and hang it on the bed or crib as well as on the door
   - E. Complete the pediatric admission assessment form with the parents' and patient's assistance.
   - F. Attach the patient security tag to the child's leg or arm and activate it per policy. Inform the parents what this is for, where on the unit they are able to go with the child and answer any questions related to child security and safety.

G. After confirming correct name and date of birth, apply the armband to the pediatric patient.
H. Apply a duplicate armband to the legal guardian of the pediatric patient. (Parent/Legal guardian)
I. Complete a **CODE AMBER INFORMATION SHEET. Place it in the first section of the chart.**
J. Ensure that photo of the child is uploaded onto the EHR.
K. Make the patient as comfortable as possible.
L. Discuss NIHD fall prevention and precautions taken while patient is in the hospital.
    a. Show the older pediatric patient and all parents how to use the call bell.
    b. Explain intake and output (I&O) as well as the need to measure all I&O of fluids.
    c. Explain the use of the urinal, bedpan, commode, and emesis bag.
    d. If the pediatric patient is able to ambulate, give them a full room orientation.
    e. Place a pitcher of water at the bedside if patient is able to drink fluids.
    f. Explain the use of the pediatric pain scale.
    g. Give parents WIFI password.
M. Review Physicians orders:
    a. If medication is ordered, print out medication information from Up-to-Date on each medication the RN will be administering
    b. Calculate dosage based on the pediatric patient's weight
    c. Verify dose with second RN. (**New Dose calculation needed with weight change.)**
N. Place vital signs chart taped to vitals machine. Normal ranges highlighted.
O. Include parents in the care of the child, being considerate and kind in your approach.
    a. Provide parents with the Pediatric Unit Welcome Letter. Allow the parent time to read the letter and stand by to answer any questions they may have.
    b. Parents are to be encouraged to become involved in the child's care.
    c. Explain to parents that no smoking is allowed at Northern Inyo Hospital including the outside grounds. The Parent Letter discusses the smoking policy.
P. Explain all treatments and procedures the parent and patient should anticipate.
Q. Initiate Patient Care Plan and share with parent and patient as appropriate.
R. At time of discharge, **Child Safety Seat** form will be signed.

REFERENCES:

1. General Acute Care Hospitals, 22 CCR Div.5, 2014.
2. ANA. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pediatric Standards of Care and Routines
2. Newborn & pediatric Abduction Prevention Safety and Security
3. Weights for Infant and Pediatric Patients

Supersedes: v.7 Admission Procedure of Pediatric Patient*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Age Related and Population Specific Care		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Nursing Department		
Date Last Modified: 07/29/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/01/2014	

PURPOSE:

To provide age related population specific care to patients served at Northern Inyo Healthcare District (NIHD), across the life span, from neonates to the older adult.

POLICY:

1. Staff will be trained and competent to provide effective care, treatment and services to several groups according to the following distinctions.
    - Age, ranging from neonates to the older adult
    - Particular disease or condition
    - Point of wellness – illness spectrum, including conditions considered urgent, acute or chronic
    - Level of physical and mental ability
    - Availability of family and social support
2. Ages and population specific care are identified in each job description.

DEFINITION:

The population specific age groups at NIHD are defined as:

Neonatal: Birth to 27 days of age
Pediatric: 28 days to 13 years of age
Adult: 14 years of age to 65 years of age
Older Adult: Over 65 years of age

PROCEDURE:

1. Nursing Leaders will assure staff competency (through policy and procedure; job descriptions, and practice standards) for the ages and populations served in the departments. Developmental ages are identified according to physical, motor/sensory adaptation, cognitive, psychological characteristics and appropriate interventions. The attached charts serve as a guideline.
2. The physical environment for persons of all ages and population specific need will be safe and comfortable.
3. The social environment will be compatible with the activities appropriate to the age group served, developmental age (peer group) and population specific need. Furniture and equipment will be provided appropriate to age, size, developmental and condition specific needs of the population.
4. Nursing Leaders, in collaboration with District Education Services, are responsible to maintain a process to ensure that all staff responsible for the assessment, treatment, and care of patients is trained and

competent to care for the age groups and specific populations identified in the department job descriptions including:

- Ability to obtain information and interpret information in terms of patient needs (assessment)
- Demonstrate knowledge of growth and development including interventions
- Understand the range of treatments and care requirements for populations served such as bariatric, diabetic, limited English proficiency, pain, end of life care, etc.

5. Training and competency are achieved by orientation, ongoing competency, performance feedback and ongoing performance improvement.

REFERENCES:

1. The Joint Commission (Jan 2022) Comprehensive Accreditation Manual for Critical Access Hospitals, Functional Chapter Human Resources HR.01.05.03, Number 5. Oakbrook, IL: Joint Commission

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Standards of Patient Care in the Perinatal Unit
2. Standards of Care RHC
3. Standards of Care in the Perioperative Unit
4. Standards of Care in the Perioperative Unit Pediatric Patients
5. Standards of Care in the Outpatient Infusion Unit
6. Standards of Care in ICU
7. Standards of Care for the Emergency Department
8. Standards of Care- Acute- sub acute services- Adult patient
9. Standards of Care- Swing Bed Resident
10. Pediatric Standards of Care in the OPD/PACU
11. Pediatric Standards of Care and Routines
12. DI – Standards of Care
13. Standards of Care in the Respiratory Care Department

RECORD RETENTION AND DESTRUCTION:

Documentation related to patient care is entered into the patient's medical record, which is maintained by the NIHD Medical Records Department.

Supersedes: v.1 Age Related and Population Specific Care

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Compliance with Information Blocking Rule		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 10/20/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
This document applies specifically to Electronic Health Information Exchange or Use. It is a reference documents designed to support Northern Inyo Healthcare District (NIHD) workforce with understanding of the Information Blocking Rules, 45 CFR Part 171, promulgated by the Office of the National Coordinator for Health Information Technology ("ONC") in order to implement Section 4004 of the 21st Century Cures Act of 2016.

DEFINITIONS:
Access: The ability or means necessary to make Electronic Health Information (EHI) available for Exchange or Use.
Actor: A healthcare provider, Health Information Exchange (HIE), or Health Information Technology (IT) Developer of Certified Health IT.
Affiliate: Any person or entity controlling, controlled by or under common control with another person or entity.
Control: The direct or indirect power to govern the management and policies of an entity; or the power or authority through a management agreement or otherwise to approve an entity's transactions.
Electronic Health Information (EHI): Electronic protected health information (ePHI) to the extent that it would be included in a designated record set, regardless of whether the group of records are used or maintained by or for a covered entity. As of October 6, 2022, EHI includes all documents (data elements) **except** the following:

1. Psychotherapy notes;
2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. EHI excludes de-identified information.

Exchange: The ability for EHI to be transmitted between and among different technologies, systems, platforms or networks.
Healthcare Provider: Any hospital, health care clinic, physician, advanced practice provider (APP), home health agency, long term care facility, ambulatory surgery center, imaging and oncology center, emergency medical services provider, group practice, skilled nursing facility, nursing facility, renal dialysis center, community mental health center, federally qualified health center, pharmacist, pharmacy, laboratory, rural health clinic, therapist or Indian health service or tribe provider.
Health IT Developer of Certified Health IT: Any company business unit that develops or offers health information technology (IT) that has one or more modules certified under a voluntary certification program recognized under the ONC Health IT Certification Program. This defined term does NOT include any health IT self-developed by NIHD for their own use.

Health Information Exchange (HIE)/Health Information Network (HIN): Any NIHD business unit that determines, or has the discretion to administer any requirement, policy, or agreement that permits, enables, or requires the use of any technology or services for Access, Exchange or Use of EHI:

1. Among more than two unaffiliated individuals or entities that are enabled to exchange with each other; and
2. That is for a treatment, payment, or healthcare operations purpose.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, which is included in regulations 45 CFR parts 160 and 164.
Practice: Refers to an act or omission by an Actor.
United States Core Data for Interoperability (USCDI): The standardized set of health data classes and constituent data elements set forth at www.healthit.gov/USCDI.
USCDI Data elements: The data elements represented in the USCDI standard.
Use: The ability for EHI, once Accessed or Exchanged, to be understood and acted upon.

POLICY:
NIHD workforce will support disclosure of protected health information (PHI) per HIPAA and California state privacy requirements without information blocking, unless an exception applies.
NIHD workforce will refrain from interference with Access, Exchange or Use of electronic health information (EHI), except when required to do so by law. This applies to patient, third party payor or healthcare providers requesting EHI access.

Information Blocking – means a practice that:

1. Except as required by law or covered by an Information Blocking Exception, is likely to interfere with Access, Exchange or Use of EHI; and
2. If conducted by
    A. A Healthcare Provider, such provider knows that such practice is unreasonable and is likely to interfere with Access, Exchange or Use of EHI; or
    B. A Health Information Technology (IT) Developer of Certified Health IT or Health Information Network (HIN) knows, or should know, that such practice is likely to interfere with Access, Exchange or Use of EHI.

Information Blocking Exception – refers to each of the following exceptions:

1. Preventing Harm Exception – practices that substantially reduce a risk of harm to a patient or another person;
2. Privacy Exception – practices intended to protect an individual's privacy such as obtaining an authorization that complies with HIPAA or applicable California law or honoring a patient's wishes not to share PHI;
3. Security Exception – practices that protect the security of EHI;
4. Infeasibility Exception – practices that are due to a request for EHI being infeasible, such as due to a disaster, an inability to segment data or factors such as cost;
5. Health IT Performance Exception – practices implemented to perform maintenance or improvements to health IT or to address a third-party application that is negatively impacting the health IT's performance;
6. Content and Manner Exception - practices tied to providing EHI in the manner requested or through an alternative;
7. Fees Exception – practices involving charging fees in connection with exchanging EHI; and
8. Licensing Exception – practices involving licensing interoperability elements needed to Exchange EHI.

NIHD is committed to exchanging and making EHI available and usable for authorized and permitted purposes in accordance with applicable law. We seek to avoid practices that are likely to interfere with the Access, Exchange or Use of EHI except as required by law, permitted by an information blocking exception, or otherwise permitted by the information blocking rules. If you believe an exception applies, consult with the HIMS Manager or Compliance Officer.

When a request for EHI is not being met, NIHD workforce will document the incident in an unusual occurrence report (UOR). Documentation of the reasons for the lack of Access, Exchange or Use of the EHI shall be included in the UOR. The reason for the failure of EHI access related to 'Information Blocking Exceptions' shall be specified.

HIPAA RULES	INFORMATION BLOCKING RULE
1) Specifies when protected health information (PHI) may be shared with third parties i.e., other than patient	1) Mandates that ePHI must be accessible to patients and other third parties.
2) Grants patients the right to inspect and obtain a copy of PHI (paper or electronic) in the designated record set, except for psych or therapy notes or information compiled in anticipation of litigation.	2) Grants patients and third parties access to all ePHI after 10/5/2022.
3) Provider must act on a request for access to PHI within 30 days of the request.	3) The best practice is for ePHI to be accessible at all times.
4) Provider may deny a request for access if: Such would jeopardize the health, safety or security of the patient; Record refers to a third person; and disclosure would create a risk of harm to that person.	4)Provider may deny access if one of 'eight exceptions' are satisfied.
5) Access must be allowed in the form (paper or electronic) requested by the patient "if it is readily producible in that format."	5) Access must be allowed in an electronic format that does not impose unreasonable barriers.
6) Fees: Patients- providers may charge a reasonable, cost-based fee for copies, media, labor and postage. Third Parties- providers may charge whatever they wish.	6) Fees: Patients- Providers may not charge a fee for allowing electronic access, but may still charge for copies, media, etc. Third parties- providers may only charge a reasonable, cost-based fee except for fees to "perform an export of switching health IT or to provide patients their ePHI."
7) Defines who may or must have access to PHI.	7) Provides that access must be allowed to those who are allowed access under HIPAA.
8) Specifies when a release (authorization) is or is not required to share PHI.	8) Does not address, but if sharing is allowed, with or without a release, access to ePHI must be allowed. The intent is that the information blocking provision would not conflict with the HIPAA Privacy Rule (with respect to the privacy of PHI.

9) Patient has the right to request 'confidential communications' specifying that PHI may not be shared with certain parties.	9) If provider accepts the patient's request not to share ePHI, this is not information blocking.
10) HIPAA Security Rule sets a baseline for information technology practices that must be implemented to protect ePHI.	10) Security measures are allowed, but may not unreasonably block access to authorized parties even where such measures are allowed under the HIPAA Security Rule.

PROCEDURE:

I. Record requests for EHI, will be handled primarily via the Health Information Management Service (HIMS), who will work closely with NIHD Information Technology Services (ITS) and NIHD Compliance Office.
   A. Compliance will confirm that the Access, Exchange or Use of EHI complies with applicable law, and privacy.
   B. ITS will confirm that the security and integrity of the District's Information System is maintained.
   C. Requests for EHI must comply with HIPAA, including the minimum necessary standard, where applicable.
   D. Requests to Access, Exchange or Use EHI must be evaluated promptly.
      1. Most single patient and multiple patient EHI requests will follow NIHD HIPAA procedures for receipt and processing of third-party requests for PHI, which may be sent in electronic format.
      2. Patient Portal use by patients and patients' personal representatives may be utilized when available. Patients will be offered Patient Portal set-up opportunities to increase potential for rapid access to EHI.
      3. Requests for EHI must be handled by person whose assigned job responsibilities include the disclosure, access or transmittal of the PHI at issue. Staff in the HIMS department will perform this task.

II. Requests for EHI must be handled by workforce whose assigned job responsibilities include the disclosure, access or transmittal of the PHI. These workforce members serve in the HIMS department at NIHD.
   A. In the absence of HIMS staff to complete the EHI transmission, the "infeasibility' exception may need to be utilized.
      1. Unusual Occurrence Report (UOR) shall be completed by the workforce member receiving the request when unable to transmit the EHI.
      2. Protected health information (PHI) documents may need to be transmitted via other routes such as Fax, printed and sent via mail or scanned and sent via secure email.
   B. Every effort will be made to assure records are sent timely to assure no delay in treatment.
   C. Third-parties requesting Access, Exchange or Use EHI may be asked to clarify the content, manner, and/or purpose of the request to assist NIHD affiliates with confirming:
      1. That the potential Access, use or exchange is permitted by law;
      2. Whether NIHD affiliates can furnish the requested EHI content; and

3. Whether the NIHD affiliates can provide the EHI in the manner requested. Alternative to the content and/or manner requested will be identified and offered when necessary in accordance with District guidelines.

III. Any issue that may interfere with the Access, Exchange or Use of EHI should be evaluated to determine if it is covered under the 'Information Blocking Exceptions'.
   A. If the exceptions do NOT apply, subject matter experts shall be consulted at the District. These may include:
      1. HIMS Manager;
      2. Department of service location Director or Manager;
      3. Compliance Officer; and/or
      4. Administrator-On-Call.
   B. Legal consultation may be required, but will be only done at the direction of the Compliance Officer or Administrator-On-Call.

REFERENCES:

1. 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program, 45 CFR Parts 170 and 171.
2. Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164.
3. *The New Information Blocking Rule: What it Means for Healthcare Providers*, Parsons Behle & Latimer Healthcare Law Update; August 9, 2021.

RECORD RETENTION AND DESTRUCTION:

Release of Information (ROI) related to patient medical records and/or billing are maintained for 15 years for adults and 25 years for minors.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Compliance with Information Blocking Rule
2. InQuiseek - #380 Medical Records Policy
3. Authorization for the Release of Laboratory Results to the Patient
4. Communicating Protected Health Information Via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
7. Workforce Access to His or Her Own Protected Health Information

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Death and Disposition of Body		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Hospital Clinical Units		
Date Last Modified: 07/08/2022	Last Review Date: No Review Date	Version: 7
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/2009	

PURPOSE:
To instruct the Nursing Workforce on the procedure following a patient's death related to disposition of the body and personal belongings, and to ensure that the remains of deceased patients (hereinafter "the body") are handled in accordance with patient/family wishes and the needs of the District while complying with industry standards for disposition.

POLICY:
1. In the event of a patient's death, the nursing staff will follow the following procedure related to Death and Disposition of Body; Organ/Tissue/Eye Donation; and Coroner's Case policies as appropriate.

2. 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 (as listed in Title 17, California Code of Regulation, Section 2500 (c), i.e., HIV disease, Hepatitis, etc.) without written authorization of the patient's representative.

3. Any instructions given to the hospital in writing by the patient for the disposition (type of disposition, or place of interment) of the body will be carried out as required by law.

4. If the coroner is called, the coroner will receive the body regardless of the deceased patient's written instructions, or any instructions of the patient's survivors.

5. If there are no written instructions in the chart for the disposition of the deceased patient's body, the hospital will follow the instructions as provided by the person with the most authority. The following persons in the order listed below will determine the plan for the remains of the deceased.
    a. Person appointed as agent for the patient through a power of attorney.
    b. Spouse or domestic partner
    c. Adult (over 18) child, or the majority of the surviving adult children, or if the majority of surviving adult children are not available, the instructions of the children available
    d. Parent(s) of the deceased. If both parents are alive, but one is not available, then, the instructions of the one that is available will be followed.
    e. Sibling(s)
    f. Next of kin in order of degrees of kinship
    g. Public Administrator

6. If after contacting an out of town funeral director as instructed, that funeral director is unable or unwilling to remove the body from the hospital within 3 hours of death, or if the bed is needed immediately, the hospital shall call the local funeral director in Bishop California to remove the body.

7. If the local funeral director is called to remove the body of a patient whose instructions required using an out of town funeral home, or if the instructions of the deceased patient's agent requires using an out of town funeral home, then, the House Supervisor (HS) will inform the agent or next of kin that the body had to be removed by the local funeral director and there will be a charge from them for this service.

8. The patient's belongings are either given to the family or placed in a bag and given to the mortuary attendant. A list of belongings sent either home or to the mortuary should be noted on the "Release of Body to Mortuary Form." The original form will be maintained by Northern Inyo Healthcare District (NIHD) in the medical record. A copy of the form will be sent with the body.

9. Notification of the Organ Procurement Organization will be completed per policy and documented on the "Release of Body to Mortuary Form." See "Organ/Tissue/Eye Donation" policy for procedure.

10. Should an Autopsy be required, the physician shall discuss the rationale with the next of kin and obtain a signature on the California Hospital Association form 11-1 found in the consent manual (located on the NIHD Intranet>Resources>Information>Compliance>CHA Manuals>Consent Manual).

PROCEDURE:

1. The nurse shall notify the attending physician or Emergency Department physician to pronounce the patient's death.

2. The physician shall notify the family of the patient's death or will request that the Registered Nurse (RN) provide this communication.

3. If the family wishes to view the body, the RN will accommodate this request.

4. The nurse shall prepare the body for transfer to the mortuary. Follow established policy if a coroner's case. When death is not a coroner's case, all tubes, dressings, (unless containing drainage), etc. shall be removed prior to transfer.

5. The HS, or their designee,will report all deaths to the Organ Procurement Organization following the Organ /Tissue/Eye Donation policy, prior to releasing the body to the mortuary. All releases of patient information to tissue/organ procurement/donor organizations must be documented on the Release of Body to Mortuary form, for HIPAA tracking purposes.

6. HS or designee will:
    a. Check the chart for instructions for disposition of the decedent's remains.
    b. Call the funeral director listed or the County Coroner if the case warrants.
    c. Call the funeral director chosen by the person in authority in accordance with this policy if there are no written instructions.
    d. Call the local funeral director if the body cannot be picked up within 3 hours, OR, if the supervisor determines that the bed is needed sooner than 3 hours.
    e. Fill out all necessary paperwork and file the copy of the Release of Body in the chart.

7. The mortuary attendant will sign the RELEASE OF BODY TO MORTUARY (form HIPAA-43). This completed form remains in the medical record of the patient. The hospital may release to the mortuary:
    a. the patient's name
    b. date and time of death
    c. the patient's face sheet

8. The House Supervisor will provide a copy of the Release of Body form to the NIHD Social Worker, who will follow-up with the family of the deceased by telephone within the following month.

REFERENCES:

1. California Hospital Association. Consent Manual (2021) Chapter 14 *Death, Autopsies and Anatomical Gifts*
2. California Hospital Association. Consent Manual (2021) Chapter 18.12 *Reporting Communicable Diseases*

RECORD RETENTION AND DESTRUCTION:

Documentation related to death and disposition of the body are included in the patient's medical record. Medical records are maintained by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Coroner's Case
2. Organ/Tissue/Eye Donation
3. Release of Body to Mortuary **Approved Forms** found on intranet under Forms>HIPAA>HIPPA43
4. Death and Disposition of Body

Supersedes: v.6 Death-Disposition of Body*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: De-escalation Team		
Owner: CEO	Department: Administration	
Scope: District Wide		
Date Last Modified: 08/31/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/01/2018	

PURPOSE:

To provide an expedient intervention response to situations involving individual(s) who display escalating, aggressive, hostile, violent, combative, or potentially dangerous behavior that exceed a workforce member's resources and require additional support to de-escalate.

POLICY:

1. The De-escalation Team will take responsibility and proactive measures for the safety and security of all individuals ~~on hospital property~~ within the hospital building by effectively responding to an escalating event and minimizing the number of potential harm and injuries. Staff members outside of the hospital building, including outpatient clinics and Rehab, should immediately call 9-1-1 for assistance during an escalating event.
2. Any De-escalation Team response should be in accordance with the procedure defined in this policy.
3. The De-escalation Team should be initiated for situations involving patients, visitors and/or other individuals exhibiting escalating, unarmed, violent, aggressive, and/or combative behavior. Situations involving active shooters and weapon violence require different response strategies. Follow the facilities protocol for reporting and addressing other situations.
4. Workforce members who are assigned to the De-escalation Team must have completed the training requirements in order to respond to the code. This code is not intended for all workforce members to respond.
5. This policy does not disallow any workforce member from contacting law enforcement. Any workforce member may seek assistance and intervention ~~form~~ from law enforcement when an escalating and/or violent incident occurs.

Definitions:

De-escalation Team is a group of key individuals who are in-house or immediately available at the time of a request for the De-escalation Team and can quickly respond to the situation within the hospital building, notify internal leaders and law enforcement if required, and mitigate further harm. The team in collaboration with the Workplace Violence Prevention Assessment Team (V-PAT) to follow-up after the incident has occurred, further investigate the problem, and to create strategies to mitigate, communicate and provide support when needed.

The De-escalation Team Code is a response intended for a situation in which a patient, visitor, or other individual on hospital premises behaving in an aggressive, violent, combative, and/or potentially dangerous manner towards themselves, a workforce member, or others and indicates a potential for escalating or is escalating beyond a workforce member's resources. The Code responders use non-violent intervention strategies to defuse or regain control of a situation ~~be~~ by using verbal de-escalation techniques or physical techniques that employ the least restrictive measure possible.

Guidelines:

De-escalation Team Responders and their responsibilities include:

1. House Supervisor
    a. Can act as the Team Leader
    b. Excuses excess personnel when there are an adequate number of responders
    c. Assures unit safety and order is maintained
    d. Responsible for ensuring an informal debriefing session is held immediately following the incident for the team members and others involved in the event.
2. Social Worker (if available)
    a. Can act as a Team Leader
    b. Supports the workforce member with de-escalation techniques
    c. Can assist with Post Incident Response for workforce members
3. Emergency Department Charge Nurse
    a. Supports the workforce member with de-escalation techniques
    b. Assures the safety and security of the unit
    c. Can act as the Team Leader
4. Security Personnel (if available)
    a. Takes immediate steps to assure safety of environment and workforce members
    b. Is positioned within close proximity to take immediate action, as necessary
    c. May assist with de-escalation
    d. Provides advice regarding need for involvement of Law Enforcement

During an intervention, there should be one and only one identified person talking to the individual. There should be an agreed-upon plan and assigned duties for workforce members before a restraint or escort is initiated. All response team members should know their role and duties.

Training Requirements:

1. Workforce Members assigned to respond to a De-escalation Team Code, will receive education and training annually.

PROCEDURE:

1. Escalating Behavior Levels for initiating the De-escalation Team:
    a. Threats and intimidation or refusing to follow instructions.
    b. Verbal or physical expressions of violence.
    c. Uncontrolled anger characterized by aggressive body postures and disposition.

2. INITIATING THE DE-ESCALATION TEAM CODE:

a. As an individual escalates past the workforce member's resources to de-escalate and/or their behavior escalates the De-escalation Team will be called by a workforce member or designee, by dialing "71" and paging "De-escalation Team Code" to report to designated location.
b. If an escalating situation arises outside of the hospital building, in outpatient clinics or Rehab, staff should immediately dial 9-1-1.

3. WORKFORCE MEMBER RESPONSIBILITIES:
    a. The primary care nurse or workforce member who encounters or is caring for the escalating individual, take the following steps:
        I. Remain calm
        II. Provide details of the incident to the Team Leader including:
            A. Brief history of the incident
            B. Medical status
            C. Events leading to the current situation
            D. What action has been taken
            E. What action is believed to be required of the team
        III. Assist team as directed by the Team Leader.
        IV. Complete Workplace Violence Incident Report Form
    b. If a "De-escalation Team Code" is initiated in your area, take the following steps:
        I. If possible, remove all individuals in immediate danger to a safe area
        II. Reduce noise producing equipment
        III. Speak calmly
        IV. Remove any loose equipment that could be used as a weapon or cause injury
        V. The workforce member with the most knowledge of the individual or the situation will remain with the individual and report information to the Team Leader.

4. DE-ESCALATION TEAM RESPONDERS RESPONSIBILITIES:
    a. Report to scene of incident as quickly as possible
    b. The Team Leader role is assumed by:
        I. The first person on the scene, or
        II. A team member with confidence and competence in handling crisis situations, or
        III. A team member who has a rapport with the acting-out individual
    c. The Team Leader briefs the responders of the situation and coordinates the response and action plan.
        I. Possible incident action plan (IAP) objectives may include:
            A. Utilize de-escalation techniques
            B. Prevent harm and injury to self and other workforce members
    d. If the situation cannot be resolved using the De-escalation Team, contact Law Enforcement for assistance, if they have not yet been contacted or responded to the situation.
    e. Report any injuries immediately to Team Leader and refer personnel to obtain medical treatment and follow the Injury and Illness Prevention Program.
    f. Assure area is safe and secure for personnel and other patients to return.
    g. The Team Leader or designee, completes a De-escalation Team Code Response Form and attaches any pertinent documentation and submits through the UOR process. All personnel resume their normal duties.

5. POST INCIDENT RESPONSE

a. In the event of a patient, family member and/or workforce member injury or at the request of the De-escalation Team, a Root Cause Analysis (RCA) and/or After Action Review (AAR) will be conducted by the Risk Manager or designee.
b. Employee Assistance Program, defusing, crisis management briefing, critical incident stress debriefing, and/or other workforce member assistance programs will be offered to workforce members involved in the response, as appropriate.

REFERENCES:

1. California Occupations Safety and Health Standards Board (2016). *Section 3342. Workplace Violence Prevention in Health care*. Retrieved from http://www.calhospital.org/sites/main/files/file-attachments/workplace-violence-prevention-in-health-care-15day.pdf
2. Kelley, E. "Reducing Violence in the Emergency Department: A Rapid Response Team Approach." *Journal of Emergency Nursing* 2014; 40.1: 60-4.
3. Techniques for Effective Aggression Management Workbook, HSS (2017).

RECORD RETENTION AND DESTRUCTION:
Records related to workplace violence will be maintained for a minimum of six (6) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Injury and Illness Prevention Program
2. Patient Restraints
3. Active Shooter

Supersedes: v.1 De-escalation Team

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Departments That Deliver Nursing Care to Patients		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Nursing Services		
Date Last Modified: 09/07/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/01/2014	

PURPOSE:

To identify the departments that meet the definition of practicing nursing using the nursing process to deliver patient care.

POLICY:

1. Based on the Northern Inyo Healthcare District (NIHD) definition of nursing care, the following departments or services are identified as delivering nursing care to patients:
    - Pre-Admission testing (PAT)
    - Same Day Surgery (SDS)
    - Post Anesthesia Care Unit (PACU)
    - Infusion Center
    - Interventional Radiology
    - Acute/Subacute, Telemetry, and Pediatrics
    - Swing
    - Intensive Care Unit
    - Triage/Ante-Partum/Intra-Partum/Delivery/Recovery/Post-Partum
    - Pediatric/Neonate
    - Emergency Department
2. The following departments or services may be required to have licensed nurses employed due to the nature of the job, but do not require the licensed nurse to deliver nursing care as defined by NIHD:
    - Central Sterile Processing
    - Infection Control
    - Employee Health
    - Clinical Informatics
    - Clinics (Rural Health Clinics, Primary and Specialty Clinics)
    - District Education
    - Case Management
    - Clinics

REFERENCES:

1. The Joint Commission (CAMCAH Manual) January 2022, Nursing Functional Chapter NR 02.01.01 EP 1. Oakbrook Terrace, Illinois.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Plan for the Provision of Nursing Care

Supersedes: v.2 Departments That Deliver Nursing Care to Patients

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Patient Priority		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging Department		
Date Last Modified: 11/02/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/15/2011	

Purpose:
To identify the priority of patients when the technologist must determine which study to perform first. In the event of conflict, final determination will be made by the radiologist.

Policy:
The priority of patient examinations follows these criteria:

1. Premature newborns in respiratory distress
2. ER Stroke Protocol Patients
3. Operating room patients under anesthesia
4. Stat requests in this order
    a. Code Blue
    b. ED, ICU, PACU, OB
    c. Other in-patients
5. Timed exams, in progress (ex. nuclear medicine patients already injected, timed barium studies etc.)
6. Urgent requests for physicians waiting in the department
7. Fasting patients in this order
    a. Very young or very old
    b. Diabetic
    c. Inpatients
    d. Outpatients
8. Routine exams by order time (inpatients) or in order scheduled.

REFERENCES:

- National Library of Medicine - **https://pubmed.ncbi.nlm.nih.gov/26547804/**
- American College of Radiology - https://www.acrdsi.org/DSI-Services/Define-AI/Use-Cases/Prioritization-of-Exams-on-the-Worklist

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES:

1. DI timeliness for critical results

Supersedes: v.4 Diagnostic Imaging - Patient Priority

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Education of Patient and Family		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: Perioperative Services, Perinatal Services, ICU, Acute & Subacute Services		
Date Last Modified: 07/06/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 3/16/16	

PURPOSE:
To ensure that all Northern Inyo Healthcare District (NIHD) patients and families/caretakers are appropriately educated to ensure a safe and optimal discharge.

POLICY:
1. The patient and/or, when appropriate, his or her family are provided with appropriate education and training to increase knowledge of the patient's illness and treatment needs and to learn skills and behaviors that promote recovery and improve function.

    a. The assessment considers cultural and religion practice, emotional barriers, drive and motivation to learn, physical and cognitive limitations, language barriers and the financial implications of care choices

2. Based on the patient's/family's assessed learning needs, education may include the following:

    a. Instruction on patient rights and responsibilities

    b. Explanation of the patient's plan of care, treatment and services

    c. Instruction in preventive health practices and safety issues

    d. Infection control measures shall be reviewed with the patient and/or family, when appropriate, as soon as possible upon patient's entrance into the hospital

        i. Infection control measures to be reviewed with the patient and family, as appropriate, include hand hygiene, respiratory hygiene, contact precautions.

    e. The safe and effective use of medication, including side effects and reporting these side effects, in accordance with legal requirements and patient needs, when applicable

    f. Instruction in pain assessment, management, methods and the risk for pain

g. Information on risks associated with procedures, treatment plans and what to "look out for" after specific procedures or courses of care; to report any concerns immediately to healthcare providers; encourage the patient and family to ask questions

h. Surgical patients and families shall receive information regarding the measures the hospital takes to prevent adverse events in surgery. Topics to be reviewed include:

   i. Patient identification: the patient may be asked several times what his/her name and birth date is

   ii. Surgical procedure: the patient may be asked several times what surgery he/she will be having done

   iii. Marking of the surgical site

   iv. Measures to prevent surgical infections

i. The safe and effective use of medical equipment and supplies, when applicable

j. Instruction on potential drug-food interactions and counseling on nutrition intervention and/or modified diets, as appropriate

k. Instruction on maintaining oral health, as appropriate

l. Instruction in rehabilitation techniques to facilitate adaptation to and/or functional independence in the environment, if needed

m. Instruction in processes for reporting concerns about safety

n. Access to available community resources, if needed

o. When and how to obtain further treatment, if needed

3. The patient and/or, when appropriate, his or her family are provided with the specific knowledge and/or skills required to meet the patient's ongoing healthcare needs. Such instruction is presented in ways understandable to the patient and/or his or her family and includes, but is not limited to, the patient's and family's responsibilities in the patient's care.

4. With due regard for privacy, the hospital teaches and helps patients maintain good standards for personal hygiene and grooming, including bathing, brushing teeth, caring for hair, nails and using the toilet.

5. The patient and/or when appropriate his or her family are provided with information from the "Speak Up" program to support patient/family involvement in care and to ask questions etc.

PROCEDURE:

1. Upon admission, the Registered Nurse (RN) will begin the nursing process for patient education as follows:

    a. Assess learning needs and learning capabilities of patient

    b. Establish teaching plan based on goals and objectives of patient education for the individual

    c. Implement the teaching plan and evaluate learner's response

    d. Patient/family education and understanding shall be documented in the patient's medical record

2. Upon admission, the RN will orient the patient to the environment: physical, patient rights and responsibilities, hospital staff, safety issues to include the reporting of quality of care concerns and/or errors observed by the patient and/or family and other pertinent issues.

3. Teaching will be initiated when the patient's condition permits. Teaching will be modified, as needed, to meet individual needs; i.e., language barrier, physical limitations. The family and/or significant others will be included in patient education as frequently as possible, when appropriate.

4. Education will include information, as necessary, about patient responsibilities in his/her own care, including, but not limited to responsibilities for:

    a. Providing information

    b. Asking questions and obtaining information about his/her care

    c. Reporting concerns or possible errors

    d. Infection control practices, such as hand hygiene, respiratory hygiene practices (if applicable) and contact precautions (if applicable)

    e. Following instructions

f. Accepting the consequences of not following care and/or treatment

g. Following rules and regulations regarding care and conduct

h. Showing respect and consideration for other patients/hospital personnel and property

i. Meeting financial considerations

5. Relevant written materials including a discharge instruction sheet will be given to the patient by an RN. The patient will sign the discharge instruction sheet after the patient education has been completed and he/she will retain a copy of his/her discharge instructions for home use.

6. Such patient education includes instruction in the specific knowledge and/or skills needed by the patient and/or where appropriate, his/her significant others, to meet the patient's ongoing healthcare needs, including:

a. Basic health practices and safety

b. The plan for care, treatment and services

c. Safe and effective use of medication, including potential side effects

d. Safe and effective use of medical equipment

e. Potential drug-food interactions and counseling on medical diets

f. Maintaining oral health

g. Understanding the pain assessment and management processes

h. Instructions about any follow-up care and how to obtain care

i. Information provided to the patient/family at the time of discharge is provided to the individual or organization providing continuing care of the patient

j. Habilitation or rehabilitation techniques to help the patient reach his/her maximum independence possible

REFERENCES:

1. TJC Comprehensive Accreditation Manual for Critical Access Hospitals. Functional Chapter Provision of Care: Standard PC 02.03.01EP's 1, 2,3

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Emergency Department Education of Patient and Family
2. Clinic Education of Patient and Family

Supersedes: v.1 Education of Patient and Family*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Evaluation and Assessment of Patients' Nutritional Needs		
Owner: Registered Dietitian	Department: Dietary	
Scope: In-patient, RD		
Date Last Modified: 08/15/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To codify the method of evaluation and assessment of patients' nutritional needs by the healthcare team.

POLICY:

1. Evaluation and assessment of patients' nutritional needs by a Registered Dietitian shall be initiated within 48 hours in response to any of the following:
    a. Malnutrition Screening Score of $\geq$2 as indicated in the initial screening titled "Adult Patient History" performed by a registered nurse
    b. BMI <18.5
    c. Consult order by physician, patient, patient's representative, or member of the healthcare team
    d. New order for enteral or parenteral nutrition
    e. New diagnosis of diabetes
    f. Patients with Stage II or greater pressure injury
2. If a patient is NPO/CL diet for more than 3 days, patient shall be seen on the 4th day
3. If there is no nutritional risk, the Registered Dietitian will evaluate need for assessment in patients with a stay longer than 3 days (on the 4th day).
    a. If full assessment is not warranted, a note shall be entered indicating reason why full assessment is not warranted
4. Obstetrical patients shall be seen upon consult by Physician, Patient, Patient's representative, or member of the healthcare team.
5. Best practices will include parameters of documentation using the Nutrition Care Process and standards set by the Academy of Nutrition and Dietetics.
6. Dietary assessment, recommendations, diet prescription, assessment of effects of nutritional therapy and follow-up must be charted upon completion of dietary assessment by the dietitian.
7. Nutritional assessment calculations and recommendations are referenced from the Nutrition Care Manual and/or Academy of Nutrition & Dietetics unless specifically ordered otherwise by a physician.

REFERENCES:

1. Academy of Nutrition & Dietetics. eNCPT (2016)
2. California Code of Regulations: Title 22- Article 5, § 72523(a) (4-D) (2010)

CROSS REFERENCE P&P:

1. Nursing Assessment and Reassessment

RECORD RETENTION AND DESTRUCTION:

Per medical records policy at NIHD.

Supersedes: v.3 Evaluation and Assessment of Patients' Nutritional Needs

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Nursing Care Plan		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope:		
Date Last Modified: 07/19/2022	Last Review Date: No Review Date	Version: 8
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

1. Nursing care plans are designed to:
    a. Allow nursing staff to provide patients with individualized safe and quality care by carrying out the nursing process in a systematic fashion.
    b. Identify the planning process when patient goals and expected outcomes are established and nursing interventions selected.
2. After the RN completes the initial nursing assessment, appropriate plans of care are developed.
3. Nursing Care plans have been incorporated into the electronic health record to facilitate report and continuity of care through ease of access.
4. Nursing care plans shall also be considered when determining patient acuity.

POLICY:

1. The nursing care plan is developed incorporating information from the initial nursing assessment, Physician History & Physical (H&P) and physician order sets.
    a. The care plan gives direction in providing care for the patient/family and is used as a means of communication that allows for the continuity and consistency of care.
    b. Care planning and the development of an individualized plan of care will be based on established nursing standards of care and standards of practice that reflect patient needs identified through the assessment process.
    c. The plan of care will be consistent with therapies of other disciplines, patient/family needs and will be focused on collaborating with other disciplines.
2. The initial nursing assessment is completed by the RN within time frames established for each nursing department. (See Nursing Assessment and Reassessment chart time frames)
    a. Referrals to the interdisciplinary team are generated based on patient's answers to clinical screen questions within the initial nursing assessment.
    b. Patient problems are identified and prioritized in the selection of a medical problem or nursing diagnosis with the development of a plan of care.
3. The evaluation of the patient's response to the plan of care is reviewed and evaluated each shift. The plan of care is updated each shift when patient condition changes.
4. The patient progress towards the goal is evaluated as part of the daily interdisciplinary care conference.
5. The framework for nursing practice is the nursing process which reflects the delivery of care based on the following steps:
    a. Assessment
    b. Identification and prioritization of patient problems or needs
    c. Mutual planning and establishment of goals and interventions
    d. Implementation of interventions by nursing and the health care team

PROCEDURE:

1. After completing the initial nursing assessment, the RN identifies patient needs or problems.
    a. Automatic referrals triggered by clinical screens built into the initial nursing assessment are sent to members of the interdisciplinary team.
    b. Those interdisciplinary team members who receive a referral, complete an assessment, and when appropriate, contact the medical staff practitioner and/or initiate a care/treatment plan.
2. The RN develops the plan of care in collaboration with the patient/family-caregiver from the identified initial nursing assessment patient needs or problems (see references below).
3. The plan of care and patient response, including progress toward goals/outcomes and discharge, are reviewed as part of the shift report hand off using SBAR-QC.

REFERENCES:

1. TJC Comprehensive Accreditation Manual for Critical Access Hospitals. Function Chapter Provision of Care. RC.02.01.01, EP 2
2. Gulanick & Myers (2014) Nursing Care Plans Diagnoses Interventions and Outcomes. Elsivier: Philadelphia.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Nursing Assessment & Reassessment
2. Interdisciplinary Plan of Care
3. Nursing Standards
4. Plan for the Provision of Nursing Care

Supersedes: v.7 Nursing Care Plan*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Patient Safety Attendant or 1:1 Staffing Guidelines		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Emergency Department and Inpatient Units		
Date Last Modified: 06/01/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/1992	

PURPOSE:

The purpose of a Patient Safety Attendant is to help keep the patient oriented to place and/or help assure the patient's safety by one-to-one observation.

POLICY:

1. A Medical Staff Provider may write an order for a Patient Safety Attendant however a nurse may also initiate the use of a Patient Safety Attendant through assessment and by collaboration with other team members. Patient Safety Attendant criteria include:
    a. Suicide precaution (All patients on suicide precautions will have a Patient Safety Attendant until a Medical Staff Provider has cleared the patient from such precautions.)
    b. Protecting patients from harm when they are at high risk for falls
    c. Patient disorientation/non cooperative
2. With the exception of a patient placed on suicide precautions (one-to-one observation), the patient's family may serve as a patient safety attendant.
3. Patient Safety Attendant may be from different levels of care providers, including Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nurse Aid (CNA), Clerk, Security, Environmental Services (EVS), etc.
4. Performance standards of a patient safety attendant (what the patient safety attendant may do for and with the patient) will be based on the patient safety attendant's job description.

PROCEDURE:

1. When a Patient Safety Attendant is deemed necessary for the safety of the patient, the RN or designee will notify the House Supervisor (HS) for coverage. The HS will find staffing coverage.
    a. Patient Safety Attendants are usually not provided in ICU or when staffing meets 1-2 patient ratio.
2. If a patient's family member chooses to sit with the patient, instructions will be given that the family member is to:
    a. Call for assistance as needed using the call bell.
    b. Not to leave the patient unattended.
3. A guest meal tray may be ordered for the family member who is sitting with the patient.
4. All patient care is under the direction of the RN assigned to the patient. The RN will:
    a. Give direction to the Patient Safety Attendant based on the workforce member's job description performance standards.

b. Check on the Patient Safety Attendant when completing hourly rounding every hour from 0800-2200 and every two hours from 2200-0800.

5. The Patient Safety Attendant will be located in the room with the patient. The Patient Safety Attendant will:
    a. Not leave the room (i.e. breaks and meals unless relieved by another person).
    b. Notify the RN of any assistance needed or concerns.
    c. Document utilizing the 'close observation' form every 15 minutes for patients requiring a safety attendant (see attached document).
    d. Follow the 'Safety Attendant Guidelines' (see attached document).
6. The patient need for a Patient Safety Attendant should be re-assessed on an ongoing basis but not less that every 24 hours.
    a. Patient Safety Attendant continuation will be reviewed at the daily interdisciplinary team meeting.

REFERENCES:

1. McFarlane-Kolb, H. (2004) Falls Risk assessment, Multi-targeted Interventions and Impact on Hospital Falls. International Journal of Nursing Practice 10: 199-206
2. NCPS Falls Toolkit; 2004 National Center for Patient Safety.http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/completebooklet.pdf.
3. Care of the Psychiatric Patient in the Emergency Department, ACEP Emergency Medicine Practice Committee (2014)
4. Sentinel Event Alert: New Alert Focuses on Suicidal Ideation, The Joint Commission Perspectives, (2016)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Management of the Behavioral Health Patient (5150 and non-5150)
2. Fall prevention and management

RECORD RETENTION AND DESTRUCTION:

Safety Attendant and Guideline for Close Observation form is utilized for documentation. This is sent to NIHD Medical Records Department and scanned into the patient medical records. NIHD Medical Records Department is responsible for maintenance of the medical record.

Supersedes: v.4 Patient Safety Attendant or 1:1 Staffing Guidelines*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Recognizing and Reporting Swing Bed Resident Abuse/Neglect		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: Acute/Subacute, Rehabilitation Dept., House Supervisors		
Date Last Modified: 07/06/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/2014	

PURPOSE:

1. To ensure resident safety and provide staff with guidelines and criteria for the recognition of potential elder abuse or neglect through the implementation of comprehensive training and education.
2. The policy also outlines reporting responsibility of licensed staff.

POLICY:

1. Northern Inyo Healthcare District (NIHD) shall protect the elderly and/or dependent adults who exhibit signs of abuse in accordance with state, federal and county elder abuse reporting laws. Facility protocols shall include assessment completion, intervention, documentation and referrals.
2. All employees are responsible for being observant and reporting all suspected or obvious incidents of patient abuse.
    a. If an observation is made that an elder or dependent adult has had a physical injury or injuries which appear to have been inflicted by other than accidental means by any person.
3. Any suspected dependent adult/elder abuse will be reported to the House Supervisor in collaboration with employee's immediate supervisor, using the appropriate form (see attached).
4. The staff will be educated regarding the following signs/symptoms of abuse:
    a. **Signs/Symptoms of Physical Abuse:**
        - Bruises
        - Welts
        - Lacerations
        - Puncture wounds
        - Dehydration
        - Malnutrition
        - Internal injuries/bleeding
        - Sprains
        - Dislocations
        - Fractures
        - Skull fractures
        - Orbital fractures
        - Spiral fractures
        - Signs of over-medication or underutilization or required medication
        - Burns
        - Poor hygiene
        - Lack of needed medical attention

- Multiple injuries in various stages of healing
- Broken eyeglasses, signs of being restrained, signs of being subjected to punishment
- The elder's report of being kicked, slapped, punched, hot or mistreated
- The elder's sudden unexplained change in behavior
- The caregiver's refusal to allow visitors to see the elder alone

Note: Abuse may be present with one of the above; however, abuse symptoms are often clustered.

b. **Fiduciary Abuse:**
   - A situation in which a person who stands in a position of trust with the elder willfully steals the money or property of that elder or appropriates the elder's money of property to any use of purpose not in the due and lawful execution of his/her trust
   - Elder and dependent adult financial abuse includes lack of money to buy food or medication, someone consistently visiting around the first of the month when Social Security checks are received and/or checks written to strangers
   - Cashing an elder person's checks without authorization from the elder, forging the elder's signature
   - Coercing or deceiving the elder to sign any document
   - Improper use of conservatorship/guardianship
   - Sudden unexplained changes in the elder's bank account or banking practice (withdrawal of large sums of money by anyone other than the elder), inclusion of additional names on the elder's bank signature card without the elder's knowledge or permission
   - Unauthorized withdrawal from the elder's bank account using the elder's ATM card
   - Abrupt changes in the elder's will or other financial documents, revision of the tenancy name(s) on the elder's hour property deed
   - Unexplained disappearance of valuables or funds
   - Unpaid bills despite the availability of adequate financial resources
   - Substandard care (health and general living conditions) provided despite the availability of adequate resources
   - Sudden appearance of previously uninvolved relatives claiming their rights to the elder's affairs and possessions
   - Unexplained and/or sudden transfer of the elder's assets to a family member or someone outside of the family
   - Reports of fiduciary abuse and/or financial exploitation of the elder by either the elder or concerned individuals (close friends, neighbors, etc.)

c. **Emotional Abuse:**
   - Infliction of distress, psychological/mental pain or anguish through verbal or nonverbal acts
   - Verbal assaults, insults, threats
   - Intimidation, humiliation, harassment
   - Isolation of the elder from family, friends or support group
   - Isolation of the elder from regular activities
   - The elder appears emotionally agitated, withdrawn or upset
   - The elder is uncharacteristically non-communicative or non-responsive
   - The elder exhibits unusual behavior that is generally attributed to dementia (rocking, sucking, etc.)
   - The elder is frequently tearful without cause
   - The elder shows signs of severe depression

d. **Neglect:**
   - Failure or refusal to fulfill any part of a person's obligations or duties to the elder
   - The elder or concerned individual reports neglect or mistreatment
   - Failure to assist in personal hygiene or in providing food and clothing for an elder
   - Failure to provide medical care for an elder's physical and mental health needs, although a person's voluntarily relying upon treatment by spiritual needs through prayer in lieu of medical treatment does not constitute neglect
   - Failure to prevent an elder from suffering malnutrition or dehydration
   - Failure of an individual with fiduciary responsibilities to provide care for an elder
   - Failure of an in-home service provider to provide necessary care
   - Presence of untreated pressure ulcers
   - Presence of unsanitary and unclean living conditions (unclean and/or inadequate clothing, presence of scabies, lice, strong urine/fecal smell)
   - Presence of unfit living conditions (inadequate heating or air conditioning, improper wiring, nor running water, unsafe building conditions, etc.) or failure to protect the elder from health and safety hazards

e. **Self-Neglect by the Resident:**
   - Behavior of the resident that threatens their own health or safety
     - ❖ This excludes the situation where a mentally competent elder, able to understand the consequences of his/her actions, makes a decision that is conscious and voluntary to engage in acts that threaten safety; and these decisions are made as a matter of personal choice
   - Refusal or failure of the resident to provide themselves with adequate nourishment, fluids, clothing, shelter, medication
   - Refusal or failure of the resident to engage in personal hygiene
   - Refusal or failure of the resident to provide him/herself with adequate safety and security precautions; living in unclean, hazardous or unsafe living quarters
   - Lack of necessary medical aids, such as eyeglasses, hearing aids, dentures
   - Homelessness, living with infestations of insects or vermin

f. **Abandonment:**
   - Desertion of an elder at a nursing facility, hospital, or other healthcare entity
   - Desertion of an elder at a public location such as a shopping center, supermarket, bus station, etc.
   - Elder's own report or the report of a concerned individual of the elder being abandoned

g. **Sexual Abuse:**
   Includes but is not limited to:
   - Rape
   - Sodomy
   - Non-consensual fondling, molestation
   - Sexual assault or battery
   - Coerced nudity
   - Sexually explicit photographing
   - Bruising around breasts or genital area
   - Unexplained vaginal or anal bleeding or tearing

- Torn, stained, bloody underclothing
- Unexplained venereal disease or genital infections
- The elder's report of being sexually assaulted or raped

5. It shall be the responsibility of the licensed employee or designee who observes the suspected abuse to initiate the reporting process by contacting the shift House Supervisor. The House Supervisor will contact the employee's immediate supervisor and collaborate to initiate the reporting process and take any other actions.
    a. The Initial Documentation of Alleged Swing Bed Patient Abuse form shall be used to document the information reported to the California Department of Public Health (CDPH) and the local Ombudsman.
    b. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, the local Ombudsman, and CDPH
    c. The resident's physician shall be notified of the suspected abuse.
6. If an employee is suspected of abuse:
    a. The immediate supervisor will be notified that the allegations have been made
    b. The employee will be suspended until an investigation into the allegation of abuse has occurred
7. The Chief Nursing Officer or Quality Department will oversee the in-house investigation.
    a. The designated hospital representative will also work with CDPH and local law enforcement and cooperate in their investigation.
    b. If an employee is suspected of abuse and suspended, the investigation will determine the outcome of the suspension

DEFINITIONS:

1. Dependent Adult - Any person residing in this state, over the age of 18, who has physical or mental limitations which restrict the ability to carry out normal activities or to protect an individual's rights. This includes, but is not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.
2. Financial or Material Exploitation – the illegal or improper use of an elder's funds, property or assets.
3. Abandonment - A situation in which a person who has the care of or custody of an elder deserts or willfully forsakes the elder under circumstances in which a reasonable person would continue to provide care or custody.
4. Sexual Abuse – Non-consensual sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent.

REFERENCES:

1. CDPH (4/200/) State Operations Manual Appendix W-Survey protocol Regulations and Interpretive Guidelines CAH and Swing Beds in CAH
2. CHA (41st Edition, 2014) Consent Manual: A Reference for Consent and Related Healthcare Law. Abuse of Elder and Dependent Adults, p19.18 and Mandatory Reporting, p19.23. CHA Publications

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Employees Discipline Process

Supersedes: v.1 Recognizing and Reporting Swing Bed Resident Abuse/Neglect*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol – Physician Assistant in the Operating Room		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 06/21/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/01/2018	

PURPOSE:
To establish guidelines for the adequate supervision and qualifications of the Physician Assistant (PA) who assists the surgeon during a surgical procedure.

POLICY:
1. The Physician Assistant (PA) 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.
2. Only a PA currently licensed in California, who meets all the criteria specified in Appendix A may perform this procedure.
3. The PA will be evaluated for continued competency as per the *General Physician Assistant Protocol.*
4. The PA may function under this protocol only when the following conditions are met:
    a. The attending surgeon has determined that the PA can provide the type of assistance needed during the specific surgery.
    b. The PA functions under the supervision of the attending surgeon. The attending surgeon does not need to be physically present in the operating room for those portions of the procedure (usually setup and final closure) which in the judgment of the attending surgeon the PA may safely do without direct and in-person supervision. The attending surgeon must be able to be present immediately if needed and must have a reliable way to be contacted and summoned, such as a cell phone, if needed. Specifically, the attending surgeon may be in such places as the recovery room, the pre-op area, the wards of the hospital, an on campus office, or the Emergency Department.
5. The PA practices within the appropriate limitations and may choose not to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

PROTOCOL:
The PA will:
1. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
2. Provide retraction by:
    a. Closely observing the operative field at all times.
    b. Demonstrating stamina for sustained retraction.

    c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
    d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
    e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
3. Provide hemostasis by:
    a. Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
    b. Sponging and utilizing pressure, as necessary.
    c. Utilizing suctioning techniques.
    d. Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
    e. Placing suture ligatures in the muscle, subcutaneous and skin layer.
    f. Placing hemoclips on bleeders, as directed by the surgeon.
4. Perform knot tying by:
    a. Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
    b. Tying knots firmly to avoid slipping.
    c. Avoiding undue friction to prevent fraying of suture.
    d. "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
    e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
5. Perform dissection as directed by the surgeon by:
    a. Having knowledge of the anatomy.
    b. Demonstrating the ability to use the appropriate instrumentation.
    c. For abdominal surgery: dissection includes only layers above the fascial layer.
6. Provide closure of layers of tissue as directed by the surgeon; sutures fascia, subcutaneous tissue and skin by:
    a. Correctly approximating the layers, under direction of the surgeon.
    b. 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.
    c. Correctly approximating skin edges when utilizing skin staples or suture.
7. Assist the surgeon at the completion of the surgical procedure by:
    a. Affixing and stabilizing all drains.
    b. Cleaning the wound and applying the dressing.
    c. Assisting with applying casts; splints, bulky dressings, abduction devices.

REFERENCES:

1. "Medical Services Performable." California Code of Regulations. 16 CCR § 1399.541.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.2 Standardized Protocol – Physician Assistant in the Operating Room

APPENDIX A

A Physician Assistant who is approved as a PA at Northern Inyo Healthcare District may function as first assistant if all of the following conditions exist:

1. Currently licensed as a PA in California.
2. Successful completion of an accredited Physician Assistant program. (A copy of the certificate of completion will be placed in the PA's personnel file and the Medical Staff credentials file.)
3. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a PA.
4. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the PA assists.
5. Demonstrated ability to function effectively and harmoniously as a team member.
6. Current BLS certification; ACLS certification preferred.
7. Able to perform effectively in stressful and emergency situations.

ATTACHMENT 1 – LIST OF AUTHORIZED PHYSICIAN ASSISTANTS

1. _____ _____ _____
   NAME SIGNATURE DATE

2. _____ _____ _____
   NAME SIGNATURE DATE

3. _____ _____ _____
   NAME SIGNATURE DATE

4. _____ _____ _____
   NAME SIGNATURE DATE

LIST OF SUPERVISING PHYSICIANS

1. _____ _____ _____
   NAME SIGNATURE DATE

2. _____ _____ _____
   NAME SIGNATURE DATE

3. _____ _____ _____
   NAME SIGNATURE DATE

4. _____ _____ _____
   NAME SIGNATURE DATE

5. _____ _____ _____
   NAME SIGNATURE DATE

6. _____ _____ _____
   NAME SIGNATURE DATE

7. _____ _____ _____
   NAME SIGNATURE DATE

8. _____ _____ _____
   NAME SIGNATURE DATE

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Swing Bed Patient Restraints		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope:		
Date Last Modified: 08/17/2022	Last Review Date: No Review Date	Version: 8
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To delineate standards of care for the patient who is restrained which promotes an environment conducive to maintaining patient dignity, while protecting patient safety. All swing bed patients will be advised of their right for freedom from restraints used in the provision of swing bed care unless clinically necessary, and of their right to freedom from restraints used in behavioral management unless clinically necessary. These are included in the "*Patient's Bill of Rights"* given to the patient on admission to Swing Bed Status.

POLICY:

A. It is the policy of Northern Inyo Hospital (NIHD) to create a physical, social and cultural environment that limits the use of restraint to appropriate and justified situations, and, to reduce restraint use through preventive or alternative methods which focus on the patient's rights, dignity and well-being. Patients have the right to be free from restraints of any form that are not medically necessary. Restraint may only be imposed to ensure the immediate physical safety of the patient, staff, or others and must be discontinued at the earliest possible time.

B. The decision to use a restraint is not driven by diagnosis. Comprehensive assessment of the patient and environment, in conjunction with individualized patient care planning, should be used to determine those interventions that will best ensure the patient's safety and well-being with the least risk. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient. Restraint may only be used if needed to improve the patient's well being when less restrictive interventions have been determined to be ineffective in protecting the patient and others from harm. Restraints, if deemed appropriate, are implemented using safe techniques identified in this policy and reinforced during annual staff education. The restraint shall be discontinued at the earliest possible time, regardless of the scheduled expiration of the order.

C. Patient's rights, dignity and well-being are protected during restraint use to assure the following:

1. Respect for the patient as an individual
2. Safe and clean environment
3. Protection of the patient's modesty, visibility and body temperature

D. The hospital does not permit restraint for management of violent or self-destructive behavior to be used for the purpose of coercion, discipline, convenience, or staff retaliation. Restraints are never a substitute for adequate staffing.

E. The patient and family will be informed of the organization's policy/procedure on the use of restraints.

1. Staff will explain the need for the use of restraint to the patient/family/ significant other to increase their understanding and decrease their fears about the use of restraint.

2. Patient and/or family will be encouraged to be involved in decision-making. Incorporating patient/family preferences in the care process may help minimize restraint use.

3. The patient/family/significant other are assured that the least restrictive device will be utilized, that restraints are discontinued as soon as possible, and that the patient's basic needs for nutrition, personal care, and exercise are met during the use of the restraint.

4. In the event that the patient chooses not to include the family/significant other, or that participation would have a detrimental effect on the patient, family/significant other involvement would not be applicable.

5. Staff will attempt to promptly contact the family to notify them when restraints are used as appropriate.

F. The use of restraints must be in accordance with the telephone order or written order of a physician.

G. A Registered Nurse (RN) may make the decision to initiate a restraint in an emergent situation when the risk to the patient is such that an order from a physician cannot be obtained before restraining the patient.

H. Per the restraint orders, the RN may discontinue restraints prior to the expiration of the order when the action/behavior leading to the need for restraints is no longer evident. If the restraints must be re-initiated, another order must be obtained.

DEFINITIONS:

A. Physical Restraints: Physical restraint is any manual or physical method or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, or head freely.

1. Bed side rails: Side rails present an inherent safety risk, particularly when the patient is elderly or disoriented. Even when they are not used intentionally as a restraint, patients may become trapped between the mattress or bed frame and the side rail.

a. Side rails used to physically restrict a person's freedom of movement or physical activity in order to protect the patient or others from injury is considered restraint. Therefore, when all four side rails of a four rail system are raised, it is considered a restraint.

b. Individual patient needs are assessed for the use of side rails.

c. Infants and children will have crib rails and side rails up at all times which are not considered restraint.

d. The upper two side rails of a four rail system may be placed in the up position to provide patient access to bed control, the nurse call system, or to assist the patient in turning in bed and are not considered restraint.

e. The upper two side rails and one lower side rail of a four-rail system or one side of a two-rail system may be up for patient protection and comfort as long as the patient's ability to get out of bed is not restricted and are not considered restraint.

f. The upper and lower two side rails of a four rail system on specialty beds (i.e. lateral rotation beds) may be up for patient protection and in order for the bed to properly operate and are not considered restraint.

2. Devices and Immobilization

a. Devices, which serve multiple purposes when they have the effect of restricting a patient's movement and cannot be easily removed by the patient, constitute a restraint. (e.g. Geri chair, elbow immobilizers to prevent the patient from reaching tubes, etc.)

b. Patient assessment for the use of the device should be based on the least risk for the patient and the risk of what might happen if the device is not used versus the risk it poses as a restraint.

B. Drugs used as a restraint: Chemical restraint is defined as medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychological condition. These are medications used in addition to or in replacement of the patient's regular drug regimen to control aggressive and/or violent behavior during an emergency.

1. A standard treatment for a medication used to address a patient's condition would include all of the following:

a. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.

b. The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's knowledge of that patient's expected and actual response to the medication.

c. If the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with others, then the medication is not being used as a standard

treatment for the patient's condition.

d. Whether or not the use of a medication is voluntary, or even whether the drug is administered as a one-time dose or PRN are not factors in determining if a drug is being used as a standard treatment. The use of PRN medications is only prohibited if the drug is being used as restraint.

2. NIHD does not use chemical restraints as a means of coercion, discipline, convenience or retaliation by staff. Medications that comprise the patient's regular medical regimen (including PRN medications) are not considered drug restraints, even if their purpose is to control ongoing behavior.

C. Seclusion: Seclusion of an individual is involuntarily confining an individual alone in a room or area where he/she is physically prevented from leaving. NIHD's policy and practice prohibits the use of seclusion.

D. NIHD prohibits the use of restraints when the patient is in a prone position.

E. Exceptions: Therapeutic or protective interventions that, although they may restrict activity, are ***not*** considered restraint interventions include:

1. A restraint does not include devices, such as prescribed orthopedic devices, surgical dressings or bandages, protective helmets, or methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests.

2. A restraint does not include methods that protect the patient from falling out of bed.

    a. Examples include raising the side rails when a patient is on a stretcher; recovering from anesthesia; sedated; on seizure precautions, experiencing involuntary movement; or on certain types of therapeutic beds to prevent the patient from falling out of the bed.

3. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, highchair lap belts, raised crib rails and crib covers) that a safety-conscious child care provider outside a healthcare setting would utilize to protect an infant, toddler or preschool-aged child would not be considered restraint or seclusion for the purposes of this regulation.

4. A physical escort would include a "light" grasp to escort the patient to a desired location

    a. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

5. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint (e.g. knee immobilizers for medical clinical purposes, abductor pillow, postural support, or orthopedic devices).

6. A position or securing device used to maintain the position, limit mobility or temporarily immobilize the patient during medical, dental, diagnostic or surgical procedures.

7. The use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons is not considered restraint.

8. Placing hand mitts on a patient to prevent the patient from pulling on tubes or scratching him or herself would not be considered a restraint. Mitts shall never be secured in any way that prevents free movement of the arms. Mitts shall be applied loosely enough to ensure circulation, sensation and movement. If soft limb (wrist) restraints are used in conjunction with mitts, this would be considered a restraint because of the use of the soft limb (Wrist) restraint.

9. A medication used to control a patient's behavior that is standard treatment for the patient's medical or psychiatric conditions (i.e. drug or alcohol withdrawal, psychiatric diagnosis) is not considered chemical restraint.

10. If the patient is on a stretcher, there is an increased risk of falling from a stretcher without raised side rails due to its narrow width and high center of gravity. Additionally, since stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rails are not considered restraint but a prudent safety intervention.

F. The following functional guidelines should be considered when defining an intervention as a physical restraint:

1. Does the patient have the ability and skill to easily remove the intervention? (If the answer is no, then intervention is a restraint).

2. Is the patient's freedom to move when the intervention is in place less than their freedom to move without the intervention, or is the patient's access to their body when the intervention is in place less than their access to their body without the interventions? (If the answer is yes, then intervention is a restraint).

3. Utilization of a functional assessment allows for individual assessment of each device and situation that could potentially be used to inhibit an individual's movement. Therefore, if the effect of using an object fits the definition of restraint for a patient at a specific point in time, then for that patient, the device is a restraint.

APPROVED TYPES OF RESTRAINTS

A. **Soft limb restraints**
B. **Four (4) side rails up (See definitions)**
C. **Safety Vest**

ALTERNATIVES TO RESTRAINTS/LEAST RESTRICTIVE DEVICE

A. Alternatives to restraints do not always need to be tried, but prior to the use of restraints; alternative interventions must be determined to be ineffective to protect the patient or others from harm.

B. Alternatives attempted or rationale for not attempting alternatives must be documented.

C. Efforts are taken to develop and promote preventive strategies and use safe and effective alternatives when appropriate as follows:

1. Identify and treat the cause of the behavior (e.g. medical re-evaluation, reposition, put to bed if fatigued, change environmental noise level, lighting, furnishings, or equipment, or if possible, change or eliminate bothersome treatments).

2. Increase observation/supervision.

3. Involve the family and significant others.

4. Provide diversionary measures (e.g. formal activities, visitors, exercise, reorganize the ADLs).

5. Consider and eliminate barriers; manipulate the environment (e.g. increase the lighting, leave side rails down, decrease noise, call bell accessible).

6. Re-orient patients/provide reality orientation.

7. Evaluate medication regimen (e.g. pain, agitation, and initiation).

D. Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.

<u>Examples of Alternatives to Physical Restraints</u>

All behaviors can be viewed as a symptom and each may arise from a variety of causes or be indicative of an array of unmet needs. Medical re-evaluation is always appropriate. Involvement of the interdisciplinary team (i.e. OT/PT assessment) may identify additional alternatives.

Observe the patient's behavior, investigate its meaning, and develop creative and individualized alternatives. Educate the patient and family to reduce the use of physical restraints.

Behavior Exhibited	Suggested Options, if available
Falls	Bathroom rounds Grab rails and raised toilet seats Side rails kept down Bed in low position Increase the light in the room Eliminate hazards, clear a path Ambulate frequently / supervised ambulation Bed Alarm / Chair Alarm Family supervision Call bell within reach Wear supportive shoes Gripping rubber mats / nonslip surface in chairs Keep patient in view of staff Wedge cushions Adequate pain medication Place commode at bedside Provide glasses, hearing aid, dentures, purse, etc. If fatigued and in the chair, transfer to the bed

	Place pillow or rolled blanket under mattress to create lip at edge Evaluate meds to decrease the possibility of side effects Make sure clothing, tubing, etc. not interfering with walking Consult with PT for alternatives
Scratching	Eliminate itch and treat the cause Diversional activities
Pulling at Tubes	Wear Briefs over Foley catheter Hide or camouflage IV tubing Get tubes out as soon as possible Provide patient something else to "fiddle" with Consider alternatives for NG tubes
Pulling at wounds or dressings	Overdress wounds Hide or camouflage dressings Medicate for pain Supervise confused patients carefully Use abdominal binders when possible Evaluate to see if tape or dressing is itching Try calming music / distract the patient with TV, activities, etc. Consult with school program for learning activities If active play activities are not available, provide stimulation with music, audio books, and mobiles. colorful surroundings, etc.
Wandering	Determine where the patient is going and why Anticipate needs; learn past patterns and coping styles Have hearing aid and glasses available Use STOP signs

	Decrease stimuli (ex. light, noise, interruptions) Exercise patient or walk them frequently Reminisce and validation Use alarms Family / friend / volunteer supervision Test for urinary tract infections (UTI) and treat as indicated and ordered Assess pain level. Treat as indicated and ordered Place bed in lowest position Reality orientation / psychosocial intervention Offer interesting TV program, game or activity Consult with OT / PT for alternatives
Rummaging and Scavenging	Busy boxes Reorientation Family / friend / volunteer supervision
Combative	Control for visual and auditory stimuli Music therapy and relaxation tapes Assess pain level or medication side effects Explain slowly what you are trying to do and move slowly Rest periods Contracting, when appropriate Consistent personnel Family / friend / volunteer involvement Provide reality links: TV, radio, calendar, clock Explain procedures to reduce fear and convey a sense of calm Involve the patient in conversation, don't talk over them Use active listening to elicit the patient's perspective

	Allow patient I family as much control over daily routine as possible

E. When an individual patient's assessed needs indicate the use of restraint, the least restrictive means should be chosen. For example, hand mittens for a patient who is scratching an irritated skin rash may be effective instead of the more restrictive soft wrist restraints.

F. Less restrictive measures may still constitute a restraint for which an order must be obtained if the patient cannot readily remove the device.

RESTRAINTS TO PREVENT INTERFERENCE WITH MEDICAL AND SURGICAL CARE

A. Definition of Restraints used for non-behavioral health patients (Non-violent and non-self destructive behavior) purposes

1. The patient is performing some action that interferes or has the potential to interfere with medical and /or surgical healing.

a. The patient pulls at, attempts to remove, actually removes, or dislodges IVs, drains, tubes, surgical dressings or other therapies or treatments.

b. The patient gets out of bed unassisted when assessed as unstable or when activity may be detrimental to the patient.

B. Clinical Justification

1. After assessing/evaluating a patient's physical or emotional condition, and despite attempts at alternative solutions, the documented continuance of a patient activity that will interfere with medical therapy justifies initiation or continued use of restraints.

2. If, based on a complete nursing assessment/evaluation, an RN assesses a patient to need a restraint to prevent interference with medical and surgical care, then that RN shall notify the patient's treating physician who may give an order for restraints.

C. Initiation of Restraints

1. If the patient is not in immediate danger, the RN may obtain an order for the restraint prior to applying restraints.

2. The RN may only apply restraints to prevent interference with medical and surgical care without receiving a physician's order if the patient's safety will be jeopardized without immediate use. The RN, after appropriate assessment, may make the decision to initiate and apply a restraint if the physician is not immediately available.

a. The RN who determines that the patient requires restraints will notify the physician and obtain a telephone order or written order. The order must be obtained immediately (within 1 hour) after the initiation of restraints. If the episode that led to restraints is a significant change for the patient, the physician will be notified immediately.

b. A physician will examine the patient within 24 hours of initiation of restraint used to prevent interference with medical or surgical care, and will enter a written order into the patient's medical record.

D. Physician's Order

1. A physician's order for the management of non-behavioral health patients (Non-violent and non-self destructive behavior) must be obtained for each restraint episode.

2. Restraint orders must include:

a. Date and time order was written

b. Restraint category: Non-behavioral health patients (Non-violent and non-self destructive behavior)

c. The type of restraint to be used

d. Time specific

e. The reason for restraint (i.e. patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint).

f. Signature of a physician in the appropriate time frame.

g. Cannot be written as “PRN."

3. Each written order for a physical restraint to prevent interference with medical and surgical care is to be renewed no less often than every twenty four (24) hours.

4. Example of Physician order

a. Restrain wrists for up to twenty-four hours using soft wrist restraints to prevent dislodging IV tubes.

E. Physician Assessment and Continuation of Restraint orders

Continued use of restraints beyond the first 24 hours is authorized by a physician renewing the original order or issuing a new order if restraint continues to be clinically justified.

1. Such renewal or new order is issued no less often than every 24 hours and is based on a documented face-to-face examination of the patient by the physician. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.

2. If the patient's attending physician is not the physician who has ordered the restraint, then the patient's attending physician should be notified of the initiation of the restraint order as soon as possible.

F. Early Termination

1. The restraint will be terminated as soon as possible when the initial action is no longer evident or alternatives are effective.

2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(e)

G. Re-application

1. If a patient was recently released from interference with medical and surgical care restraint due to non-behavioral health (Non-violent and non-self destructive behavior) and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.

2. Staff cannot discontinue an order and re-start it under the same order because that would constitute a PRN order. Each episode of restraint use must be initiated in accordance with the order of a physician.

3. A temporary release that occurs for the purpose of caring for a patient's needs-for example toileting, feeding, and range of motion or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/ Ongoing Assessment of the Patient

1. An RN/LVN/CNA who has demonstrated competency in the application and monitoring of restraints may apply and monitor the restraints.

2. The RN is responsible to assess the patient on an ongoing basis and determine whether restraints should be continued or terminated.

3. After applying restraints, immediately perform an initial assessment to ensure the well being of the patient, safe and proper application, and that there is no evidence of injury. If the patient's response is negative, make immediate changes.

4. During the period of restraint, the patient must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction with the patient, or direct assessment and will be done at a minimum of every 2 hours. Documentation of assessment will include relevant orders for use, results of patient monitoring, reassessment, and significant changes in patient's condition.

    a. Assessment for patients who are restrained with soft limb restraints, mitts, or side rails, will be documented at least every 2 hours.

5. The RN assessment includes the following:

    a. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)

    b. Circulation/sensation/movement (CSM) of affected extremities

    c. Well-being - the patient's physical and emotional well-being is addressed

    d. Application: the restraint is safely and properly applied

    e. Signs of injury associated with applying restraint

f. Vital Signs: Done if per patient physical/emotional status the RN assesses the need for vital signs

g. Release and ROM to restrained extremity every 2 hours

h. Whether less restrictive methods are possible

i. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible.

j. Dignity and rights are maintained. Attention is given and interventions are provided to meet the patient's physical needs including but not limited to:

1) Hydration

2) Nutrition

3) Elimination

4) Hygiene

RESTRAINTS FOR MANAGEMENT OF VIOLENT AND/OR SELF-DESTRUCTIVE BEHAVIOR

A. Definition: Behavioral health (Violent and/or self destructive behavior) Restraint

1. The patient is displaying assaultive/ aggressive behavior that poses imminent risk of physical harm to him/her, the staff and/or others.

2. Restraints for management of violent or self-destructive behavior is an emergency measure that should be reserved for those occasions when unanticipated aggressive or destructive behavior places the patient or others in imminent danger and nonphysical intervention would not be effective.

3. The use of restraints for the management of violent or self-destructive behavior is not based on a patient's restraint history or solely on a history of dangerous behavior.

4. Whenever possible, non-physical interventions are used to avoid the use of restraints for the management of violent or self-destructive behavior through de-escalation techniques. when there is an imminent risk of physical harm, physical interventions will need to be applied.

B. Clinical Justification

1. After assessing/evaluating a patient's emotional condition, and after consideration or trial of alternative solutions, the documented continuance of a patient behavior that gives reasonable probability of harm to self or others justifies the initiation or continued use of restraints.

2. The RN must justify the use of the restraint in the patient's medical record. This includes the specific behavior that placed the patient or others at risk and the alternatives attempted.

C. Initiation of Restraints

1. In an emergent condition when the RN has assessed the patient and evaluates that the behavior is aggressive/assaultive then the RN may make the decision to restrain the patient.

2. The RN must inform the physician for the need for restraints for the management of violent or self-destructive behavior, obtain a telephone order or written order, and consult with the physician about the patient's physical and psychological condition immediately (within 1 hour) after initiation of the restraint.

3. The in-person evaluation and documentation by the physician, conducted within 1 hour of the initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following:

    a. An evaluation of the patient's immediate situation.

    b. The patient's condition or symptom(s) that warranted the use of the restraint.

    c. Alternatives or less restrictive interventions attempted (as applicable).

    d. The patient's medical and behavioral condition.

    e. A description of the intervention used.

    f. The patient's response to the intervention used, including the need to continue or terminate use of restraint.

D. Physician Order

1. A physician's order for a restraint for management of behavioral health restraints (violent and/or self-destructive behavior) must be obtained for each restraint episode.

2. Restraint orders must include:

    a. Date and time order was written.

    b. Restraint category: Behavioral Health (Management of Violent and/or Self-Destructive Behavior).

    c. Type of restraint to be used.

    d. Time specific.

    e. Reason for restraint; description of the patient's behavior'

    f. Signature of a physician within the appropriate period of time.

    g. Cannot be written as "PRN."

3. Verbal and written orders for restraints used for the management of behavioral health (violent and/or self-destructive behavior) are time-limited as indicated below. Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

    a. 4 hours for adults ages 18 and older

    b. 2 hours for children and adolescents ages 9-17

c. 1 hour for children under 9 years of age.

E. Physician Assessment and Continuation of Restraints

1. The physician must complete a face-to-face evaluation of the patient and evaluate the need for restraint within one hour after the initiation of the restraint. A telephone call is not adequate.

2. Upon initiation of restraints for management of violent or self-destructive behavior and on an ongoing basis, the physician will provide the following:

   a. Reviews with staff the physical and psychological status of the patient and supplies staff with guidance in identifying ways to help the patient regain control so that restraints can be discontinued.

   b. Reevaluates the efficacy of the patient's plan of care, treatment, and services and determines whether restraints should be continued.

   c. Works with the patient to identify ways to help regain control.

   d. Supplies the order.

3. When restraint is continued for management of violent or self-destructive behavior and the individual providing the order is someone other than the patient's physician, the patient's responsible physician is notified of the patient's status.

4. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.

5. Every 24 hours, the physician primarily responsible for the patient's ongoing care evaluates the patient in person before writing a new restraint order for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

6. If the patient is released from restraint used for management of violent or self-destructive behavior prior to the expiration of the original order, the physician still has to conduct an in-person evaluation of the patient within 24 hours of the initiation of restraint and original order.

F. Early Termination

1. The use of physical restraint must be limited to the duration of the emergency safety situation regardless of the length of the order. The physician has the discretion to decide that the order should be written for a shorter period of time. Staff should assess, monitor, and assist the patient to regain control, and re-evaluate the patient so that he or she is released from the restraints at the earliest possible time.

2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(F)

G. Reapplication of Restraints

1. If the patient was recently released from restraints for the management of violent or self-destructive behavior and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.

2. Staff cannot discontinue an order and re-start it under the same order if the patient's behavior escalates again after he or she has been released. Each episode of restraint use must be initiated in accordance with the order of a physician; PRN orders are prohibited

3. A temporary release that occurs for the purpose of caring for a patient's needs - for example toileting, feeding, and range of motion - or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/Ongoing Assessment of Patients

1. During the time of restraint use for the management of violent or self-destructive behavior, there will be continuous in-person observation by an assigned staff member who is competent in the use of restraints.

2. During the period of restraint use for management of violent and/or self-destructive behavior, all patients must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction, or direct assessment.

3. After applying restraints, the RN will immediately perform an initial assessment to ensure the well being of the patient, safe and proper application, and that there is no evidence of injury. If the patient's response is negative, make immediate changes.

a. Assessment of the patient in restraints for management of violent or self-destructive behavior is performed at the initiation of restraints and minimally every 15 minutes thereafter. This assessment includes the following:

b. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)

c. Circulation/sensation/movement (CSM) of affected extremities

d. Well-being. The patient's physical and emotional well-being is addressed

e. Application: the restraint is safely and properly applied

f. Signs of injury associated with applying restraint

g. Vital Signs: Completed if the RN’s assessment warrants the need for vital signs

h. Release and range of motion (ROM) to restrained extremity every 15 minutes

i. Whether less restrictive methods are possible

j. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible

k. Dignity and rights are maintained. Attention is given to the patient's needs including but not limited to:

1) Hydration

2) Nutrition

3) Elimination

4) Hygiene

5) Physical or psychological status and comfort.

4. If the patient is in a physical hold for management of violent or self-destructive behavior, another staff person who is competent in the use of restraint and who is not involved in the physical hold is assigned to observe the patient.

5. Staff members help patients meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior by attempting alternatives and providing for less restrictive measures whenever possible.

   a. Assisting to meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior can include the following interventions:

      1) Appropriate implementation of medical plan of care to stabilize the disease process causing the aggressive/assaultive behavior

      2) Decrease environmental stimuli to a minimum

      3) Set clear, consistent, and enforceable limits on behavior

      4) Attend and respond positively to patient anxiety or anger with active listening and validation of patient distress

      5) Work with patient to identify the internal and interpersonal factors that provoke violence/aggression

      6) Work with patient to identify what supports are lacking and problem-solve ways to achieve needed support

      7) Role-play alternative behaviors with patient that they can use in stressful and overwhelming situations

      8) Work with patient to set goals for their behavior

      9) Provide patient with other outlets for stress and anxiety

      10) Provide patient and family/significant other with community resources that teach anger management and stress reduction techniques

      11) Utilize de-escalation techniques for staff who are trained in this

:

RESTRAINT APPLICATION

A. Competent staff applies restraint corr.ctly and appropriately to protect patient safety.

B. Please reference Lippincott for limb and vest restraint application.

C. If a patient must be restrained in the supine position, ensure that the head is free to rotate to the side and, when possible, the head of the bed is elevated to minimize the risk of aspiration.

D. Secure Restraint so that it may be released immediately in emergency situations.

E. Verify that the order for restraint includes rationale for restraint, length of time and type of restraints to be used, and extremity or body part(s) to be restrained

F. All limb restraints are to be kept in full view and not covered with sheet or bedspread.

DOCUMENTATION

A. Documentation of restraint application for non-behavioral health (non-violent, non-self destructive behavior), or for behavioral health (violent and/or self-destructive behavior) includes the following:

1. In the Electronic Health Record (EHR)

a. Initial assessment/clinical justification that includes the patient's behavior or actions that led to the use of the restraint.

b. Alternatives/Interventions attempted before use of restraint or rationale on why these were not appropriate with this patient.

c. Choice of less restrictive means as applicable.

d. Time of application and termination.

e. Family notification of restraint application, if appropriate

f. When the patient no longer needs to be restrained, documentation must include the time and rationale for removal from restraints

g. Physician's order, which includes type of restraint, time limit and reason for restraint.

2. Patient family teaching is documented on the Restraint Education section.

CARE PLANNING

A. A modification to the patient's plan of care must accompany the use of restraints for either Non-behavioral health (Non-violent, non-self destructive behavior) or management of behavioral health (violent and/or self-destructive behavior)

B. Nursing documentation will reflect assessment intervention, evaluation, and re-intervention process with a focus on utilizing the restraint for the shortest period of time and the least restrictive measures

C. Care plan modifications may include but are not limited to the following:

1. Patient care problem

2. Outcome-oriented goal

3. Restraint intervention used

4. The Nursing documentation will reflect the date the restraint was initiated and discontinued and appropriate interventions taken to ensure patient safety

EDUCATION

A. Physicians and other licensed independent practitioners authorized to order restraints are educated on the policy during their orientation. Education on policy changes occurs during policy review and approval at medical department meetings

B. Education and training in the proper and safe use of restraints shall be provided as part of the employee's initial orientation and before participating in the use of restraints. Competency will be evaluated during orientation and annually. The nursing department education plan will include annual restraint education.

C. Education and training of staff with direct patient contact shall include but not be limited to:

1. Hospital policy on restraints

2. Understanding that behaviors are sometimes related to the patient's medical condition

3. The use of alternative interventions and least restrictive measures

4. The initiation, safe application, and removal of all types of restraints used including monitoring and reassessment criteria. Training includes how to recognize and respond to signs of physical and psychological distress, and patient monitoring/observation/assessment and reassessment parameters.

5. Monitoring the physical and psychological well-being of the patient who is restrained, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person physician evaluation conducted within one hour of initiation of behavioral health (Violent and/or self destructive behavior) restraints.

6. Patient comfort, modesty, well being, dignity, rights and respect, hygiene, psychological status, elimination, nutrition, hydration needs and to recognize signs of physical distress in restrained patients.

7. Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of behavioral restraints.

8. Determination of underlying causes of behavior that may be related to a medical condition. (i.e. hypoglycemia, DTs, delirium and how that may be related to the patient's emotional condition).

9. Recognition of how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way an individual reacts to physical contact and restraints.

10. Use of nonphysical intervention skills

11. Methods for choosing the least restrictive interventions based on an assessment of the patient's medical or behavioral status or condition

12. Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

13. Clinical justification of specific behavioral changes that indicate that restraints are no longer necessary

PERFORMANCE IMPROVEMENT

REPORTING OF PATIENT DEATHS ASSOCIATED WITH RESTRAINT

NIHD must report deaths associated with restraint to its CMS regional office no later than the close of business the next business day following knowledge of the patient's death. [CMS 482.13(f)(7)]

NIHD must report to its CMS Regional Office each death that occurs:

1. While a patient is in restraint, except when no seclusion has been used and the only restraint used was a soft, cloth-like 2-point wrist restraint.

    a. Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device must be reported to CMS.

    b. Death associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints must be reported to CMS.

2. Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was a soft, 2-point wrist restraint

3. Within one (1) week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time

Patient Death Reporting- Only in 2-Point Soft Wrist Restraints and no seclusion:

NIHD must maintain an internal log or other type of tracking system for recording information within seven (7) days of a patient's death that occurs:

1. While a patient is only in 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and

2. Within 24 hours of the patient being removed from 2-point soft, cloth-like non-rigid wrist restraints where there was no use of any other type of restraint or seclusion

3. This log must be made readily available to CMS immediately upon request.

It is the responsibility of the Chief Executive Officer, or his/her designee, to report the incident to CMS after notification of hospital group administration and document in the patient's medical record the date and time the death was reported to CMS.

REFERENCES:

1. Centers for Medicare and Medicaid Services (CMS). Federal Register Part IV: Department of Health and Human Services. Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient's Rights; Final Rule. December 8, 2006. 42 CFR Part 482: (pp.71378-71428).
2. Centers for Medicare and Medicaid Services (CMS). Restraint Rate per 1000 LTCH Days Measure Specifications*. June 11, 2012. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/downloads/restraintrateper1000-ltchdaysmeasurespecifications.pdf
3. Centers for Medicare and Medicaid Services (CMS), State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, 04-01-2015
4. California Department of Public Health, Licensing and Certification Program, General Acute Care Hospital Memorandum, Subject: Centers for Medicare and Medicaid (CMS) Death Reporting Requirements, August 3, 2009.
5. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive Accreditation Manual for Hospitals Update 1, June 2010(pp. PC.03.02.01-PC.03.02.11) Oakbrook Terrace, IL: Joint Commission Resources, Inc.
6. Management of Aggressive Behavior. MOAB Training International, Inc. 2007. Kulpsville, PA: Cricket Press, Inc.
7. Title 22, California Code of Regulations, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, section 73095, 73403-73409.2005. State of California, Office of Administrative Law.
8. Varcarolis, EM. Manual of Psychiatric Nursing Care Plans: Diagnoses, Clinical Tools, and
9. Psychopharmacology, 3rd edition. 2006. (pp. 497-517). St Louis, MO: Saunder Elsevier.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Forensics
2. Lippincott limb restraint application
3. Lippincott vest restraint application
4. Swing Bed Patient Restraints

Supersedes: v.7 Swing Bed Patient Restraints*

RESOLUTION NO. 22-17

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 November, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Jody Veenker, Chair
Board of Directors

ATTEST:

_____
Name: Autumn Tyerman
Title: Board Clerk

CALL TO ORDER

The meeting was called to order at 5:30 p.m. by Jody Veenker, Northern Inyo Health Care District (NIHD) Board Chair.

PRESENT

Jody Veenker, Chair
Mary Mae Kilpatrick, Vice Chair
Jean Turner, Treasurer
Robert Sharp, Member-at-Large (arrived at 6:15 p.m.)
Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer (via zoom)
Allison Partridge RN, MSN, Chief Nursing Officer
Stephen DelRossi, Chief Financial Officer
Joy Engblade, MD, Chief Medical Officer
Sierra Bourne, MD, Chief of Staff

ABSENT

Topah Spoonhunter, Secretary

POSTPONMENT OF AGENDA ITEM E

Chair Veenker announced that Agenda Item E (*NIH Foundation Board Member to be considered for approval*) would be postponed due to illness of the candidate.

OPPORTUNITY FOR PUBLIC COMMENT

Chair 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. Public comments were heard from the following:

- Anneke Bishop
- Samantha Bumgarner
- Rebecca Street
- Kaylyn Rickford

Jean Turner, NIHD Board Treasurer, acknowledged Maureen, an employee at Rural Health Clinic (RHC), for her support with an appointment scheduling conflict.

NEW BUSINESS

APPROVAL OF THE ACTUARIAL DEFINED BENEFIT POLICY

Human Resource Director Alison Murray brought attention to the approval of the Actuarial Defined Benefit Policy. Stuart Herskowitz of Hooker & Holcombe introduced himself and Ellen A. Kucenski. Mr. Herskowitz explained that Ms. Kucenski has been working with Chief Financial Officer Stephen DelRossi on the new actuarial policy. Ms. Kucenski presented the policy and asked if members of the Board had questions.

A discussion between CFO DelRossi and the Board of Directors took place.

It was moved by District Treasurer Jean Turner, seconded by Vice Chair Kilpatrick and passed with a 3 to 0 vote to approve the Actuarial Defined Benefit Policy.

AYES: Jean Turner, Mary Mae Kilpatrick and Jody Veenker
NOES:
ABSENT: Robert Sharp and Topah Spoonhunter

2022 JOINT COMISSION SURVEY RESULTS

Chief Medical Officer Joy Engblade welcomed RN Manager Alison Feinberg who oversaw the 2022 Joint Commission Survey. Ms. Feinberg provided an overview of the accreditation process through contracting with the Joint Commission, as well as the process and timeline to become compliant. Ms. Feinberg asked if the Board of Directors had any questions.

Vice Chair Kilpatrick asked for clarification on policy compliance. Chief Nursing Officer Alison Partridge, Chair Veenker and Vice Chair Kilpatrick commended the staff.

NIHD SHADOWING, STUDENT AND VOLUNTEER PROGRAM OPPORTUNITIES AND PARTNERSHIP PROCESS

Human Resource Manager Marjorie Routt presented the Northern Inyo Healthcare District shadowing, student and volunteer program. She outlined the process and requirements for students and volunteers to participate. Ms. Routt asked if the board had any questions.

Chair Veenker and Vice Chair Kilpatrick commented on how NIHD has benefited from this program.

NORTHERN INYO HEALTHCARE DISTRICT 2020/2021 BIENNIAL RURAL HEALTH CLINIC EVALUATION

CMO Engblade introduced Doctor Stacy Brown who would present the 2020-2021 Rural Health Clinic Biennial Evaluation. Dr. Brown provided a detailed overview of the report. He also announced he would be stepping away from his leadership position.

A discussion took place between the Board of Directors and Dr. Brown. Vice Chair Kilpatrick and Treasurer Turner thanked Dr. Brown for his service.

NEW FOUNDATION BOARD MEMBER APPROVAL

Chair Veenker announced that Item E, *New Foundation Board Member Approval*, would be postponed to the November 16, 2022 Board of Directors Meeting due to candidate illness.

DISTRICT TELEPHONE SYSTEM UPDATE

IT Director Bryan Harper provided an update on the telephone system. A discussion took place and Project Manager Lynda Vance provided additional clarification regarding the new system.

INTERIM CEO CONTRACT APPROVAL

Chair Veenker introduced the Interim CEO contract for Mr. Lionel Chadwick and stated HR Director Alison Murray would present the contract details. Ms. Murray reviewed the recruitment process and the contract. Ms. Murray asked if any board members had questions. Chair Veenker opened questions to the public.

A discussion took place and clarification was provided. Chair Veenker stated the compensation terms Article II paragraph 2.4 and Article III paragraphs 3.1-3.5 as follows: term from 12/1/22-3/31/23; compensation of $7,000/week; completion incentive of $8,000 provided Mr. Chadwick remains through 3/31/23; the same fringe benefits as other District management level employees; car rental reimbursement of $1,900 per month; advancement of housing deposit of $1,000 which shall be refunded upon the end of the term of the agreement; monthly housing subsidy of $3,000 per month, plus associated reasonable expenses for utilities and cable service; incidental expenses incurred in the normal course of providing services to the District; travel expenses to Bishop at the commencement of the term and a return to Mr. Chadwick's place of residence following the completion of the term; and severance in the amount of the remaining term of the agreement if Mr. Chadwick's employment is terminated without cause prior to the end of the term.

It was moved by Treasurer Turner, seconded by Robert Sharp, Member at Large, and passed with a 4 to 0 vote to approve the Interim CEO Contract.

AYES: Jean Turner, Mary Mae Kilpatrick, Robert Sharp and Jody Veenker

NOES:
ABSENT: Topah Spoonhunter

CHIEF OF STAFF REPORT, SIERRA BOURNE MD

Chief Medical Officer Joy Engblade announced that she would be presenting the Chief of Staff Report on behalf Doctor Sierra Bourne. Dr. Engblade reported the Medical Executive Committee recommends approval of the following policies:

1. Medical Direction RHC
2. New Line of Service

Chair Veenker expressed appreciation for the thorough new line of service.

It was moved by Robert Sharp, seconded by Vice Chair Kilpatrick and passed with a 4 to 0 vote to approve the *Medical Direction RHC* and *New Line of Service*.

AYES: Jean Turner, Mary Mae Kilpatrick, Robert Sharp and Jody Veenker
NOES:
ABSENT: Robert Sharp and Topah Spoonhunter

Dr. Engblade noted there was nothing additional to report.

CONSENT AGENDA

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

1. *Approval of District Board Resolution 22-15, to continue to allow Board meetings to be held virtually*
2. *Approval of minutes of the September 21,2022 Regular board Meeting Agenda*
3. *Approval of the October 6, 2022 Special Board Meeting Agenda*
4. *Approval of the Grand Jury Report dated October 11, 2022*
5. *Financial and Statistical reports for August 31, 2022*
6. *Approval of Policies and Procedures*
    A. *Temporary Loaning of district Equipment*
    B. *Accessibility & Labeling of Piped Med Gas System EC. 02.05.09 EP11*

It was moved by Vice Chair Kilpatrick, seconded by Treasurer Turner and passed with a 4-0 vote to approve all six (6) consent agenda items.

AYES: Mary Mae Kilpatrick, Jean Turner, Jody Veenker and Robert Sharp

ABSENT: Topah Spoonhunter

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Chair Veenker asked if any members of the Board of Directors wished to report on any items of interest.

Several Board Members expressed interest in the upcoming employee Halloween costume contest. Treasurer Turner acknowledged the flexibility of the staff, from preparing for the Joint Commission Survey to event planning.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair 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 7:03 p.m. Chair Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. *Conference with Labor Negotiators, Agency Designated Representatives: Irma Rodriguez Moisa and Andrew M. Aller; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6)*

B. *Conference with Legal Counsel- Anticipated Litigation. Gov't Code 54956.9(d)(2). Number of potential cases: (1)*

Chair Veenker 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 7:27 p.m. the meeting returned to Open Session. Chair Veenker reported that the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 7:27 pm.

_____
Jody Veenker, Chair

Attest: _____

Topah Spoonhunter, Secretary

CALL TO ORDER

The meeting was called to order at 5:30 p.m. by Jody Veenker, Northern Inyo Health Care District (NIHD) Board Chair.

PRESENT

Jody Veenker, Chair
Mary Mae Kilpatrick, Vice Chair
Jean Turner, Treasurer
Robert Sharp, Member-at-Large
Topah Spoonhunter, Secretary
Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer (present via zoom)
Joy Engblade, MD, Chief Medical Officer (present via zoom)

ABSENT

Allison Partridge RN, MSN, Chief Nursing Officer
Stephen Del Rossi, Chief Financial Officer

OPPORTUNITY FOR PUBLIC COMMENT

Chair Veenker reported that at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No comments were heard.

OPEN SESSION:

WITTFKIEFFER CEO SEARCH SERVICES PROPOSAL

Chair Veenker called attention to the consideration of the WittKieffer Chief Executive Officer (CEO) search services proposal. Treasurer Turner requested the Human Resource Director, Alison Murray, explain the current CEO recruitment process in comparison to the WittKieffer proposal. A discussion took place.

It was moved by Robert Sharp, seconded by Jean Turner, and passed with a 5-0 vote to table this item until the November 16, 2022 Board of Directors Meeting.

AYES: Jody Veenker, Mary Mae Kilpatrick, Jean Turner, Topah Spoonhunter, Robert Sharp

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair 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 5:59 p.m. Chair Veenker announced the meeting would adjourn to Closed Session to all the NIHD Board of Directors to:

A. Conference with Legal Counsel - Anticipated Litigation. Gov't Code 54956.9(d)(2). Number of potential cases: (1)

RETURN TO OPEN SESSION AND REPORT OF ANY ACTION TAKEN

At 8:05 p.m., the meeting returned to Open Session. Chair Veenker announced that the Board took no reportable action.

ADJOURNMENT

Adjournment at 8:06 p.m.

_____
Jody Veenker, Chair

Attest: _____
Topah Spoonhunter, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

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

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: November 2022

TO: NIHD Board of Directors

FROM: Kelli Davis, Chief Executive Officer (CEO)

RE: Monthly CEO Report– Northern Inyo Healthcare District

REPORT DETAIL

Healthcare Legislation and Informational Updates
United States Government Accountability Office - Report to Congressional Committees – Maternal Health: Availability of Hospital Based Obstetric Care in Rural Areas – Article attached

California Hospital Association - Minimum Wage Update – Article attached

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

Closing
This is my last participation in a meeting of the NIHD Board of Directors. It has been my honor to serve our community and the team members of the District in a leadership role for 12 years. I feel fortunate to have had the opportunity to serve our community alongside so many gifted and dedicated employees and providers.

I will forever hold a special place in my heart for NIHD.

I look forward to what the future holds for me in my next healthcare leadership role!

Respectfully submitted,

Kelli Davis

Kelli Davis - CEO

Minimum Wage Update

November 3, 2022

This update provides the latest information on a series of local ballot initiatives and ordinances underway that aim to increase the minimum wage to $25 an hour for some health care workers in some California cities and place operational restrictions (such as the inability to lay off workers) on affected hospitals. The California Hospital Association (CHA) expects that more ordinances will be introduced at the local level, that statewide $25 an hour minimum wage legislation will be introduced, and that a ballot initiative for statewide $25 an hour minimum wage will be attempted in 2024. While local initiatives only affect certain hospitals, it's important that all hospital leaders be aware of the growing push for a new minimum wage and our advocacy activities underway.

OVERVIEW

After months of lobbying city councils, filing referenda, engaging in litigation and other activities, not a single minimum wage ordinance has yet gone into effect. Two measures are on this November's ballot and four measures will likely be on the 2024 ballot, while four cities have taken no action. CHA and the Hospital Association of Southern California (HASC) are actively engaged on behalf of hospitals statewide. Below is a snapshot of the latest news.

BALLOT INITIATIVES ON THE NOVEMBER 2022 BALLOT: DUARTE AND INGLEWOOD – THE HOME STRETCH

All eyes are on the cities of Inglewood and Duarte on Election Day and the outcome of ballot initiatives there. Following the election on Nov. 8, votes must be certified by Dec. 8. If early results are available sooner, we will share them with hospital leaders. **NOTE: If we are unsuccessful, hospitals will have 10 days from the city councils' certification to implement the new law.**

City of Duarte, Measure J and City of Inglewood, Measure HC

Voters in the cities of Duarte and Inglewood will be voting on minimum wage measures on Nov. 8. CHA and HASC are actively running aggressive and high-visibility campaigns in each city — No on Measure J and No on Measure HC. The campaigns include expansive paid media with targeted digital and social ads, cable, radio, print and billboard advertising in English and Spanish. Ads feature local health care workers and key third-party endorsements voicing opposition to the measures (primarily based on the arguments that the measures are unequal, unfair, and would increase health care costs). Third-party supporters of our opposition include:

- NAACP Inglewood/South Bay
- Los Angeles County Medical Association
- Los Angeles Metro Hispanic Chamber
- Latinx Physicians of California
- Minority Health Institute
- California Senior Advocates League

The campaign has also been advancing an earned media effort as well as comprehensive operations on the ground in Inglewood and Duarte that includes phone calls, texts, and home visits to voters.

Importantly, SEIU-UHW is running aggressive campaigns in each city to urge voters to support the measures. In their campaign materials, the union is spreading inaccurate information about hospitals, disparaging hospital CEOs, and employing other aggressive tactics.

Campaign finance filings show UHW has spent more than $11 million in support of the minimum wage measures in the 10 cities it targeted.

ORDINANCES AND LEGAL ACTIVITIES

LOS ANGELES

After the L.A. City Council passed the ordinance directly in a 9-0 vote, CHA and HASC moved quickly to collect more than 88,000 signatures to qualify a referendum to freeze the ordinance and give voters the right to decide. The City Council then placed the referendum on the March 2024 ballot. In recent weeks, the city has called for a special election in April 2023 for the seat vacated by the resignation of L.A. City Council President Nury Martinez. Currently, this April 2023 election is only in Martinez's district, meaning the referendum cannot appear on this earlier ballot.

DOWNEY

CHA and HASC also collected more than 17,500 signatures to qualify a referendum in Downey after the City Council directly passed the ordinance — pausing the law until voters can decide. On Oct. 11, the Downey City Council voted to place the CHA/HASC referendum measure on the November 2024 ballot.

MONTEREY PARK

After a successful CHA/HASC lawsuit challenging the authority of the council to pass the ordinance with only two votes, the Monterey Park City Council on Oct. 5 voted to rescind the ordinance and instead place the measure on the November 2024 ballot.

LONG BEACH

After the Long Beach City Council passed the minimum wage ordinance directly, CHA and HASC quickly moved to gather signatures for a referendum in that city. Roughly 40,000 signatures were submitted and the Los Angeles County Clerk's Office is currently validating those submissions. A report from the county is expected Nov. 3. Once validated, the City Council will have to take a vote to place the referendum on a future ballot, likely in April 2024.

BALDWIN PARK

Proponents did not gather enough signatures to qualify the measure for the ballot. However, UHW lobbied the council aggressively to pass an ordinance. After weeks of deliberation and discussion with HASC and community partners, the council opted not to adopt a measure.

LYNWOOD

Proponents did not gather enough signatures to qualify the measure for the ballot and the City Council took no action to explore an ordinance.

ANAHEIM

Proponents never turned in signatures for Anaheim and the City Council took no action to explore an ordinance.

ON THE HORIZON

CULVER CITY

The Culver City Council is the remaining city currently exploring an ordinance. UHW did not collect enough signatures to qualify an initiative, so the City Council is under no time constraint to do anything on this matter. The mayor recently asked for support from three council members to discuss a health care worker wage increase at a future meeting, but did not receive three affirmative voices in support. At this

point, the earliest the council could discuss this matter would be at its December meeting.

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United States Government Accountability Office

Report to Congressional Committees

October 2022

MATERNAL HEALTH

Availability of Hospital-Based Obstetric Care in Rural Areas

Accessible Version

GAO-23-105515

GAO Highlights

Highlights of GAO-23-105515, a report to congressional committees

October 2022

MATERNAL HEALTH

Availability of Hospital-Based Obstetric Care in Rural Areas

Why GAO Did This Study

Access to obstetric care is a growing concern in rural U.S. communities, given recent closures of hospitals in rural areas. The loss of hospital-based obstetric services in rural areas is associated with increases in out-of-hospital births and pre-term births, which may contribute to poor maternal and infant outcomes. These have been more prevalent in rural areas and non-White racial and ethnic groups.

House Report 116-450 directed GAO to report on ways to improve access to obstetrics care in rural areas. This report is focused on the hospitals and clinicians that provide delivery services, and describes (1) the availability of hospital-based obstetric services in rural areas, (2) stakeholder perspectives on factors that affect such availability, and (3) stakeholder perspectives on efforts federal agencies, states, and others could take to increase such availability.

GAO reviewed literature published from 2011 through 2022, interviewed researchers and provider associations, and conducted semi-structured interviews with 19 selected stakeholders to obtain their perspectives on factors that affect the availability of care and efforts to address such factors. Stakeholders, comprised of provider associations, patient advocacy groups, researchers, and federal agencies, were selected to represent diverse perspectives, including various obstetric clinicians and organizations representing different racial and ethnic groups.

GAO provided a draft of this report to HHS. HHS provided technical comments, which GAO incorporated as appropriate.

View GAO-23-105515. For more information, contact Alyssa M. Hundrup at (202) 512-7114 or HundrupA@gao.gov

What GAO Found

Research indicates that the number of rural hospitals providing obstetric services declined from 2004 through 2018, and more than half of rural counties did not have such services in 2018, according to the most recent data available. Studies showed that closures were focused in rural counties that were sparsely populated, had a majority of Black or African American residents, and were considered low income. Studies also showed differences in the type of clinicians delivering babies in rural and urban areas. Specifically, family physicians were more common in rural areas than in urban areas, while obstetrician-gynecologists and midwives were more common in urban areas, though the prevalence and types of clinicians varied by state.

Stakeholders GAO interviewed most often ranked two factors as most important among a list of seven factors potentially affecting the availability of obstetric care in rural areas. Specifically, stakeholders said:

- **Medicaid reimbursement rates** set by states do not cover the full cost of providing obstetric services. This may mean particular financial losses for hospitals providing these services in rural areas, where a higher proportion of births are covered by Medicaid. Medicaid covered 50 percent of rural births in 2018, compared to 43 percent of births for the United States as a whole, according to the most recent analysis from the Medicaid and CHIP Payment and Access Commission.
- **Recruiting and retaining providers** is particularly challenging for rural areas, as they must compete with urban areas for a limited pool of providers to staff obstetric units that require a full range of maternal health providers, such as physicians and nurses, as well as anesthesiologists.

Stakeholders GAO interviewed most often cited the following efforts federal agencies, states, and others could take to increase the availability of obstetric care in rural areas. Specifically, stakeholders said:

- **Increasing Medicaid reimbursement** would help to keep obstetric services open, as Medicaid covers a higher proportion of births in rural areas than urban areas.
- **Increasing remote consultations**, such as through videoconferencing or phone calls, between clinicians could help ensure that rural patients who live longer distances from higher levels of obstetric care have access to such care through their own clinicians in their communities.
- **Establishing regional partnerships**—such as a hub-and-spoke model where a larger hospital (hub) partners with smaller rural hospitals (spokes) for care coordination and to provide training and other resources—could help ensure rural patients receive risk-appropriate care in their communities. For example, a specialist from the hub hospital could help manage a rural patient's high-risk condition as needed and support the rural clinician for planning delivery at the local hospital.

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
HRSA	Health Resources and Services Administration
OB/GYN	obstetrician/gynecologist

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

October 19, 2022

The Honorable Patty Murray
Chair
The Honorable Roy Blunt
Ranking Member
Committee on Appropriations
Labor, Health and Human Services, Education,
and Related Agencies Subcommittee
United States Senate

The Honorable Rosa DeLauro
Chair
The Honorable Tom Cole
Ranking Member
Committee on Appropriations
Labor, Health and Human Services, Education,
and Related Agencies Subcommittee
House of Representatives

Access to obstetric care is a growing concern for the millions of women of reproductive age that live in rural areas in the United States.[1] Recent closures of rural hospitals and difficulties recruiting and retaining clinicians that provide obstetric services, such as family physicians and obstetricians/gynecologists (OB/GYN), may have reduced the availability of hospital-based obstetric care in rural areas.[2] As we have reported, from January 2013 through February 2020, 101 rural hospitals closed, out of the approximately 2,260 rural hospitals that were open in 2013; such

[1]Reproductive age for women, also known as child-bearing age, is generally defined as between the ages of 15 and 44. Throughout this report, we may use the term "women" to describe the population that generally may become pregnant. However, this term does not include all people who can become pregnant. For example, people who do not identify as either male or female may become pregnant, as may some transgender men.

[2]There are various ways to define a rural area, and no consistent definition is used across government programs, according to the Health Resources and Services Administration. When we refer to rural counties, this includes both micropolitan and noncore counties. According to the Office of Management and Budget, micropolitan counties include nonmetropolitan counties with an urban core of 10,000 to 49,999 inhabitants. Noncore counties include non-metropolitan counties that do not qualify as micropolitan, and have an urban core of less than 10,000 residents.

closures generally were caused by financial distress, in part, from low-patient volumes.[3]

Nearly all births in the United States occur in hospitals.[4] In rural counties, the loss of hospital-based obstetric care is associated with increases in pre-term births, distance traveled for obstetric care, out-of-hospital births, and births in hospitals without obstetric units.[5] All of these may contribute to poor maternal and adverse infant health outcomes, which have been more prevalent in rural areas and for non-White racial and ethnic groups, particularly for Black or African American and American Indian or Alaska Native populations. For example, we have previously reported increasing rates of maternal mortality in the United States, with deaths during pregnancy or due to pregnancy-related causes disproportionately occurring in those same populations.[6]

Various federal agencies within the Department of Health and Human Services, including the Health Resources and Services Administration (HRSA) and Centers for Medicare & Medicaid Services (CMS), have sought to improve rural health outcomes and prevent maternal mortality and morbidity through grants, financial incentives to providers, and other efforts. State, local, and other efforts also aim to improve access to obstetric services in rural hospitals.

House Report 116-450 includes provisions for us to report on ways to improve access to obstetric care in rural areas.[7] This report focuses on

[3]See GAO, *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services*, GAO-21-93 (Washington, D.C.: Dec. 22, 2020) and *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, GAO-18-634 (Washington, D.C.: Aug. 29, 2018).

[4]In 2017, 98.4 percent of births occurred in hospitals, and 1.6 percent of births occurred out of hospitals. MacDorman, M. and Declercq, E. "Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017." *Birth*, vol. 46 no. 2 (2019).

[5]See, for example, K.B. Kozhimannil, P. Hung, C. Henning-Smith, M.M. Casey, and S. Prasad. "Association Between Loss of Hospital-based Obstetric Services and Birth Outcomes in Rural Counties in the United States." *Journal of the American Medical Association*, vol. 319, no. 12 (2018), and GAO-21-93.

[6]See GAO, *Maternal Mortality: Trends in Pregnancy-Related Deaths and Federal Efforts to Reduce Them*, GAO-20-248 (Washington, D.C.: Mar. 12, 2020) and *Maternal Mortality And Morbidity: Additional Efforts Needed to Assess Program Data for Rural and Underserved Areas*, GAO-21-283 (Washington, D.C.: April 8, 2021).

[7]H.R. Rep. No. 116-450, at 57, 214 (2020).

obstetric care in rural areas, specifically on hospitals and clinicians that provide delivery services. Specifically, this report describes

1. the availability of hospital-based obstetric services in rural areas,
2. stakeholder perspectives on factors that affect the availability of hospitals and clinicians that provide hospital-based obstetric care in rural areas, and
3. stakeholder perspectives on ongoing and proposed efforts federal agencies, states, and others could take to increase the availability of rural hospital-based obstetric care.

To describe the availability of hospital-based obstetric services in rural areas, we conducted a literature review of relevant research published from 2011 through 2022. We also interviewed researchers, including those from three rural health research centers that conduct relevant work; officials from provider associations that represent clinicians providing obstetric services; and officials from several agencies within the Department of Health and Human Services—HRSA, CMS, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality.[8]

To describe stakeholder perspectives on factors that affect the availability of hospitals and clinicians that provide obstetric services in rural areas and ongoing and proposed efforts to address such factors, we first identified lists of factors and efforts by conducting a literature review (as described above) and interviewing researchers, provider associations, and federal agencies (as described above). We then conducted semi-structured interviews with 19 selected stakeholders representing provider associations, researchers, patient advocacy organizations, and federal agencies to obtain their perspectives on the list of factors that we identified as well as a list of efforts that could be taken to address such factors. As part of these interviews, we asked the selected stakeholders to rank the list of factors from most to least important and rate the efforts based on their perceived effect on the availability of obstetric care in rural

[8]Specifically, we interviewed researchers from the North Carolina Rural Health Research Program, which conducts research on hospital closures; the University of Minnesota Rural Health Research Center, which conducts research on maternal health and access; and the Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center, which conducts research on the healthcare workforce. In addition, we interviewed researchers from the March of Dimes and National Rural Health Association. In terms of provider associations, we interviewed the American Academy of Family Physicians, American College of Nurse Midwives, and American College of Obstetricians and Gynecologists.

areas. We selected these stakeholders to represent a diversity of perspectives and experiences, including those representing different racial and ethnic groups, and from clinicians that provide obstetric care or other clinical care during delivery. In presenting the results, we used modifiers to quantify stakeholders' views.[9] See appendix I for additional details on our scope and methodology for this report.

We conducted this performance audit from November 2021 to October 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Characteristics of Rural Populations

In 2020, 46 million people lived in rural areas in the United States, making up 14 percent of the total population, according to U.S. Census data.[10] These data showed that 24 percent of people that lived in rural areas in 2020 were from racial and ethnic groups that were not White, which is less than their representation in the United States as a whole.[11] However, different regions of the United States contained more racial and ethnic

[9]When we report the results, we use the term "some" stakeholders to represent more than 0 but less than or equal to 20 percent of responses (1-4 stakeholders); "several" stakeholders to represent more than 20 percent but less than or equal to 40 percent of responses (5-8 stakeholders); "many" stakeholders to represent more than 40 percent but less than or equal to 60 percent of responses (9-11 stakeholders); "most" stakeholders" to represent more than 60 percent but less than or equal to 80 percent of responses (12-15 stakeholders); and, "nearly all" stakeholders to represent more than 80 percent but less than 100 percent of responses (16-18 stakeholders).

[10]U.S. Department of Agriculture. Economic Research Service, *Rural America at a Glance, 2021 Edition*. Economic Information Bulletin Number 230 (Washington, D.C.: November 2021).

[11]In 2020, 42 percent of residents in the United States were from racial and ethnic groups that were not White. See Brookings, "Mapping Rural America's Diversity and Demographic Change," *The Avenue* (Washington, D.C.: Sept. 28, 2021), https://www.brookings.edu/blog/the-avenue/2021/09/28/mapping-rural-americas-diversity-and-demographic-change/ (accessed Aug. 11, 2022).

diversity, with rural counties in the South and West being particularly diverse.

Census data show that rural areas also lost population overall between 2010 and 2020 compared to urban areas, seeing a decline in population of 0.6 percent compared to an increase of 8.8 percent, respectively. Most of the population losses in rural counties have been concentrated in those counties with persistent poverty (5.7 percent decrease in population) compared to rural counties with no persistent poverty (0.1 percent increase in population).[12] Additionally, those rural counties with persistent poverty also had high percentages of people from racial and ethnic groups that were not White.

Compared to their urban counterparts, rural residents tend to be older, poorer, and sicker.[13] Rural residents are also more likely to be covered by Medicaid, a federal-state health-care financing program for certain low-income and medically needy individuals, than residents living in urban areas. Medicaid is administered by states, according to federal requirements, and states set reimbursement rates. Under the Patient Protection and Affordable Care Act, states had the option to expand Medicaid to cover nearly all adults with incomes up to 133 percent of the federal poverty level, thereby increasing the number of beneficiaries covered by the program.[14] In 2018, Medicaid covered 50 percent of births in rural areas, compared to 43 percent for the United States as a whole, according to the most recent analysis we identified.[15]

[12]The Economic Research Service defines counties as having persistent poverty if 20 percent or more of the population lived at or below the Federal poverty line during the four consecutive U.S. Census measurements dating to 1980.

[13]J. Foutz, S. Artiga, R. Garfield. "The Role of Medicaid in Rural America. Kaiser Family Foundation (Washington, D.C.: April 2017).

[14]The Patient Protection and Affordable Care Act gave states the option to expand their Medicaid programs by covering nearly all adults with incomes at or below 133 percent of the federal poverty level beginning January 1, 2014. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The Act also permitted an early expansion option, whereby states could expand eligibility for this population, or a subset of this population, starting on April 1, 2010. States choosing to expand their Medicaid programs receive a higher federal matching rate for the enrollees covered by the expansion.

[15]Medicaid and CHIP Payment and Access Commission. *Fact Sheet: Medicaid's Role in Financing Maternity Care* (Washington, D.C.: January 2020).

Overall, the number of births in the United States has been in decline for nearly the last 30 years, according to the Centers for Disease Control and Prevention's National Vital Statistics System.[16] Yet, research shows that women in rural areas were more likely to have children and have higher numbers of children than their urban counterparts.[17] Despite this, the number of total births in rural areas is smaller than in urban areas because of the population size differences in the numbers of women in rural and urban areas.

Types of Clinicians That Provide Obstetric Services in Hospitals

A variety of clinicians provide obstetric services in hospitals in the United States, with the support of nurses and other clinical staff, such as anesthesiologists. Clinicians providing obstetric services in hospitals include the following:

- **OB/GYNs,** physicians that specialize in providing care related to pregnancy, including attending births (i.e., delivering babies) at hospitals, and the female reproductive system. The practice of obstetrics and gynecology includes surgical expertise due to the nature of the care provided, such as for caesarean sections.
- **Family physicians,** considered primary care physicians, as they provide comprehensive first contact and continuing care for persons with a broad range of health concerns, including obstetric care. Family physicians may attend births in hospitals and may also perform caesarean sections, depending on their training.
- **Certified nurse-midwives and certified midwives,** both generally attend births in hospitals, birthing centers, or in homes. Certified nurse-midwives can provide a full range of primary care services, including obstetric care; have prescriptive authority; and are eligible to practice in all U.S. states. Certified midwives provide a full range of

[16]The overall birth rate in 1990 was 16.7 per 1,000, while the birth rate was 11.6 in 2018. See National Center for Health Statistics. *Health, United States, 2019.* (Hyattsville, M.D.: 2021).

[17]K. Daniels, G.M. Martinez, C.N. Nugent. "Urban and Rural Variation in Fertility-related Behavior among U.S. Women, 2011-2015." *National Center for Health Statistics Data Brief*, No. 297, January 2018.

primary care services similar to certified nurse-midwives, but their ability to practice is limited to certain states.[18]

Additionally, doulas—trained professionals that provide physical, emotional, and informational support to mothers before, during, and shortly after childbirth—may assist patients in hospitals. Doulas do not provide clinical care, such as delivering babies.

Education required for physicians to practice. Physicians, including family physicians and OB/GYNs, typically undergo graduate medical education, also known as residencies, to complete their formal education as physicians.

- Residency programs for family physicians are generally 3 years and involve rotations in obstetrics, pediatrics, general surgery, emergency medicine, and inpatient hospital care.
- OB/GYNs generally participate in residency programs for 4 years and may rotate in specialties, such as maternal fetal medicine, reproductive endocrinology, and gynecologic oncology, among other things.[19]

Each state has its own "scope of practice" requirements, which typically define a physician's practice and qualifications, among other things. Once physicians are certified and licensed, they then submit their credentials to specific hospitals and other facilities to be granted privileges to practice within their designated scope, through a process known as credentialing and privileging.

Education required for midwifery practice. Formal education requirements vary depending on the type of midwife. Certified nurse-midwives and certified midwives complete graduate degrees in midwifery education. Certified nurse-midwives complete nursing training before or during their midwifery education programs, while certified midwives

[18]Another type of midwife, known as certified professional midwives, mostly attend births in homes or birth centers, and are thus not a focus of this report. Certified professional midwives provide care, education, counseling, and support during the pregnancy, birth, and the postpartum period.

[19]Physicians may also undergo additional graduate medical education in specific subspecialties, also referred to as fellowships. For example, family physicians can opt to get more specialized training in obstetric care. According to a 2008 study, 5 percent of family medicine residents end up subspecializing. See E. Salsberg, et al, "US Residency Training Before and After the 1997 Balanced Budget Act," *Journal of the American Medical Association*, vol. 300, no. 10 (2008): 1174-1180.

complete required health and science courses before or during their midwifery education programs.

States' scope of practice requirements for midwifery practice differ, and not all states will license certified midwives to practice. Similar to physicians, once midwives are certified and licensed, they then submit their credentials and apply for privileges to practice in specific hospitals and other facilities.

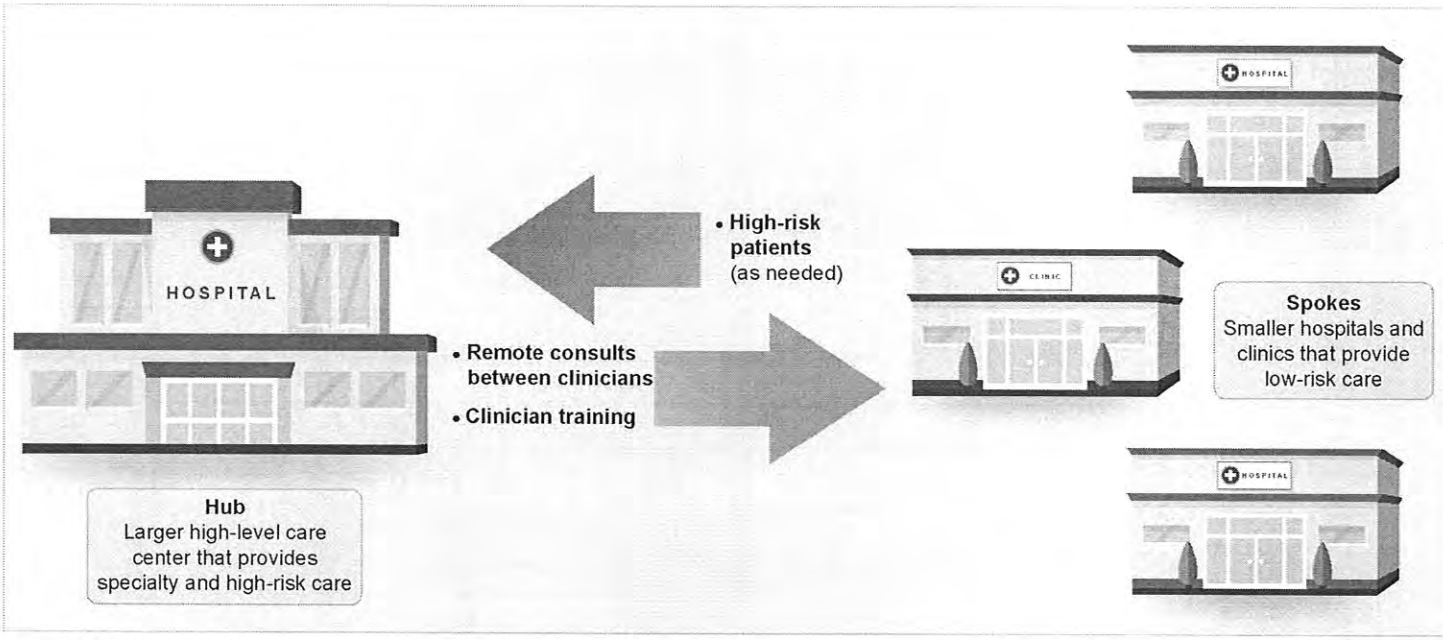
Regionalization and Levels of Care

Depending on their size and resources, rural hospitals and other facilities have different capacities to provide different levels of risk-appropriate obstetric care. Perinatal regionalization is intended to help ensure that pregnant patients and newborns have access to risk-appropriate care when needed and generally involves coordination amongst hospitals and facilities with different levels of care within a given geographic area.[20] There are many models for regionalization, including a hub-and-spoke model, in which larger and smaller facilities connect to provide care at the level of care needed (see Figure 1). The levels range from Level I facilities that provide basic care for low to moderate risk pregnancies and low risk newborns to Level IV regional perinatal centers and regional neonatal intensive care units that provide care for the most complex maternal and neonatal conditions and critically ill pregnant women and newborn infants.[21]

[20]The term perinatal refers to the time period around the time of birth. Regionalization first started in the 1970s with an emphasis on neonatal care and improving those outcomes, and subsequent research found it to be effective at improving neonatal health outcomes. More recently, the American College of Obstetricians and Gynecologists and the Society of Maternal-Fetal Medicine established levels of maternal care given high and increasing rates of maternal mortality rates in the United States. Evidence of the beneficial effect of regionalization on maternal outcomes is so far limited. See, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care, Eighth Edition*. (Elk Grove, Ill., and Washington, D.C.: September 2017).

[21]Accredited birthing centers are not assigned a level because well-established standards governing birth centers are already available. These centers provide care for low-risk women with uncomplicated pregnancies who are expected to have uncomplicated births. The Centers for Disease Control and Prevention developed the Levels of Care Assessment Tool to support decision-making about risk-appropriate care at a regional level. Twenty-five states implemented this tool to identify local resources and identify gaps, as of May 2022.

Figure 1: Illustration of Hub-and-Spoke Model



Source: GAO. | GAO-23-105515

Research Shows More than Half of Rural Counties Do Not Have Hospital-Based Obstetric Services

Various studies we reviewed and interviews with researchers indicate that in rural areas, hospital-based obstetric services have declined, and more than half of rural counties did not have such services as recently as 2018. Specifically, studies we reviewed found the following:

- From 2014 through 2018, nearly 3 percent of rural counties (53 counties) lost hospital-based obstetric services, leaving about 56 percent of rural counties with no obstetric services in 2018.[22]
- According to another study, as of 2017, just under half of all hospitals operating in rural areas provided obstetric services (987 hospitals).[23]
- In 2014, 54 percent of rural counties had no hospital-based obstetric services, with 9 percent of rural counties (179 counties) losing obstetric services from 2004 through 2014, according to an additional study.[24]

Research suggests that the availability of hospital-based obstetric services in rural counties varies by state, with the Southern region of the United States having the lowest density of rural hospital-based obstetric services available to women of childbearing age. Specifically, one study found that as of 2014, six states had no hospital-based obstetric services in more than two-thirds of their rural counties, while six states had

[22]K.B. Kozhimannil, J.D. Interrante, M.S. Tuttle, and C. Henning-Smith. "Changes in Hospital-Based Obstetric Services in Rural US Counties, 2014-2018." *Journal of the American Medical Association*, vol. 324, no. 2 (2020): 197. This analysis of hospital closures was based on the American Hospital Association Annual Survey, the CMS Provider of Services file, and the Area Health Resources File. Data from 2018 was the most recent available at the time of the study, and we did not identify more recent information through our literature review and web searches.

[23]K.B. Kozhimannil, J.D. Interrante, M.S. Tuttle, C. Henning-Smith, and L. Admon. "Characteristics of US Rural Hospitals by Obstetric Service Availability, 2017." *American Journal of Public Health*, vol. 110, no. 9 (2020): 1315. The March of Dimes reported that generally 45 percent of U.S. hospitals in 2018 were providing obstetric services. See March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S., 2020 Report* (Arlington, Va.: 2020).

[24]P. Hung, C.E. Henning-Smith, M.M. Casey, and K.B. Kozhimannil. "Access to Obstetric Services in Rural Counties Still Declining, With 9 Percent Losing Services, 2004-14." *Health Affairs*, vol. 36, no. 9 (2017): 1663. Between 2004 and 2014, 898 rural counties did not have any hospital-based obstetric services and 179 rural counties lost services. The closures include hospitals that closed obstetric units as well as hospitals with obstetric units that closed entirely. This analysis of hospital closures was based on the American Hospital Association Annual Survey, the CMS Provider of Services file, and the Area Health Resources file.

hospital-based obstetric services in 80 percent or more of rural counties.[25] Another study from 2021 found that as a region, the South had the lowest density of rural hospital-based obstetric services in the nation and the West had the highest density—7 rural hospitals offering obstetric services per 100,000 women of reproductive age and 15 per 100,000, respectively.[26]

Research indicates that declines in hospital-based obstetric services were more likely in rural counties that were sparsely populated, low-income, and where the majority of the population is Black or African American. In particular, three studies found that many of the hospitals that closed their obstetric services at some point between 2004 and 2018 were in rural noncore counties, and those counties were less likely to have hospital-based obstetric services even before any closures.[27] Additionally, two studies found that closures that occurred at some point between 2004 and 2018 were more likely in rural counties with a majority of Black or African American residents, and one of the two studies found that closures between 2004 and 2014 were more likely in rural counties with lower median household incomes.[28]

[25]University of Minnesota Rural Health Research Center. *Policy Brief: State Variability in Access to Hospital-Based Obstetric Services in Rural U.S. Counties.* (Minneapolis, Minn.: University of Minnesota, April 2017). The six states with over two-thirds of rural counties with no hospital-based obstetric services in 2014 were North Dakota (85 percent), Florida (83 percent), Virginia (79 percent), Alaska (73 percent), Nevada (69 percent) and South Dakota (69 percent). The six states with 80 percent or more of rural counties with hospital-based obstetric services in 2014 were Connecticut, Hawaii, Maine, and Massachusetts (100 percent); New Hampshire (86 percent); and Vermont (82 percent).

[26]University of Minnesota Rural Health Research Center. *Policy Brief: State and Regional Differences in Access to Hospital-Based Obstetric Services for Rural Residents, 2018.* (Minneapolis, Minn., University of Minnesota: August 2021). This article presents information for women of reproductive age between the ages of 15 through 49 years.

[27]Noncore counties have an urban core with fewer than 10,000 residents. See University of Minnesota Rural Health Research Center. *Health Policy Brief: Closure of Hospital Obstetric Services Disproportionately Affects Less-Populated Rural Counties.* (Minneapolis, Minn., University of Minnesota: April 2017). This study examined rural hospital obstetric services closures between 2004 through 2014. Additionally, see University of Minnesota Rural Health Research Center, *Policy Brief: Rural and Urban Hospital Characteristics by Obstetric Service Provision Status, 2010-2018.* (Minneapolis, Minn., University of Minnesota: April 2021); and P. Hung, et al. *Health Affairs*, 2017.

[28]P. Hung, et al. *Health Affairs*, 2017; and University of Minnesota Rural Health Research Center, *Rural and Urban Hospital Characteristics,* 2021.

Researchers that we interviewed, and hospital closure information from the North Carolina Rural Health Research Program, noted that the rate of hospital closures generally appeared to decrease during the COVID-19 pandemic in 2021 and 2022.[29] The researchers said they expected this was likely due to increased federal funding to hospitals to respond to the pandemic, and they expected that closures would continue after such aid dissipates. One study reported that the increased federal funding will be fully distributed by the end of 2022, and unless additional funding is authorized, rural hospitals are expected to return to pre-pandemic levels of profitability.[30]

In addition, we found the prevalence of certain types of clinicians providing hospital-based obstetric services in rural areas differed from urban areas. In particular, studies we reviewed found that family physicians providing obstetric services were more common in rural areas than they were in urban areas. In contrast, research shows that OB/GYNs and midwives were more prevalent in urban areas.

For example, one study estimated that in 2019:

- **In rural counties overall,** there were 34 family physicians, 35 OB/GYNs, and 9 advanced practice midwives per 100,000 women of childbearing age.[31]

[29]The North Carolina Rural Health Research Program tracks hospital closures. See, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (accessed August 17, 2022).

[30]See North Carolina Rural Health Research Program. Findings Brief: Rural Hospital Profitability during the Global COVID-19 Pandemic Requires Careful Interpretation. (Chapel Hill, N.C., University of North Carolina at Chapel Hill: March 2022).

[31]Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center. *The Supply and Rural-Urban Distribution of the Obstetrical Care Workforce in the U.S.* (Seattle, Wash., University of Washington, June 2020). Advanced practice midwives include certified nurse midwives. The study used data from the American Board of Family Medicine to only include family physicians that reported delivering babies in its estimates of family physicians.

- **In urban counties overall,** there were 10 family physicians, 60 OB/GYNs, and 11 advanced practice midwives per 100,000 women of childbearing age.[32]

Additionally, the study found that the prevalence and types of clinicians practicing in rural areas varied by state though OB/GYNs tended to largely practice in micropolitan counties, whereas family physicians were much more prevalent in the more sparsely populated rural counties (i.e., noncore counties).[33] Overall, about 30 percent of rural counties did not have any clinicians providing hospital-based obstetric services in 2019, according to the study.[34]

Two other studies that surveyed hospitals in nine states found that the trends in the types of clinicians attending births (i.e., delivering babies) were also dependent on birth volumes.[35] In hospitals with low birth volumes, which one study defined as less than 240 births annually, family physicians and general surgeons were more likely to attend births than OB/GYNs and midwives.[36] In contrast, higher birth volume hospitals were more likely to have OB/GYNs and midwives attending births.

[32]Additionally, another study focused on OB/GYN relocations between 2005 and 2015 found that OB/GYNs were predominantly relocating to urban counties. See I.M. Xierali, M.A. Nivet, and W.F. Rayburn. "Relocation of Obstetrician-Gynecologists in the United States, 2005-2015." *Obstetrics & Gynecology*, vol. 129, no. 3 (2017): 543.

[33]Micropolitan counties include nonmetropolitan counties with an urban core of 10,000 to 49,999 inhabitants. Noncore counties include non-metropolitan counties that do not qualify as micropolitan, and have an urban core of less than 10,000 residents.

[34]The March of Dimes similarly reported in its 2020 report that 40 percent of U.S. counties overall (1,248 counties) had no clinician providing obstetric services, such as an OB/GYN or certified nurse midwife. See March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S. 2020 Report*.

[35]K.B. Kozhimannil, M.M. Casey, P. Hung, X. Han, S. Prasad, and I.S. Moscovice. "The Rural Obstetric Workforce in US Hospitals: Challenges and Opportunities." *Journal of Rural Health*, vol. 31, no. 4 (2015); and University of Minnesota Rural Health Research Center. *Health Policy Brief: State Variations in the Rural OB Workforce*. (Minneapolis, Minn., University of Minnesota: May 2016).

[36]According to the American Hospital Association Annual Survey data from 2018, approximately 36 percent of rural hospitals had fewer than 200 births. K.B. Kozhimannil, J.D. Interrante, L.K. Admon, and B.L. Basile Ibraham. "Rural Hospital Administrators' Beliefs about Safety, Financial Viability, and Community Needs for Offering Obstetric Care. *Journal of the American Medical Association Health Forum*, vol. 3, no. 3 (2022).

Research also shows that the proportion of family physicians attending births has been decreasing in the United States, but those that do so primarily practice in rural counties.

- In particular, one study found that the percentage of family physicians in the United States that attend births decreased from 23 percent in 2000 to just below 10 percent in 2010.[37]
- Another study found similar trends in percentages of family physicians attending births between 2003 and 2009, with deliveries being more common in rural areas. Of those family physicians that attended births, about half reported attending few births—between 1 and 25 births a year.[38]
- Lastly, another more recent study found that between 2017 and 2018, about 7 percent of family physicians reported attending births.[39] This study also found that few family physicians (2 percent) reported conducting caesarean sections, and of those that did, more than half did so in rural counties without any OB/GYNs, indicating that without a family physician providing such care, a patient may have had to travel farther away for a caesarean section.

Factors Cited by Stakeholders That Affect the Availability of Hospital-Based Obstetric Care in Rural Areas

The 19 stakeholders we interviewed, including provider associations, researchers, other experts, and federal agencies, most often cited financial factors and staffing issues as the top factors affecting the availability of rural hospital-based obstetric care, specifically for hospitals and clinicians that provide delivery services. Specifically, stakeholders ranked two factors highest among a list of seven factors we presented to

[37]S.T. Tong, L.A. Makaroff, I.M. Xierali, JC. Puffer, W.P. Newton, and A.W. Bazemore. "Family Physicians in the Maternity Care Workforce: Factors Influencing Declining Trends." *Maternal and Child Health Journal*, vol. 17 (2013): 1576.

[38]W.F. Rayburn, S.M. Petterson, and R.L. Phillips. "Trends in Family Physicians Performing Deliveries, 2003-2010." *Birth*, vol. 41, no. 1, (2014): 26-32.

[39]S.T. Tong, A.R. Eden, Z.J. Morgan, A.W. Bazemore, and L.E. Peterson. "The Essential Role of Family Physicians in Providing Cesarean Sections in Rural Communities." *Journal of the American Board of Family Medicine*, vol. 34, no. 1 (2021): 10.

them as potentially affecting the availability of rural hospital-based obstetric care: 1) Medicaid reimbursement and coverage, and 2) recruiting and retaining clinicians. The other five factors include organizational factors, training opportunities, medical liability insurance, scope of practice requirements for clinicians, and community factors.

Several stakeholders stated that all seven of the factors we identified have important effects on the availability of obstetric care, even ones they ranked as less important.[40] The stakeholders added that different rural areas may need to prioritize addressing different factors depending on the specific challenges faced by the hospitals and communities, and therefore, the level of importance for each factor may be different depending on the particular area.

The seven factors are detailed below in order of the stakeholders' overall rank of importance.

Medicaid reimbursement and coverage. Several stakeholders discussed the financial burden of providing obstetric services, including low rates of Medicaid reimbursement for such services that may have a negative impact, particularly for rural hospitals.

Hospital-based obstetric services can be costly to operate, in large part because of the need for continuous everyday coverage by nursing and physicians trained in obstetric care, according to some stakeholders we interviewed. Several stakeholders, in addition to one research organization and one provider association, said that obstetric units were often the hospital units with the biggest financial losses for the rural hospitals, and thus, first to close when hospitals faced financial difficulties.

Research we reviewed and some stakeholders stated that Medicaid reimbursement rates, which are determined by the states, do not cover

[40]We defined modifiers to quantify stakeholders' views as follows: "some" stakeholders represents more than 0 but less than or equal to 20 percent of responses (1-4 stakeholders); "several" stakeholders represents more than 20 percent but less than or equal to 40 percent of responses (5-8 stakeholders); "many" stakeholders represents more than 40 percent but less than or equal to 60 percent of responses (9-11 stakeholders); "most" stakeholders" represents more than 60 percent but less than or equal to 80 percent of responses (12-15 stakeholders); and, "nearly all" stakeholders represents more than 80 percent but less than 100 percent of responses (16-18 stakeholders).

the full cost of providing obstetric services to a patient and only pays about 50 percent of what private insurers pay for childbirth-related services.[41] As Medicaid covers a higher proportion of births in rural areas compared to urban areas, Medicaid reimbursement rates may cause rural hospitals to suffer financial losses if they provide obstetric services, according to several stakeholders and researchers from a rural health research program. Some stakeholders also explained that hospitals typically rely on private health insurance payments, non-obstetrical surgical care, and other supporting services to subsidize losses from their obstetric units, all of which rural hospitals usually lack. This makes rural hospitals especially vulnerable to financial losses in providing obstetric care.

Recruiting and retaining clinicians. Some stakeholders emphasized that hospital obstetric units need to be staffed by a full range of maternal health clinicians, including physicians and nurses, as well as anesthesiologists, and must be staffed all day, every day, even when birth volume is low. Without sufficient staff, some stakeholders emphasized that the hospitals cannot provide such services, and rural hospitals struggle more to recruit staff than urban hospitals.[42] Some stakeholders explained that recruiting and retaining enough providers to staff obstetric units also relates to financial viability concerns of rural hospitals, as staffing an obstetric unit is one of the most significant costs that rural hospitals face.

Research and several stakeholders noted current workforce shortages for clinicians providing obstetric services across the country and expect more in the future. For example, HRSA estimated that the supply of OB/GYNs in 2018 for rural areas was not sufficient to meet the current demand of women's health services. By 2030, HRSA anticipated the imbalance to

[41]See, for example, National Academies of Sciences, Engineering, and Medicine, *Birth Settings in America: Outcomes, Quality, Access, and Choice* (Washington D.C.: The National Academies Press, 2020), 90.

[42]One study examining the characteristics of rural hospital-based obstetric services that closed found that the most commonly cited reason was difficulty in finding staff. The study surveyed 306 rural hospitals in nine states with at least 10 births in 2010. The 19 hospitals that reported closing their obstetric units also cited low birth volumes and financial issues, such as low reimbursement and the cost of operating the obstetric services, as reasons for the closures. P. Hung, K.B. Kozhimannil, M.M. Casey, and I.S. Moscovice. "Why are Obstetric Units in Rural Hospitals Closing Their Doors?" *Health Services Research*, vol. 51, no. 4 (2016): 1546.

grow even more, with the anticipated supply of OB/GYNs expected to meet only about 50 percent of the demand in rural areas.[43]

Research and many stakeholders also said that fewer medical residents (physicians who have completed medical school and are receiving training in a specialized area) are interested in providing obstetric care due to work-life balance concerns, such as frequent on-call rotations required by obstetric care. They added that rural areas face more challenges with recruiting as they must compete with well-resourced urban areas for providers.[44] For example, younger providers may not view rural areas as good places to start or raise families because of the frequent on-call rotations for clinicians providing obstetric services in some rural hospitals, which occurs when there are few physicians to share the call schedule, according to several stakeholders.

Several stakeholders noted that medical residents usually train in larger facilities and work with expert teams and state-of-the-art equipment, making them uncomfortable when moving to rural areas where they do not have similar support. Some of these stakeholders, in addition to other researchers from one rural health research center, further said that having one physician overseeing a facility with low birth volume places a lot of responsibility on that physician, as one bad birth outcome could

[43]HRSA estimates that these current workforce shortfalls are most seen in the regions of the U.S. West, Midwest, and South, and that future shortfalls will be particularly focused in the West and South. HRSA estimates that urban areas had a surplus of OB/GYNs in 2018, but the expected supply will only meet about 95 percent of the demand in 2030. See U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Projections of Supply and Demand for Women's Health Services Providers: 2018-2030.* (Rockville, Md.: March 2021). Similarly other researchers also predicted shortages of OB/GYNs as well as general surgeons. For example, see T.E. Williams Jr., B. Satiani, and E.C. Ellison. "A Comparison of Future Recruitment Needs in Urban and Rural Hospitals: The Rural Imperative." *Surgery*, vol. 150, no. 4 (2011): 617.

[44]See, for example, W.F. Rayburn, J.C. Klagholz, C. Murray-Krezan, L.E. Dowell, and A.L. Strunk. "Distribution of American Congress of Obstetricians and Gynecologists Fellows and Junior Fellows in Practice in the United States." *Obstetrics & Gynecology* vol. 119, no. 5 (2012): 1017.

Additionally, one policy brief shows that while medical schools are increasing class sizes, the number of residency spots in hospitals has not increased, which will only serve to worsen the physician workforce shortage in the future. See U.S. Department of Health and Human Services, HRSA, National Advisory Committee on Rural Health and Human Services. *Maternal and Obstetric Challenges in Rural America: Policy Brief and Recommendations to the Secretary* (Rockville, Md., May 2020).

have significant negative implications for the entire facility; thus, physicians may not want to take on such responsibility.

Lastly, the COVID-19 pandemic also has exacerbated existing challenges in recruiting and retaining clinicians in rural areas, particularly for nursing staff, according to some stakeholders and researchers. For example, some stakeholders said that burnout and stress were causing clinicians to leave their jobs.[45]

Organizational factors. Some stakeholders noted that a hospital's organizational structure and leadership are vital to keeping obstetric care local. They explained that to keep hospital-based obstetric services open despite challenges presented by financial factors and staffing issues, it is important for hospital leadership to prioritize providing obstetric care as a mission of the hospital. When that does not happen, it can lead to closures. Some other stakeholders stated that hospitals should dedicate themselves to matching needs of the local area to maintain support of the communities.

According to some stakeholders and other researchers from a rural health research program, corporate hospital system consolidation also affects rural obstetric care by having new leadership from larger hospital systems take over decision-making and control of local care. They explained that rural hospitals are increasingly becoming subsidiaries of larger hospital systems, which may not prioritize unprofitable or complex services, such as obstetric care, resulting in closures of obstetric units to cut costs.

- Two studies identified relationships between losses of hospital-based obstetric services in rural areas following a hospital merger or following a change to health system affiliation. However, it was not clear if the merger or change in affiliation was behind the closure or if

[45]For more information on the effect of the COVID-19 pandemic on maternal health see, GAO, *Maternal Health: Outcomes Worsened and Disparities Persisted during the Pandemic*, GAO-23-105871 (Washington, D.C.: Oct. 19, 2022).

the financial situations leading to the merger or change in affiliation resulted in the obstetric service closure.[46]

- One study also suggested that hospital affiliations may be associated with lower risk of closure for rural hospitals under financial distress, but among financially stable rural hospitals, affiliation is associated with an increased risk in closure.[47]

Training opportunities. Some stakeholders and studies cited that it may be difficult to access obstetric-related training opportunities and maintain staff competency in rural hospitals that have low-birth volumes, especially for high-risk pregnancy situations.[48] For example, staff may need to travel long distances for obstetric training, while others attend so few births that they have difficulty maintaining competencies. One study noted that over one-third of rural facilities do not meet the 200 deliveries per year that obstetric unit managers and hospital administrators said were needed to maintain staff competencies in obstetrical care.[49]

Some stakeholders cited that for low-birth-volume facilities, which also tend to have lower budgets, many providers may not have the experience or training needed to react appropriately in emergency situations, as they may rarely encounter particular complications. Maintaining competencies is especially difficult for general surgeons who perform cesarean sections,

[46]R. Mosher Henke, K.R. Fingar, H.J. Jiang, L. Liang, and T. Gibson. "Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas." *Health Affairs*, vol. 40, no. 10 (2021): 1627; and C.E. O'Hanlon, A.M. Kranz, M. DeYoreo, A. Mahmud, C.L.Damberg, and J.Timbie. "Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation." *Health Affairs*, vol. 38, no. 12 (2019): 2095.

Studies also found that hospitals that closed obstetric units were more likely to be critical access hospitals, privately owned, or affiliated with a hospital system. See University of Minnesota Rural Health Research Center, *Rural and Urban Hospital Characteristics*, 2021; K.B. Kozhimannil, et al. *American Journal of Public Health*, 2020; and P. Hung, et al. *Health Services Research*, 2016.

[47]This study also found that for-profit ownership for financially-stable rural hospitals was strongly associated with closures. See H.J. Jiang, K.R. Fingar, L. Liang, and R.M. Henke. "Risk of Closure among Independent and Multihospital-Affiliated Rural Hospitals." *Journal of the American Medical Association Health Forum*, vol. 3, no. 7, (2022).

[48]See, for example, K.B. Kozhimannil, et al. *Journal of Rural Health*, 2015.

[49]K.B. Kozhimannil, et al. *Journal of the American Medical Association Health Forum*, 2022.

noted some stakeholders from a provider association, who suggested that these clinicians would benefit from simulation training.[50]

In contrast, another stakeholder said they did not believe that training opportunities significantly affected the availability of rural obstetric care, as remote training is already widely available to providers, especially since the arrival of the COVID-19 pandemic and the increased use of telemedicine.

Medical liability insurance. Many stakeholders, including those representing physicians, said that the cost of provider malpractice coverage is expensive; and while it affects all clinicians, it may exacerbate any existing financial vulnerabilities that rural providers already face in offering obstetric care. Some stakeholders pointed out that many OB/GYNs instead focus solely on gynecology due to the costs of medical liability insurance specific to obstetric care and increased risk in providing these services. Another stakeholder stated that a family physician that provides the full range of primary care without obstetric care would pay half the medical liability insurance premiums as a family physician that also provides obstetric care.

Some stakeholders, in addition to officials from one provider association, said that malpractice insurance limitations may prevent clinicians from attending births in multiple facilities, whether for general assistance or training purposes, because their insurance does not cover them at all facilities. They added that this may restrict clinicians from providing care in other rural areas or training in higher volume facilities, which would allow them to increase their birth volumes and continue providing obstetric care in their communities. Some stakeholders stated that an OB/GYN in their area usually needs to perform around 100 deliveries a year to cover the cost of malpractice insurance and that in rural areas, this is often the total number of deliveries a provider will perform; as a result, this may not leave much to cover other expenses.

In addition, some stakeholders explained that even when clinicians have malpractice coverage, the high costs of malpractice case claims may be

[50]Simulation training offers hands-on practice simulations of critical procedures and skills to prepare rural hospitals for obstetric emergencies. This includes resources like mannequins and other simulation technology. See University of Minnesota Rural Health Research Center. *Health Policy Brief: Emergency Obstetric Training Needed in Rural Hospitals without Obstetric Units.* (Minneapolis, Minn.: University of Minnesota, November 2020).

prohibitive to them practicing in rural areas, as providers may face potentially expensive lawsuits for bad birth outcomes, even in cases when no medical malpractice occurs; these costs may exacerbate the financial issues that rural hospitals and clinicians already face. According to some stakeholders, rural providers may also face higher risks of bad outcomes and therefore malpractice lawsuits because obstetric patients in rural areas experiencing emergency medical conditions may arrive to receive care in relatively poor condition. These patients often may have to travel longer distances to initially receive care, longer distances to be transferred to another facility when needed, and face unpredictable weather in certain regions, according to some stakeholders. Several stakeholders said that for states that do not have a cap on damages for medical malpractice lawsuits, the high costs of these claims may worsen existing financial vulnerabilities for providers in rural areas.

On the other hand, some other stakeholders noted that hospitals employ over 50 percent of physicians in the United States, and since hospitals cover medical liability insurance for their physicians, the cost of medical liability insurance may not be a factor to many physicians in providing obstetric care in rural areas.

Scope of practice requirements for clinicians. Some stakeholders, in addition to officials from a provider association, cited scope of practice—regulations or other requirements that influence the services clinicians can provide—as a factor affecting the availability of certain clinicians, particularly midwives and family physicians, to provide obstetric care in rural areas. They stated that these requirements may limit the number of these clinicians who can provide rural hospital-based obstetric services.

Officials from one provider association stated that credentialing requirements, such as delivering a certain number of babies in a year, can be difficult to meet for family physicians who practice in low-volume hospitals. They explained that such requirements are typically based on delivery numbers in larger, higher-volume urban hospitals, and are not reflective of delivery volumes rural family physicians typically conduct. Such requirements can limit the type of services clinicians are authorized to provide; and family physicians are often the providers that face these types of limits in rural areas, according to one research organization and one provider association, as OB/GYNs and other specialist maternal health providers typically work in hospitals with higher delivery volumes.

Similarly, midwives can be limited by another scope of practice requirement. Certain states' scope of practice laws require collaborative

agreements between physicians and midwives or physician supervision of midwives, rather than allowing midwives to practice independently, according to some stakeholders and a policy brief from the National Advisory Committee on Rural Health and Human Services.[51] An official from the American College of Nurse-Midwives stated that restrictive scope of practice requirements was the most important factor prohibiting certified nurse-midwives and certified midwives from providing reproductive health care, including obstetric care, in rural areas within certain parts of the country.[52] The official explained that prohibiting midwives from practicing at the top of their education, clinical training, and national certification may create unnecessary paperwork for physician signatures, relegate midwives to physician extender roles, or prevent them from attending births (i.e., delivering babies), among other restrictions. Further, the official said that physicians may not want to enter collaborative or supervisory agreements with midwives for multiple reasons, such as concerns about competition from midwives and misunderstanding their liability for the midwives practice. These are barriers that keep midwives from providing care in rural areas, according to officials from the American College of Nurse-Midwives.

Community factors. Some stakeholders said that rural residents need to use local hospital-based obstetric services to keep them in their communities. Since rural hospitals serve less populous communities than urban hospitals, some provider associations and researchers from a rural health research program stated that rural hospitals often face challenges from low patient volume, and without enough volume, rural hospitals may have to close due to financial difficulties. Some stakeholders emphasized that the patients living in rural areas need to be comfortable with a certain level of risk to use local services that serve a lower volume of patients. For example, a low-risk patient may need to be comfortable delivering in a smaller facility with a lower level of care (i.e., a level 1 facility), while recognizing that there may not be higher-risk care nearby should complications arise. Some stakeholders stated that many rural hospitals face a 'bypass factor', where patients with private insurance or financial

[51]U.S. Department of Health and Human Services, HRSA, National Advisory Committee on Rural Health and Human Services. *Maternal and Obstetric Challenges in Rural America,* 2020.

[52]One study that surveyed rural hospitals in 9 states found that certified nurse-midwives attended more births in hospitals in states that allow for autonomous practice. K.B. Kozhimannil, C. Henning-Smith, and P. Hung. "The Practice of Midwifery Care in Rural US Hospitals." *Journal of Midwifery & Women's Health*, vol. 61, no. 4 (2016): 411.

means may choose to go to a larger hospital farther away, even if the type care provided is nearly the same at the smaller, more local hospital.[53] According to some stakeholders, in addition to researchers from a rural health research program, this not only decreases the volume of patients at local facilities, but also increases the proportion of Medicaid patients as they may not be able to travel as easily and thus exacerbates rural hospitals' financial issues.

Efforts Cited by Stakeholders to Help Increase the Availability of Hospital-Based Obstetric Care in Rural Areas

The 19 stakeholders we interviewed consistently rated the efforts detailed below as the efforts that federal agencies, states, and others could take to most positively affect the availability of hospital-based obstetric care in rural areas, specifically for hospitals and clinicians that provide delivery services.[54] While each of the stakeholders provided varying rankings for the specific efforts we presented to them, several stated that the appropriateness of each effort may depend on the particular

[53]According to one study, hospitals that closed obstetric services between 2010 and 2018 tended to be smaller. Another study showed that hospitals that closed obstetric services tended to have low birth volumes (which a separate study defined as under 240 births annually). One study also identified that rural hospitals that did not provide obstetric services were generally smaller and offered fewer services than hospitals providing obstetric services. See K.B. Kozhimannil, et al. *American Journal of Public Health*, 2020; University of Minnesota Rural Health Research Center, *Closure Affects Less-Populated Rural Counties,* 2017; and University of Minnesota Rural Health Research Center, *Rural and Urban Hospital Characteristics,* 2021.

[54]We presented stakeholders with a list of 21 efforts and asked them to rate the efforts based on the effect they thought a particular effort would have on the availability of obstetric care in rural areas. The stakeholders' options were: 1) likely to have a positive effect, 2) likely to have no effect, 3) likely to have a negative effect, and 4) no basis to judge.

We defined modifiers to quantify stakeholders' views as follows: "some" stakeholders represents more than 0 but less than or equal to 20 percent of responses (1-4 stakeholders); "several" stakeholders represents more than 20 percent but less than or equal to 40 percent of responses (5-8 stakeholders); "many" stakeholders represents more than 40 percent but less than or equal to 60 percent of responses (9-11 stakeholders); "most" stakeholders" represents more than 60 percent but less than or equal to 80 percent of responses (12-15 stakeholders); and, "nearly all" stakeholders represents more than 80 percent but less than 100 percent of responses (16-18 stakeholders).

circumstances of the rural hospital or clinicians. Officials from the Agency for Healthcare Research and Quality added that these efforts also need to be viewed with equity in mind to better understand the appropriateness of each effort for all racial and ethnic groups. See appendix IV for information on all the efforts we presented to stakeholders and how they ranked each effort.

Increasing Medicaid reimbursement. Each of the 19 stakeholders we interviewed said increasing Medicaid reimbursement rates for obstetric services would likely have a positive effect on increasing the availability of obstetric care in rural areas. Some stakeholders stated that Medicaid usually pays lower rates than private insurance and does not cover the full cost of providing obstetric care, and according to other researchers, increasing rates would help financially to keep obstetric services open in rural areas.[55] For example, an official from one provider association stated that the Medicaid payments they received in the past, which covered the majority of their patients, were not enough to help cover the overhead costs of their practice.

Some stakeholders also noted, however, that private insurance reimbursement rates for obstetric care may be high, making it unfair to compare Medicaid rates to private insurance rates when determining an appropriate reimbursement rate for Medicaid. In addition, one of the stakeholders noted that the federal government also provides some grants and other sources of funding to rural hospitals to help reduce financial burdens, which may help offset low Medicaid rates. CMS and Agency for Healthcare Research and Quality officials added that increasing Medicaid reimbursement rates to cover the full cost of providing obstetric care may not necessarily make up for low volumes of births in hospitals in rural areas.

Despite the agreed-upon positive effect of increasing Medicaid reimbursement for obstetric services, stakeholders disagreed on the

[55]The research we reviewed is somewhat inconclusive about the effects of the prior expansion of Medicaid beginning in 2010, to cover nearly all adults with incomes up to 133 percent of the federal poverty level on the availability of hospital-based obstetric units. One study found that states with more restrictive Medicaid income eligibility were more likely to experience closures of rural hospital-based obstetric services between 2004 and 2014. Yet another study found that Medicaid expansion prevented rural hospital closures more generally, but had little effect on the closure of hospital-based obstetric units specifically. See, P. Hung, et al. *Health Affairs*, 2017; and C. Carroll, J.D. Interarante, J.R. Daw, and K.B. Kozhimannil. "Association between Medicaid Expansion and Closure of Hospital-Based Obstetric Services." *Health Affairs*, vol. 41, no. 4 (2022): 531.

feasibility of implementation. Some stakeholders said they believed that increasing reimbursement would have few implementation barriers, as the Medicaid program is already in place and would only require additional funding. However, many other stakeholders stated that increasing Medicaid reimbursement would be a difficult task for the federal government to accomplish, as Medicaid reimbursement rates are largely determined by the states.

Increasing remote consultations. All 19 stakeholders said that increasing the use of remote consultations, such as through video conferencing or phone calls, between specialists and providers for clinical support may have a positive effect on increasing the availability of obstetric care in rural areas. Some stakeholders stated that remote consults are a useful tool for connecting clinicians in hospitals with higher and lower levels of care, thereby allowing patients who live longer distances from higher levels of care to access those services in their own communities. For example, some stakeholders explained that there are many instances where a competent clinician just needs guidance on what to do for a patient presenting with specific symptoms or conditions; there is not always a need have a specialist or sub-specialist working in-person with the patient.

Several stakeholders agreed that expanding the use of remote consultations by clinicians would likely have few barriers for implementation, as the COVID-19 pandemic has already expanded the usage of technology for remote appointments. (See figure 2 below and appendix III for an example of a program with remote consults.)

Figure 2: Example of Program with Remote Consults

The University of Arkansas for Medical Services Institute for Digital Health and Innovation High-Risk Pregnancy Program provides access to a call center that is open 24 hours a day, 7 days a week, and provides clinician education, among other things.

The call center

- provides remote consults to clinicians throughout most of the state and triage services for obstetrics patients as well.
- is staffed by highly trained, experienced nurses with backgrounds in obstetric care.

Additionally, the program provides monthly interactive videoconferences with educational information on updates and current practices to implement maternal safety bundles throughout the state.

Source: GAO interview with the Institute of Digital Health and Innovation's High Risk Pregnancy Program officials and review of relevant documentation (information); A Stockphoto/stock.adobe.com (photo). | GAO-23-105515

Establishing regional partnerships. Nearly all of the 19 stakeholders said that partnerships among hospitals and other facilities in a given region, such as the "hub-and-spoke" model, would likely have a positive effect on increasing the availability of obstetric care in rural areas. Under such a partnership, larger hospitals with more resources (hub) partner with smaller rural hospitals (spokes) for care coordination, and to provide training and other resources to rural areas and help patients receive care in their communities. For example, a specialist from the hub hospital can help manage a rural patient's high-risk condition as needed and support the rural clinician for planning delivery at the local hospital. Some stakeholders also stated that promoting regional partnerships can help improve health outcomes, and help ensure risk-appropriate care coordination between facilities that provide higher and lower levels of care. Policies and approaches can vary to account for differences in obstetric care infrastructure by geography and rurality and to address varying challenges.

In 2019, HRSA funded its first cohort of Rural Maternity and Obstetrics Management Strategies program awardees with the aim of improving maternal care in rural communities through building networks to coordinate the continuum of care and leveraging telehealth, among other things. Each of the awardees under this program developed networks in their target service areas to increase coordination and access to obstetrics care. See figure 3 below and appendix III for examples on two styles of regional partnerships under the Rural Maternity and Obstetrics Management Strategies program.

Figure 3: Examples of Programs with Regional Partnerships

The Texas Rural Maternity and Obstetrics Management Strategies Program is similar to a hub-and-spoke model.

- The goal of the program is to improve maternal outcomes and increase local facilities' ability to care for high-risk patients in the community.
- University Health in San Antonio serves as the hub. The regional hospitals and clinics, including Uvalde Memorial Hospital and Val Verde Regional Medical Center, serve as the spokes in the service areas in Texas.
- The hub receives advanced specialty referrals from the spokes and also supports capacity building efforts at the facilities serving as spokes.

The Bootheel Perinatal Network uses a community-oriented model in which all providers in this network share patient referrals and provide one another support and expertise.

- Saint Francis Medical Center leads the large network.
- Other network partners include a regional hospital system (Missouri Delta Medical Center) and a federally qualified health center network (SEMO Health Network), among others.

Source: GAO interviews with the Texas Rural Maternity and Obstetrics Management Program and Bootheel Perinatal Network and review of relevant documentation (information); SeanPavonePhoto/stock.adobe.com (photo). | GAO-23-105515

Financially incentivizing providers to practice in rural areas. Nearly all of the 19 stakeholders said financially incentivizing providers to practice in rural areas would likely have a positive effect on increasing the availability of obstetric care in rural areas. One study shows that the median education debt for medical school graduates in 2019 was usually around $200,000.[56] Some stakeholders said programs such as the National Health Service Corps Scholarship and Student Loan Repayment Program can help pay off clinicians' student loans in exchange for several years of service in rural areas (see figure 4 below). However, one stakeholder stated they found it easier for nurses to receive loan repayment from the program, whereas they found it more difficult to secure loan repayment for physicians. In addition, some stakeholders expressed concerns over clinicians leaving rural areas as soon as they meet their service requirements from the National Health Service Corps or similar programs. (See appendix III for an example of a scholarship student loan repayment program.)

[56]The study also found that 73 percent of medical school graduates reported having debt. See Association of American Medical Colleges, *Physician Education Debt and the Cost to Attend Medical School,* (Washington, D.C.: Association of American Medical Colleges, 2020).

Figure 4: Example of Scholarship and Student Loan Repayment Program

The National Health Service Corps Scholarship and Loan Repayment Program provides funding to clinicians, including obstetricians and gynecologists, family physicians, and certified nurse midwives, that practice in geographic areas deemed as Health Professional Shortage Areas, which include many rural areas. Since 1972, the program has supported over 66,000 primary care clinicians. In fiscal year 2021, there were over 2,800 clinicians that provide obstetric care participating in this program, with 30 percent of them working in rural areas, according to HRSA officials. According to program officials, about 80 percent of program participants remain in their communities for two or more years after completing the program's service obligations.

Source: GAO interview with National Health Service Corps officials and review of relevant documentation (information); terovesalainen/stock.adobe.com (photo). | GAO-23-105515

Rural training tracks. Nearly all of the 19 stakeholders said creating more opportunities for residency training in rural communities would likely have a positive effect on increasing the availability of obstetric care in rural areas. Several stakeholders cited research that found that providers who train in rural areas are more likely to stay in those areas. For example, some stakeholders stated that graduates of family medicine rural training tracks are two to three times more likely to practice in rural areas than graduates of family medicine residencies overall. Some stakeholders emphasized that new physicians today place more importance on lifestyle than previous generations, so it is important to expose them to rural communities to see if they enjoy living there.

Meanwhile, another stakeholder cautioned that having more medical residents or medical students in a hospital requires time and resources from that hospital, so it may be difficult to find additional spots for residents interested in training in rural communities. Researchers from a rural health research center noted that because most of these rural training tracks are small and only graduate around two students a year, they cannot solve the physician workforce shortage problem alone. (See figure 5 below and appendix III for an example of a rural OB/GYN training track program.)

Figure 5: Example of Rural Training Track Program

The University of Wisconsin Obstetrics and Gynecology (OB/GYN) Rural Residency Program started in 2017 and was the first OB/GYN residency program in the country to provide a decdicated rural training track. The program

- provides rotations in areas that the Federal Office of Rural Health Policy designates as rural, with rural rotations amounting to about six months of the four-year residency program.
- currently accepts one rural training track resident per year (the OB/GYN residency program also accepts 6 other non-rural residents per year).
- The program director noted that the amount of time spent in rural and non-rural settings is to balance 1) the number of OB/GYN procedures that OB/GYN medical residents are required to complete and 2) support for the rural training track resident getting a full experience practicing in rural areas.

Because the program does not meet the Medicare requirement of having more than 50 percent of a residency in a rural area to be eligible for additional Medicare graduate medical education funding for rural training tracks, the program relies on funding from the university, partner organizations, and charitable donations to cover the rural resident's training time, transportation and lodging. As of June 2022, both graduates of the rural residency program continue to practice in rural areas in the Midwest, according to the program director.

Source: GAO interview with the University of Wisconsin Medical School OB/GYN Rural Training Track Program Director and review of relevant documentation (information); SeventyFour/stock.adobe.com (photo). | GAO-23-105515

Medicaid payments for non-clinical services. Nearly all stakeholders said expanding Medicaid coverage for non-clinical services, such as payments for doulas and temporary housing, would likely have a positive effect on increasing the availability of obstetric care in rural areas. Some stakeholders stated that covering these costs would help patients pay for the true costs of obstetric care, especially those living in more outlying areas.

One study we reviewed showed that doula care can be effective at improving maternal and infant health and reducing spending on obstetric care, but most state Medicaid programs do not cover doula support.[57] However, CMS officials told us that more states are planning or considering to add Medicaid coverage for doula care in the future.

Medical liability insurance costs. Nearly all stakeholders said that reducing the costs of medical liability premiums for rural obstetric physicians would likely have a positive effect for increasing the availability of obstetric care in rural areas. Many stakeholders agreed that the costs of medical liability insurance are too high, which exacerbates challenges

[57]N. Strauss, C. Sakala, & M.P. Corry, "Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health," *The Journal of Perinatal Education*, vol. 25, no. 3 (2016): 145–149.

faced by rural providers with financial vulnerabilities and risks. Some stakeholders stated that with the exception of federally-funded community health centers and Federally Qualified Health Centers, where eligible providers have federal protection from medical liability cases, medical liability insurance is often a significant consideration to hospitals and clinicians when determining whether to provide obstetric services. These stakeholders pointed to the benefits that providers at certain federally-supported health centers receive under the Federal Tort Claims Act, which according to HRSA, extends liability protections to providers employed at these centers for the performance of medical, surgical, dental, or related functions.

However, one stakeholder noted that proposed policies to lower the cost of medical liability insurance premiums only in rural areas may cause other challenges. In particular, the stakeholder noted such lowering of rural malpractice rates may incentivize physicians who cannot afford to get insured elsewhere because of a history of quality issues to move to rural areas that have lowered malpractice insurance rates, thus potentially lowering the quality of care being provided in rural areas.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services, including CMS, HRSA, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or hundrupa@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Sincerely yours,

Alyssa M. Hundrup
Director, Health Care

Appendix I: Objectives, Scope, and Methodology

This report focuses on obstetric care in rural areas, specifically on hospitals and clinicians that provide delivery services. The objectives of this report were to describe: (1) the availability of hospital-based obstetric services in rural areas, (2) stakeholder perspectives on factors that affect the availability of hospitals and clinicians that provide hospital-based obstetric care in rural areas, and (3) stakeholder perspectives on ongoing and proposed efforts federal agencies, states, and others could take to increase the availability of hospitals and clinicians that provide hospital-based obstetric care in rural areas.

To describe the availability of hospital-based obstetric services in rural areas, we first conducted a literature review of relevant research published from 2011 through 2022. We selected these years to capture research from the 10 last years. Specifically, we conducted a structured search of multiple electronic databases, including ProQuest, Scopus, WorldCat, Dialog, EBSCO, and Cochrane Library. Our searches included various terms related to our objectives, including "obstetric," "rural," "availability", and "access," among others. We limited our search results to English language materials and those focused on the United States. The materials we reviewed included peer-reviewed articles; conference papers; government reports; and association, nonprofit, and think-tank publications.

Our structured search identified 181 articles. Analysts then reviewed the articles to identify those to include in our report that met the following criteria: (1) included original research, (2) included data that was from 2007 or more recent, and (3) were relevant to our engagement objectives. Of the 181 articles we reviewed, we identified 50 that met the criteria for inclusion. Additionally, we also identified another 37 articles that were relevant to our criteria through internet searches, a review of the bibliographies of articles we obtained, and searches of government agency websites. See appendix II for a bibliography of the articles from our structured search and additional searches.

Additionally, we interviewed researchers, including those from three rural health research centers that conduct relevant work; officials from several provider associations that represent clinicians providing obstetric

services; and officials from several agencies within the Department of Health and Human Services—HRSA, CMS, Centers for Disease Control and Prevention, and Agency for Healthcare Research and Quality.[1]

To describe stakeholder perspectives on factors that affect the availability of hospitals and clinicians that provide hospital-based obstetric care in rural areas and ongoing and proposed efforts to address such factors, we first identified lists of factors and efforts by conducting a literature review (as described above) and interviewing researchers, provider associations, and federal agencies (as described above). We then conducted semi-structured interviews with 19 selected stakeholders representing provider associations, researchers, patient advocacy organizations, and federal agencies to obtain their perspectives on the list of factors that we initially identified as well as a list of efforts that could be taken to address such factors (see table 1). As part of these interviews, we asked the selected stakeholders to rank the lists of factors from most to least important and rate the efforts based on their perceived effect on the availability of obstetric care in rural areas. We selected these stakeholders to represent a diversity of perspectives and experiences, including those representing different racial and ethnic groups, and from clinicians that provide obstetric care or other clinical care during delivery.

[1]Specifically, we interviewed researchers from the North Carolina Rural Health Research Program, which conducts research on hospital closures; the University of Minnesota Rural Health Research Center, which conducts research on maternal health and access; and the Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center, which conducts research on the healthcare workforce. In addition, we interviewed researchers from the March of Dimes and National Rural Health Association. In terms of provider associations, we interviewed the American Academy of Family Physicians, American College of Nurse Midwives, and American College of Obstetricians and Gynecologists.

Table 1: Stakeholders for Semi-Structured Interviews, by Category

Type of stakeholder	Name of stakeholder
Federal agencies	Agency for Healthcare Research and Quality
	Centers for Medicare & Medicaid Services
	Health Resources and Services Administration
Researchers	National Rural Health Association
	Commonwealth Fund
Provider associations	American Academy of Pediatrics
	American College of Nurse-Midwives
	American College of Obstetricians and Gynecologists
	American Hospital Association
	American Medical Association
	American Society of Anesthesiologists
	Association of American Medical Colleges
	Association of Women's Health, Obstetric and Neonatal Nurses
	Critical Access Hospital Coalition
	Medicaid Medical Director Network
	Migrant Clinicians Network
	National Hispanic Medical Association
Patient advocacy organizations	Great Plains Tribal Chairmen's Health Board
	Six Dimensions

Source: GAO. | GAO-23-105515

Note. The stakeholders are presented in alphabetical order by category. We selected a judgmental sample of stakeholders to represent a diversity of perspectives and experiences, including various clinicians that provide obstetric care and organizations representing different racial and ethnic groups.

In presenting the results of our stakeholder interviews, we used modifiers to quantify stakeholders' views. When we report the results,

- the term "some" stakeholders represents more than 0 but less than or equal to 20 percent of responses (1-4 stakeholders);
- the term "several" stakeholders represents more than 20 percent but less than or equal to 40 percent of responses (5-8 stakeholders);
- the term "many" stakeholders represents more than 40 percent but less than or equal to 60 percent of responses (9-11 stakeholders);
- the term "most" stakeholders" represents more than 60 percent but less than or equal to 80 percent of responses (12-15 stakeholders); and,

- the term "nearly all" stakeholders represents more than 80 percent but less than 100 percent of responses (16-18 stakeholders).

Lastly, to further describe efforts reported to be effective at increasing the availability of hospital-based obstetric services in rural areas, we identified programs that were reported to be effective at increasing obstetric care availability from researchers and provider associations we interviewed as well as from our literature review. We selected six of these programs to represent varying experiences with the type of entity facilitating the program, scope of effort, demographic groups served, and geographic areas served in the United States. We then interviewed program officials to identify characteristics that made the programs successful as well as challenges they faced. See appendix III for more detailed information about these selected programs.

Appendix II: Bibliography

American College of Nurse-Midwives, National Association of Certified Professional Midwives, National Black Midwives Alliance, National Partnership for Women and Families. *Improving Our Maternity Care Now Through Midwifery.* (Washington, D.C.: National Partnership for Women and Families, October 2021).

American College of Obstetricians and Gynecologists. "Committee Opinion No. 586: Health Disparities in Rural Women." *Obstetrics & Gynecology,* vol. 123, no. 2 Pt 1 (2014): 384-388.

American College of Obstetricians and Gynecologists. "ACOG Committee Opinion No. 798: Implementing Telehealth in Practice." *Obstetrics & Gynecology,* vol. 135, no. 2 (2020): e73-e-79.

Anderson, Britta, Adam Gingery, Maeve McClellan, Robin Rose, David Schmitz, and Pat Schou. *National Rural Health Association Policy Paper: Access to Rural Maternity Care.* (Washington, D.C.: National Rural Health Association, 2019).

Avery, Daniel M., Dwight E. Hooper, John T. McDonald, Michael W. Love, Melanie T. Tucker, and Jason M. Parton. "The Economic Impact of Rural Family Physicians Practicing Obstetrics." *The Journal of the American Board of Family Medicine,* vol. 27, no. 5 (2014): 602-610.

Banke-Thomas, Aduragbemi, Megan Wilson-Jones, Barbara Madaj, and Nynke van den Broek. "Economic evaluation of emergency obstetric care training: a systematic review." *BioMed Central Pregnancy and Childbirth,* vol. 17, no. 403 (2017).

Barnea Eytan, R., Wanda Nicholson, Gerhard Theron, Diana Ramasauskaite, Michael Stark, S. Mark Albini, Anwar H. Nassar, and International Federation of Gynecology and Obstetrics Safe Motherhood and Newborn Health Committee. "From fragmented levels of care to integrated health care: Framework toward improved maternal and newborn health." *International Journal of Gynecology and Obstetrics,* vol. 152 (2021): 155-164.

Barreto, Tyler, Anuradha Jetty, Aimee Eden, Steven Petterson, Andrew Brazemore, and Lars Peterson. "Distribution of Physician Specialties by Rurality." *The Journal of Rural Health,* vol. 37 (2021): 714-722.

Bergh, Anne-Marie, Shisana Baloyi, and Robert C. Pattinson. "What is the impact of multi-professional emergency obstetric and neonatal care training? *Best Practice & Research Clinical Obstetrics & Gynecology,* vol. 29 (2015): 1028-1043.

Bronstein, Janet M., Songthip Ounpraseuth, Jeffrey Jonkman, Curtis Lowery, David Fletcher, Richard R. Nugent, and Richard W. Hall. "Improving Perinatal Regionalization for Preterm Deliveries in a Medicaid Covered Population: Initial Impact of the Arkansas ANGELS intervention." *Health Services Research,* vol. 46, no. 4 (2011).

Burlone, Suzanne, Lisa Moore, and Wendy Johnson. "Overcoming Barriers to Accessing Obstetric Care in Underserved Communities." *Obstetrics & Gynecology,* vol. 134, no. 2 (2019): 271-275.

Carlough, Martha, Ellen Chetwynd, Sarah Muthler, and Cristen Page. "Maternity Units in Rural Hospitals in North Carolina: Successful Models for Staffing and Structure." *Southern Medical Journal,* vol. 114, no. 2 (2021).

Carroll, Caitlin, Julia D. Interrante, Jamie R. Daw, and Katy Backes Kozhimannil. "Association between Medicaid Expansion and Closure of Hospital-Based Obstetric Services." *Health Affairs,* vol. 41, no. 4 (2022): 531-539.

Centers for Medicare & Medicaid Services. *External Summary: A Conversation on Maternal Healthcare in Rural Communities: Charting a Path to Improved Access, Quality, and Outcomes.* (Baltimore, Md.: June 12, 2019).

Centers for Medicare & Medicaid Services. *Centers for Medicare & Medicaid Services Rural Health Strategy.* (Baltimore, Md.: May 2018).

Centers for Medicare & Medicaid Services. *Issue Brief: Improving Access to Maternal Health Care in Rural Communities.* (Baltimore, Md.: September 3, 2019).

Cohen, Catherine, Matthew Baird, Nirabh Koirola, Ryan Kandrack, and Grant Martsolf. "The Surgical and Anesthesia Workforce and Provision of

Surgical Services in Rural Communities: A Mixed-Methods Examination." *Journal of Rural Health,* vol. 37 (2021): 45-54.

Corcoran, Lindsay, Catherin Clary, and Sarah Brinkman. *Policy Brief: Rural Obstetric Unit Closures and Maternal and Infant Health.* (Washington, D.C.: National Rural Health Association, February 8, 2021).

Department of Health and Human Services. *Healthy Women, Healthy Pregnancies, Healthy Futures: Action Plan to Improve Maternal Health in America.* (Washington, D.C.: Dec. 2, 2020).

Department of Health and Human Services, National Advisory Committee on Rural Health and Human Services. *Maternal and Obstetric Care Challenges in Rural America: Policy Brief & Recommendations to the Secretary.* (Washington, D.C.: May 2020).

Department of Health and Human Services. *Rural Action Plan.* (Washington, D.C.: September 2020).

Deutchman, Mark, Francesca Macaluso, Emily Bray, David Evans, James Boulger, Kathleen Quinn, Carrie Pierce, et al. "The impact of family physicians in rural maternity care." *Birth,* vol. 00 (2021):1-13.

Duarte, Shirley S., Turc-Anh T. Nguyen, Colleen Koch, Kayode Williams, and Jamie D. Murphy. "Remote Obstetric Anesthesia: Leveraging Telemedicine to Improve Fetal and Maternal Outcomes." *Telemedicine and e-health,* vol. 26, no. 8 (2020).

Eden, Aimee R, and Lars E. Peterson. "Challenges Faced by Family Physicians Providing Advanced Maternity Care." *Maternal and Child Health Journal,* vol. 22 (2018): 932-940.

Fialkow, Michael F., Carrie M. Snead, and Jay Schulkin. "New Partner Recruitment to Rural Versus Urban Ob-Gyn Practices: A Survey of Practicing Ob-Gyns." *Health Services Research and Managerial Epidemiology,* vol. 4 (2017).

Fialkow, Michael F., Carrie M. Snead, and Jay Schulkin. "Benefits and Barriers to Teaching Medical Students in an Ob-Gyn Clinic." *Health Services Research and Managerial Epidemiology,* vol. 5 (2018).

Goldstein, Jessica Taylor, Scott G. Hartman, Matthew R. Meunier, Bethany Panchal, Christine Pecci, Nancy M. Zink, and Sara G. Shields.

"Supporting Family Physician Maternity Care Providers." *Family Medicine,* vol. 50, no. 9 (2018): 662-671.

Handley, Sara C., Milly Passarella, Heidi M. Herrick, Julia D. Interrante, Scott A. Lorch, Katy B. Kozhimannil, Ciaran S. Phibbs, and Elizabeth E. Foglia. "Birth Volume and Geographic Distribution of US Hospitals with Obstetric Services from 2010 to 2018." *Journal of the American Medical Association Network Open,* vol. 4, no. 10 (2021).

Henke, Rachel Mosher, Kathryn R. Fingar, H. Joanna Jiang, Lan Liang, and Teresa B. Gibson. "Access to Obstetric, Behavioral Health, And Surgical Inpatient Services after Hospital Mergers in Rural Areas." *Health Affairs,* vol. 40, no. 10 (2021): 1627-1636.

Homan, Fay F., Ardis L. Olson, and Deborah J. Johnson. "A Comparison of Cesarean Delivery Outcomes for Rural Family Physicians and Obstetricians." *Journal of the American Board of Family Medicine,* vol. 26, no. 4 (2013): 366-72.

Hostetter, Martha, Sarah Klein, and Laurie Zephyrin. *Maternity Care, Interrupted.* (New York, N.Y.: Commonwealth Fund, May 2020).

Hung, Peiyin, Michelle M. Casey, Katy B. Kozhimannil, Pinar Karaca-Mandic, and Ira S. Moscovice. "Rural-urban differences in access to hospital obstetric and neonatal care: how far is the closest one?" *Journal of Perinatology,* vol. 38 (2018): 645-652.

Hung, Peiyin, Carrie E. Henning-Smith, Michelle M. Casey, and Katy B. Kozhimannil. "Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14." *Health Affairs,* vol. 36, no. 9 (2017):1663-1671.

Hung, Peiyin, Katy B. Kozhimannil, Michelle M. Casey, and Ira S. Moscovice. "Why Are Obstetric Units in Rural Hospitals Closing Their Doors?" *Health Services Research,* vol. 51, no. 4 (2016).

Jefferson, Karen, Mary Ellen Bouchard, and Lisa Summers. "The Regulation of Professional Midwifery in the United States." *Journal of Nursing Regulation,* vol. 11, no. 4 (2021): 26-38.

Jiang, Joanna H., Kathryn R. Fingar Lan-Liang, and Rachel Mosher Henke. "Risk of Closure among Independent and Multihospital-Affiliated

Rural Hospitals." *Journal of the American Medical Association Health Forum,* vol. 3, no.7 (2022).

Kozhimannil, Katy. "Rural-urban differences in childbirth care, 2002-2010, and implications for the future." *Medical Care,* vol. 52, no.1 (2014).

Kozhimannil, Katy B., Julia D. Interrante, Lindsay K. Admon, and Bridget L. Basile Ibrahim. "Rural Hospital Administrators' Beliefs about Safety, Financial Viability, and Community Need for Offering Obstetric Care." *Journal of the American Medical Association Health Forum,* vol. 3, no. 3 (2022).

Kozhimannil, Katy B., Julia D. Interrante, Mariana S. Tuttle, Mary Gilbertson, and Kristin DeArruda Wharton. "Local Capacity for Emergency Births in Rural Hospitals without Obstetrics Services." *The Journal of Rural Health,* vol. 37 (2021): 385-393.

Kozhimannil, Katy B., Julia D. Interrante, Mariana S. Tuttle, Carrie Henning-Smith, and Lindsay Admon. "Characteristics of US Rural Hospitals by Obstetric Service Availability, 2017." *American Journal of Public Health,* vol. 110, no. 9 (2020).

Kozhimannil, Katy B., Carrie Henning-Smith, and Peiyin Hung. "The Practice of Midwifery in Rural US Hospitals." *Journal of Midwifery & Women's Health,* vol. 61, no. 4 (2016): 411-418.

Kozhimannil, Katy Backes, Julia D. Interrante, Carrie Henning-Smith, and Lindsay K. Admon. "Rural-Urban Differences in Severe Maternal Morbidity and Mortality in the US, 2007-15." *Health Affairs,* vol. 38, no. 12 (2019): 2077-2085.

Kozhimannil, Katy B., Julia D. Interrante, Mariana K. S. Tuttle, and Carrie Henning-Smith. "Changes in Hospital-Based Obstetric Services in Rural US Counties, 2014-2018." *Journal of the American Medical Association,* vol. 324, no. 2 (2020).

Kozhimannil, Katy B., Michelle M. Casey, Peiyin Hung, Xinxin Han, Shailendra Prasad, and Ira S. Moscovice. "The Rural Obstetric Workforce in US Hospitals: Challenges and Opportunities." *Journal of Rural Health,* vol. 31, no. 4 (2015): 365-372.

Kozhimannil, K. B., P. Hung, M.M. Casey, and S.A. Lorch. "Factors associated with high-risk rural women giving birth in non-NICU hospital settings." *Journal of Perinatology,* vol. 36 (2016): 510-515.

Lee, Hyunjung, Ashley H. Hirai, Ching-Ching Claire Lin, and John E. Snyder. "Determinants of rural-urban differences in health care provider visits among women of reproductive age in the United States." *Public Library of Science ONE,* vol. 15, no. 12 (2020).

Lowery, Curtis L., Janet M. Bronstein, Tina L. Benton, and David A. Fletcher. "Distributing Medical Expertise: The Evolution And Impact Of Telemedicine In Arkansas." *Health Affairs,* vol. 33, no. 2 (2014): 235-243.

March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the U.S., 2020 Report.* (Arlington, Va., March of Dimes: 2020).

March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the U.S.* (Arlington, Va., March of Dimes: 2018).

Morken, Colleen, Kimberly Bruksch-Meck, Byron Crouse, and Kara Traxler. "Factors Influencing Rural Physician Retention Following Completion of a Rural Training Track Family Medicine Residency Program." *Wisconsin Medical Journal,* vol. 117, no. 5 (2018): 208-210.

Nuss, Michelle, A., Ben Robinson, and Peter F. Buckley. "A Statewide Strategy for Expanding Graduate Medical Education by Establishing New Teaching Hospitals and Residency Programs." *Academic Medicine,* vol. 90. no. 9 (2015):1264-1268.

North Carolina Rural Health Research Program. *Findings Brief: Health System Challenges for Critical Access Hospitals: Findings from a National Survey of CAH Executives.* (Chapel Hill, N.C., University of North Carolina at Chapel Hill: 2021).

O'Hanlon, Claire E., Ashley E. Kranz, Maria DeYoreo, Ammarah Mahmud, Cheryl L. Damberg, and Justin Timbie. "Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation." *Health Affairs,* vol. 38, no. 12 (2019): 2095-2104.

Page, Cristen P., Ellen Chetwynd, Adam J. Zolotor, George M. Holmes, and Emily M. Hawes. "Building the Clinical and Business Case for Opening Maternity Care Units in Critical Access Hospitals." *New England Journal of Medicine Catalyst, vol.* 2, no. 5 (2021).

Patterson, Davis G., C. Holly A. Andrilla, Lisa A. Garberson. "Preparing Physicians for Rural Practice: Availability of Rural Training in Rural-Centric Residency Programs." *Journal of Graduate Medical Education,* vol. 11, no. 5 (2019): 550-557.

Pearson, Jennifer, Kaitlyn Anderholm, Maren Bettermann, Samantha Friedrichsen, Carolina De La Rosa Mateo, Sara Richter, and Emily Onello. "Obstetrical Care in Rural Minnesota: Family Physician Perspectives on Factors Affecting the Ability to Provide Prenatal, Labor, and Delivery Care." *The Journal of Rural Health,* vol. 37 (2021): 362-372.

Peterson, Lars E., Brenna Blackburn, Robert L. Phillips, and James C. Puffer. "Structure and Characteristics of Family Medicine Maternity Care Fellowships." *Family Medicine,* vol. 46, no. 5 (2014): 354-359.

Pinto, Meredith, Roger Rochat, Monique Hennink, Adrienne D. Zertuche, and Bridget Spelke. "Bridging the Gaps in Obstetric Care: Perspectives of Service Delivery Providers on Challenges and Core Components of Care in Rural Georgia." *Maternal and Child Health Journal,* vol. 20(2016): 1349-1357.

Rayburn, William F., Jeffrey C. Klagholz, Cristina Murray-Krezan, Lana E. Dowell and Albert L. Strunk. "Distribution of American Congress of Obstetricians and Gynecologists Fellows and Junior Fellows in Practice in the United States." *Obstetrics & Gynecology,* vol. 119, no. 5 (2012): 1017-1022.

Rayburn, William F., Michael E. Richards, and Erika C. Elwell. "Drive Times to Hospitals with Perinatal Care in the United States." *Obstetrics & Gynecology,* vol. 119, no. 3 (2012): 611-616.

Rhoads, Sarah J., Hari Eswaran, Christian E. Lynch, Songthip T. Ounpraseuth, Everett F. Magann, and Curtis L. Lowery. "High-risk obstetrical call center: a model for regions with limited access to care." *The Journal of Maternal-Fetal & Neonatal Medicine,* vol. 31, no. 7 (2018): 857-865.

Schlichting, Lauren E., Tabassum Insaf, George Lui, Ali Zaidi, and Alissa Van Zutphen. "Proximity to risk-appropriate perinatal hospitals for pregnant women with congenital heart defects in New York state." *BioMed Central Pregnancy and Childbirth,* vol. 20, no. 338 (2020): 1-14.

Simpson, Kathleen Rice. "An overview of distribution of births in United States hospitals in 2008 with implications for small volume perinatal units in rural hospitals." *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* vol. 40, no. 4 (2011): 432-439.

Smulian, Elizabeth A., Leilah Zahedi, Julie Hurvitz, Abigail Talbot, Audra Williams, Zoe Julian, Adrienne D. Zertuche, and Roger Rochat. "Obstetric Provider Trainees in Georgia: Characteristics and Attitudes about Practice in Obstetric Provider Shortage Areas." *Maternal and Child Health Journal,* vol. 20 (2016): 1341-1348.

Spelke, Bridget, Adrienne D. Zertuche, and Roger Rochat. "Obstetric Provider Maldistribution: Georgia, USA, 2011." *Maternal and Child Health Journal,* vol. 20 (2016): 1333-1340.

Stapleton, Susan Rutledge, Cara Osborne, and Jessica Illuzzi. "Outcomes of Care in Birth centers: Demonstration of a Durable Model." *Journal of Midwifery & Women's Health,* vol. 58, no.1 (2013): 3-14.

Sullivan, Margaret H., Sheri Denslow, Kathleen Lorenz, Suzanne Dixon, Emma Kelly, and Kathleen A. Foley. "Exploration of the Effects of Rural Obstetric Unit Closures on Birth Outcomes in North Carolina." *The Journal of Rural Health,* vol. 37 (2021): 373-384.

Talib, Zohray, Mariellen Malloy Jewers, Julia H. Strasser, David K. Popiel, Debroa Goetz Goldberg, Candice Chen, Hayden Kepley, Fitzhugh Mullan, and Marsh Regenstein. "Primary Care Residents in Teaching Health Centers: Their Intentions to Practice in Underserved Settings after Residency Training." *Academic Medicine,* vol. 93, no. 1 (2018): 98-103.

Taporco, Jason S., Elizabeth Wolfe, Gabriela Chavez, Zev Allen, Jasmine Estrada, Kelly Thomson, Jennifer Mettling, and Michael Kennedy. "Kansas maternity deserts: a cross-sectional study of rural obstetric providers." *Rural and Remote Health,* vol. 21, no.1 (2021): 6137.

Thorsen, Maggie L., Sean Harris, Ronald McGarvey, Janelle Palacios, and Andreas Thorsen. "Evaluating disparities in access to obstetric services for American Indian women across Montana." *The Journal of Rural Health,* vol. 38 (2022): 151-160.

Tong, Sebastian T., Aimee R. Eden, Zachary J. Morgan, Andrew W. Bazemore, and Lars E. Peterson. "The Essential Role of Family

Physicians in Providing Cesarean Sections in Rural Communities." *Journal of the American Board of Family Medicine*, vol. 34, no. 1 (2021): 10-11.

University of Minnesota Rural Health Research Center. *Policy Brief: Closure of Hospital Obstetric Services Disproportionately Affects Less-Populated Rural Counties.* (Minneapolis, Minn., University of Minnesota: April 2017).

University of Minnesota Rural Health Research Center. *Policy Brief: Emergency Obstetric Training Needed in Rural Hospitals without Obstetric Units.* (Minneapolis, Minn., University of Minnesota: November 2020).

University of Minnesota Rural Health Research Center. *Policy Brief: State Variability in Access to Hospital-Based Obstetric Services in Rural U.S. Counties.* (Minneapolis, Minn., University of Minnesota: April 2017).

University of Minnesota Rural Health Research Center. *Policy Brief: State and Regional Differences in Access to Hospital-Based Obstetric Services for Rural Residents, 2018.* (Minneapolis, Minn., University of Minnesota: August 2021).

University of Minnesota Rural Health Research Center. *Policy Brief: State Variations in the Rural Obstetric Workforce.* (Minneapolis, Minn., University of Minnesota: May 2016).

University of Minnesota Rural Health Research Center. *Methodology Brief: An Enhanced Method for Identifying Hospital-Based Obstetric Unit Status.* (Minneapolis, Minn., University of Minnesota: January 2022).

University of Minnesota Rural Health Research Center. *Policy Brief: Rural and Urban Hospital Characteristics by Obstetric Service Provision Status, 2010-2018.* (Minneapolis, Minn., University of Minnesota: April 2021).

University of Minnesota Rural Health Research Center. *Policy Brief: Obstetric Services and Quality among Critical Access, Rural, and Urban Hospitals in Nine States.* (Minneapolis, Minn., University of Minnesota: June 2013).

University of Minnesota Rural Health Research Center. *Policy Brief: Obstetric Emergencies in Rural Hospitals: Challenges and Opportunities.* (Minneapolis, Minn., University of Minnesota: September 2020).

Waits, John B., Lacy Smith, and Daniel Hurst. "Effect of Access to Obstetrical Care in Rural Alabama on Perinatal, Neonatal, and Infant Outcomes: 2003-2017." *Annals of Family Medicine,* vol. 18, no. 5 (2020): 446-451.

Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center. *Policy Brief #168: The Supply and Rural-Urban Distribution of the Obstetrical Care Workforce in the U.S.* (Seattle, Wash., University of Washington, 2020).

Washington, Wyoming, Alaska, Montana, Idaho Rural Health Research Center. *Data Brief #168: The Supply and Rural-Urban Distribution of the Obstetrical Care Workforce in the U.S.: A State Level Analysis.* (Seattle, Wash., University of Washington: 2020).

Weigel, Paula A.M., Fred Ullrich, and Marcia M. Ward. "Rural Bypass of Critical Access Hospitals in Iowa: Do Visiting Surgical Specialists Make a Difference?" *The Journal of Rural Health,* vol. 34 (2018): s21-s29.

Wendling, Andrea, Valerie Taglione, Rachel Rezmer, Poe Lwin, Jessica Frost, Julia Terhune, and Jean Kerver. "Access to maternity and prenatal care services in rural Michigan." *Birth,* vol. 48 (2021): 566-573.

Williams, Thomas E., Jr., Bhagwan Satiani, and E. Christopher Ellison. "A comparison of future recruitment needs in urban and rural hospitals: The rural imperative." *Surgery,* vol. 150, no. 4 (2011): 617-625.

Xierali, Imam M., Marc A. Nivet, and William F. Rayburn. "Relocation of Obstetrician-Gynecologists in the United States, 2005-2015." *Obstetrics & Gynecology,* vol. 129, no. 3 (2017): 543-550.

Appendix III: Successes and Challenges from Selected Programs

Below we present information on six selected programs that researchers and provider associations we interviewed identified as effective at increasing obstetric care availability in rural areas for hospitals and clinicians that provide delivery services. We selected six of these programs to represent varying experiences with the type of entity facilitating the program, scope of effort, demographic groups served, and geographic areas served in the United States. In addition to descriptions of each program, we include information from program officials on characteristics that made the programs successful as well as challenges the programs faced.

Selected Programs

Bootheel Perinatal Network. This program is an example of a community-oriented regional partnership model, located in southeastern Missouri, in which all providers in the network share patient referrals and provide one another support and expertise. The program received a grant in 2019 from the Health Resources and Services Administration's (HRSA) Rural Maternity and Obstetrics Management Strategies program to help establish this network as well as achieve other program goals, including expanding training opportunities, extending racial equity educational programs, and using telehealth to provide prenatal and postpartum clinic care and support services.

National Health Service Corps Scholarship and Loan Repayment Program. This program provides funding to clinicians, including obstetricians and gynecologists (OB/GYN), family physicians, and certified nurse-midwives, that practice in geographic areas deemed as Health Professional Shortage Areas, which include many rural areas. Since 1972, the program has supported over 66,000 primary care clinicians. In fiscal year 2021, there were over 2,800 clinicians that provide obstetric care participating in this program, with 30 percent of them working in rural areas, according to HRSA officials. They added that about 80 percent of program participants remain in their communities for two or more years after completing the program's service obligations.

Texas Rural Maternity and Obstetrics Management Strategies Network Program. This program is a regional partnership using a hub-and-spoke model. The goal of the program is to improve maternal outcomes and increase local facilities' ability to care for high-risk patients in the community, according to program officials. The program received a grant in 2019 from HRSA's Rural Maternity and Obstetrics Management Strategies program to establish a network as well as support other program goals. Such goals include recruiting new staff to bolster network capacity, implementing enhanced perinatal case management services, and providing telehealth consultation and training.[1] The hub receives advanced specialty referrals from the spokes and also supports capacity building efforts at the spoke facilities.

University of Arkansas for Medical Services Institute for Digital Health and Innovation High-Risk Pregnancy Program. This multi-faceted program is designed to be a support network for high-risk obstetric patients and providers in Arkansas. The program provides remote consultations through a call center, education and support for obstetric clinicians, and case management for patients, among other things. According to the program officials, the call center is open 24 hours a day, 7 days a week and staffed by highly trained, experienced nurses with backgrounds in obstetric care.

University of Wisconsin OB/GYN Rural Residency Program. This program started in 2017 and was the first OB/GYN residency program in the country to provide a dedicated rural training track. The university currently accepts one rural training track resident and six other non-rural residents per year as part of its OB/GYN residency program. The program provides rotations in areas that HRSA's Federal Office of Rural Health Policy designates as rural, with about 6 months of rural rotations during the four-year residency program. The program director noted that the amount of time the rural training track resident spends in rural and non-rural settings is to balance 1) the number of obstetric and gynecologic procedures that OB/GYN medical residents are required to complete and 2) support for the rural training track resident getting a full experience of practicing in a rural area.

West Virginia Perinatal Partnership. This organization is a statewide collaborative that conducts outreach, education, and quality improvement

[1]University Health in San Antonio serves as the hub. The regional hospitals and clinics, including Uvalde Memorial Hospital and Val Verde Regional Medical Center, serve as the spokes in the service areas in Texas.

programs to obstetric clinicians and perinatal nurses in West Virginia to help improve access to and quality of care, according to a program official. The organization received an award in 2021 from HRSA's Rural Maternity and Obstetrics Management Strategies program to establish a regional network—the West Virginia Rural Maternity and Obstetric Management Strategies Collaborative—to increase access to maternal and obstetric care within the target service area. As of August 2022, the program is in its planning year, to set up its network and prepare to implement program activities.

Characteristics of Successful Programs

Program officials identified the following common characteristics that made their programs successful at increasing the availability of hospital-based obstetric care in the rural areas where they worked.

Relationships. Officials from five programs cited relationships with hospital administrators and clinicians as important to the success of a variety of types of programs, including an outreach and education program, partnerships, and an OB/GYN residency rural training track. For example:

- An official from an outreach and education program cited relationships with clinicians and nursing leaders as being instrumental in appropriately targeting education to meet the needs of specific hospitals and staff. The staff are able to get ideas for specific skills that require practice drills and updated information to assure that they are meeting new standards of care.
- Another official from a rural training track program said that strong investment in the relationships with hospitals participating in their residency program directly affects a positive and supportive experience for residents, which has ultimately led to graduates continuing to practice in rural areas.
- Officials from a regional partnership program also described pre-existing relationships that the "hub" hospital had with other facilities in the region ("spokes") as instrumental in the success of setting up their regionalized partnership.

Dedicated leader or staff. Officials from four programs cited the importance of program staff—whether that be the presence of a dynamic leader or programmatic staff with the right skills and dedication. For example:

- An official from a rural training track program attributed the success of the program to having a dedicated leader that makes time, puts in the effort, and has the drive to work for the program's success.
- Officials from a regional partnership program attributed much of the program's success to dedicated program staff with (1) knowledge of obstetric services and available local resources and (2) the ability to effectively listen and get at the root-cause of what is hindering access for each patient.

Funding. Officials from four programs cited adequate funding as enabling the programs to function effectively, particularly for those that provide loan repayments and scholarships. For example:

- Officials from a loan repayment program attributed the success of the program to the availability of program funding that influences the number of awards the program can provide. In particular, the officials said that an $800 million appropriation from the American Rescue Plan Act of 2021 allowed the program to fund all scholarship and loan repayments applicants in most designated Health Professional Shortage Areas in 2021.[2] The officials said in previous years, the program had only provided funding to applicants that were serving in the highest need Health Professional Shortage Areas.
- Officials from a program providing remote consults cited prior grant funding investing in telemedicine as laying the groundwork that enabled the program to be successful at providing training and support to rural clinicians. The officials said that having the infrastructure to do remote consults and telemedicine has been a "game changer" for rural communities in their state.
- An official from the rural training track program said that securing funding from various sources has allowed the program to successfully continue. Due to needs of the program to meet high volumes of procedures to fulfill medical resident educational requirements and also practice in rural areas where there are not high volumes of patients, the residents do not spend more than 50 percent of their time in rural areas, according to the program official. As a result, the official said the program is not eligible for additional Medicare graduate medical education funding for rural training track

[2]Pub. L. No. 117-2, § 2602, 135 Stat. 4, 44.

participants.[3] Instead the official said the program must use other sources of funding, such as from the university, charitable gifts, and the residency sites.

Outreach/marketing. Officials from four programs cited community outreach and marketing to advertise their programs and partners as important to program success. For example:

- Officials from the remote consult program noted that outreach and marketing helped to get clinicians to use the program. Going into the community and explaining the program helps to build awareness and understanding of how beneficial the program can be, according to program officials.
- An official from the rural training track program noted that publicizing the program helps to bring attention to the program, including for the rural hospitals that partnered for residencies. The official noted that the program receives significantly more applicants than they have spots (212 applicants for one spot in 2021, according to the official).

Challenges Faced by Selected Programs

Program officials also identified the following common challenges encountered by the various programs that affect their ability to increase the availability of obstetric care in rural areas.

Recruiting and retaining providers or hospital partners. Officials from four programs cited challenges with recruiting and retaining clinicians or hospital partners. Among other things, officials said these challenges are related to recruiting clinicians that are comfortable practicing in rural areas as well as competition among hospitals in the region. Officials from one regional partnership program noted that two hospitals left their network because of competition between them. In particular, the officials noted that concerns that hospitals would take away each other's patients

[3]Medicare offers graduate medical education payments to teaching hospitals to partially offset the costs of training full-time equivalent medical residents, up to a capped number of resident slots for each hospital. For most hospitals, caps reflect the number of residents that Medicare funded in 1996; for hospitals starting their first new GME program in 1997 or later, caps were based on the number of Medicare-funded residents trained at the end of a specific time window. Urban teaching hospitals may receive additional Medicare funding beyond its Medicare-funded graduate medical education cap if residents in their rural training track programs train for more than 50 percent of their time in a rural hospital or at rural non-hospital sites.

hindered the ability of the hospitals to work together in their regionalized network.

Funding. Officials from three programs also stated that funding was the primary challenge, particularly for keeping the program operational or for expanding the program to meet the community needs identified by the program.

Additionally, some of the challenges cited by the programs were very specific to the nature of each program:

- Officials from two regional partnership programs discussed challenges with setting up data-sharing mechanisms amongst the network partners. In particular, there were difficulties with trying to get similar data from hospitals and facilities using different electronic health record systems and in setting up information exchange systems. HRSA officials said that because of such challenges with the first cohort of Rural Maternity and Obstetrics Management Strategies program grantees, the agency strongly encouraged the applicants for fiscal year 2021 funding to include a data coordinator in their proposed programs.
- Officials from the loan repayment program said that they were required to consider OB/GYNs and other obstetrician clinicians along with primary care clinicians, meaning they could not prioritize clinicians providing obstetric services over other types of clinicians.

  The loan payment program officials noted that the Improving Access to Maternity Care Act requires HRSA to develop Maternity Care Health Professional Target Areas that will prioritize scholarship and student loan repayment funding to clinicians providing obstetric services along with other mandated priorities.[4] HRSA published a *Federal Register* notice in May 2022 that finalized the criteria used to identify Maternity Care Health Professional Target Areas within new and existing Primary Care Health Professional Shortage Areas.[5] HRSA expects to begin using the Maternity Care Health Professional Target Area criteria as it makes scholarship and student loan repayment funding decisions in fiscal year 2023.

[4]Pub. L. No. 115-320, § 2, 132 Stat. 4437 (2018).

[5]87 Fed. Reg. 30,501 (May 19, 2022).

Appendix IV: Stakeholders' Perspectives on Efforts to Address the Availability of Hospital-Based Obstetric Care in Rural Areas

This appendix provides information on perspectives of 19 selected stakeholders on a list of efforts we identified that federal agencies, states, and others could take to address factors affecting the availability of hospital-based obstetric care in rural areas, specifically for hospitals and clinicians that provide delivery services. (See appendix I for a list of selected stakeholders and additional information on our scope and methodology.)

Stakeholders provided ratings for each effort's perceived effect on the availability of obstetric care in rural areas, as: 1) likely to have a positive effect, 2) likely to have no effect, 3) likely to have a negative effect, or 4) no basis to judge. Table 2 displays the count of stakeholder ratings for each of these efforts (not including counts of "no basis to judge").

Table 2: Count of Stakeholders' Ratings for 21 Identified Efforts that Could Affect the Availability of Hospital-Based Obstetric Care in Rural Areas

	Counts of Stakeholders		
Effort	**Positive effect**	**Negative effect**	**No effect**
Increase Medicaid payments for obstetrics care	19	0	0
Increase use of telemedicine/remote consults between providers and specialists	19	0	0
Promote partnerships among hospitals and/or providers, such as "hub-and-spoke" models and consults between providers for higher-risk obstetric consultations	18	0	0
Financially incentivize providers to practice in rural communities, such as expanding funding of the National Health Service Corps loan repayment program and/or its associated sites in rural areas.	18	1	0
Create more opportunities for residency training in rural communities, such as rural training tracks in medical school and graduate medical education	17	0	1
Reduce costs of medical liability premiums for rural obstetric physicians	16	0	1
Expand Medicaid coverage for non-clinical services (e.g., temporary housing and doulas)	16	0	3

Effort	Counts of Stakeholders		
	Positive effect	Negative effect	No effect
Expand medical liability insurance coverage beyond the hospital that providers practice at to cover other hospitals, allowing for rotations and training as needed	15	0	1
Establish tiered training systems for residents to allow for advanced training in obstetric care, such as advanced maternity care training for family medicine residents who are interested in providing prenatal/intrapartum care	14	0	2
Provide cost-based reimbursement from Medicaid for critical access hospitals	14	0	2
Create rotations for rural providers to spend time practicing in higher volume hospitals	13	0	3
Train emergency responders on obstetrics care to be "obstetric ready"	13	0	6
Increase the Medicaid income eligibility threshold for pregnant women	13	1	2
Establish additional accredited midwifery education programs separate from schools of nursing for educating and training masters and/or doctoral level certified nurse-midwives and certified midwives	12	0	2
Increase funding for graduate medical education programs to support medical residents	12	0	5
Standardize scope of practice across states for midwives with accredited education	11	0	4
Assess the impacts of mergers, acquisitions, or closures of obstetrics units and hospitals and address, as needed	9	0	7
Incentivize the creation of free-standing birth centers	8	3	4
Create physician exchange programs between hospitals to increase delivery volumes for rural providers in low volume areas	7	0	7
Incentivize continuing medical education	7	0	10
Standardize scope of practice laws and eligibility requirements for providers	6	0	9

Source: GAO analysis of stakeholder interviews. | GAO-23-105515

Notes: We identified these steps that could address the factors that affect the availability of obstetrics care in rural areas through our literature review and interviews with researchers, provider associations, and federal agencies. These steps are focused on hospitals and clinicians that provide delivery services. We then had 19 selected stakeholders rate these steps as having a positive, negative, or no effect on the availability of obstetrics care or "no basis to judge." The 19 selected stakeholders represent provider associations, researchers, patient advocacy organizations, and federal agencies. We selected these stakeholders to represent a diversity of perspectives and experiences, including those representing different racial and ethnic groups and clinicians that provide obstetric care.

Counts for each effort may not add up to 19 because we did not include the count of stakeholders who provided a "no basis to judge" option for the efforts.

Seven of the 21 efforts had the highest count of "likely to have a positive effect" ratings from stakeholders, as described in this report. The

remaining 14 efforts received mixed ratings. The following is additional information on some efforts that received mixed ratings:[1]

Physician exchange programs. Some stakeholders stated that physician exchange programs can help bring rural physicians from low-birth-volume locations to larger hospitals with higher birth volume and more high-risk cases, which enables them to refresh their skills and training in providing obstetric care. However, some stakeholders emphasized that these exchange programs are limited by the capacity of clinicians in the area, especially for regions that already face clinician shortages. Several other stakeholders said that such exchanges may lead to problems of coverage at the rural physicians' home facilities while they are away. Lastly, some stakeholders stated that from the patient perspective it may not be preferable to see different providers who are rotating around for their delivery care.

Free-standing birth centers. Some stakeholders said that free-standing birth centers are a key part of the regionalization of care, and some others noted that birth centers can also help address issues in birth outcomes for non-White racial and ethnic groups specifically by providing a community-based model of care. However, some other stakeholders stated that birth centers require hospitals to be nearby to transfer higher-risk patients if needed, so birth centers may not do much to increase the availability of hospital-based obstetric care in rural areas. Researchers from one organization also stated that because of the need to be close to hospitals, most birth centers are adjacent to metropolitan areas. Lastly, some stakeholders also expressed concerns that birth centers may not always be well-regulated in certain states and may not provide care at an adequate safety level.

Scope of practice requirements for clinicians. Some stakeholders stated that expanding the scope of practice requirements for midwives to allow them to practice independently without physician supervision would increase the availability of midwives that could provide obstetric care.

[1]In presenting the results, we used modifiers to quantify stakeholders' views. Specifically, "some" stakeholders represents more than 0 but less than or equal to 20 percent of responses (1-4 stakeholders); "several" stakeholders represents more than 20 percent but less than or equal to 40 percent of responses (5-8 stakeholders); "many" stakeholders represents more than 40 percent but less than or equal to 60 percent of responses (9-11 stakeholders); "most" stakeholders" represents more than 60 percent but less than or equal to 80 percent of responses (12-15 stakeholders); and, "nearly all" stakeholders represents more than 80 percent but less than 100 percent of responses (16-18 stakeholders).

Some stakeholders also emphasized that for family physicians, maintaining or expanding their scope of practice through rotations or training can maintain and improve their skills, such as for performing caesarean sections. This could allow more family physicians to perform procedures for higher-risk patients and keep credentialing to deliver babies in low-volume settings, according to these stakeholders. However, some stakeholders expressed concerns that changing scope of practice regulations to expand the care that certain clinicians can provide may decrease the quality of care provided. Some other stakeholders stated that standardizing scope of practice across the country could potentially limit providers if the standardization is based on the states with more restrictive scopes. Lastly, several stakeholders agreed that expanding the scope of practice for providers across the nation is difficult for the federal government to accomplish, as scope of practice laws are enacted at a state level.

Appendix V: GAO Contact and Staff Acknowledgements

GAO Contact

Alyssa M. Hundrup, (202) 512-7114 or hundrupa@gao.gov

Staff Acknowledgement

In addition to the contact named above, Raymond Sendejas (Assistant Director), Rebecca Hendrickson (Analyst-in-Charge), Claire Liu, Jeanne Murphy Stone, Ebony Russ, and Sydney Wilson made key contributions to the report. Also contributing were Jennie Apter, Leia Dickerson, Emily Wilson Schwark, Ravi Sharma, and Nicole Willis.

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

DATE: November 2022

TO: Board of Directors
Northern Inyo Healthcare District

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

RE: Department Update

REPORT DETAIL

FOUNDATION

September and October saw regularly scheduled board meetings take place. In September the Board approved funding for the CAREshuttle program in the amount of $805 for regular maintenance of the vehicles. At the October meeting it was announced that the new CAREshuttle vehicle had arrived and its purchase price was $49,780. The Foundation approved that funding to the District, along with another $860 for the pink ribbons that were purchased for Breast Cancer Awareness Month. The CAREshuttle's next stop is the van conversion company that will convert the regular passenger van into an ADA compliant wheelchair van, accessible through the rear tailgate instead of the typical side-door entry for most of these vans. This will allow for greater safety of the drivers when loading a passenger because it allows for a straight shot wheeling the chair in, instead of entering perpendicular to the vehicle and having to turn the passenger 90 degrees once inside. This will also provide a much improved passenger experience as well.

The Board also had Sarah Freundt, owner of the Bishop Grocery Outlet come and introduce themselves. After a brief Q&A period, her nomination was accepted by the Board. She will be at this month's District board meeting for final approval.

GRANT WRITING

The District was awarded continued funding, in the amount of $120,000, for our ED Navigator position that facilitates care between our ED and our Medication for Addiction Treatment (MAT) services in the RHC. This funding was received from the CalBridge Behavioral Health Navigator Program and is for one year ending October 2023.

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DATE: November 2022

TO: Board of Directors
Northern Inyo Healthcare District

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

RE: Diagnostic Services Department Update

REPORT DETAIL

NEW BUSINESS

Cardiopulmonary (CP):

- The CP department is in receipt of its second blood gas analyzer. This instrument will be put into service in early November and will give our district a backup analyzer to allow us to serve our patients despite unplanned downtime of the primary instrument.
- October 24-30 is National Respiratory Care week. The district celebrated with our Respiratory Therapists by decorating the therapists' break room and providing one breakfast and one lunch for the staff of the department.
- The Cardiopulmonary department still has one vacant graveyard position. We are actively recruiting for a permanent position.

Diagnostic Imaging (DI):

- The DI department's plan to begin replacement of our Ultrasound platform is on hold in order to preserve capital dollars. Also on hold is the purchase of our AW workstation and our film printer. The AW workstation and Film Printer are being considered for non-replacement while the US units will be requested in FY 24.
- Moonlight Mammograms returned in full force this year with the DI department putting on nine events in the month of October. Final numbers are not in as of the writing of this report but I expect that we will end the month with over 100 mammograms being provided to our community as a result of the events. This is in addition to the normal mammogram volume of 170 exams per month.
- Ultrasound staffing has been very difficult with one vacancy and one medical leave in the four-person department (50% vacancy rate). We have retained the services of a traveler that started on 10-17-22 and that will assist with our coverage plans while we look for a permanent staff member. Ultrasound volume is up 23% since July of 2021, in part due to the increased volume of OB patients coming from Mammoth. Ultrasound volume is up

42% as compared to pre-pandemic volumes. The department is analyzing the need to increase routine staffing in this department an additional FTE.

Laboratory Services (the Lab):

- One of our night shift travelers, Cara, who has been with us for 2 years, is now a permanent NIHD employee! We are very excited to have her on the team
- For the first time in a long time, all of our laboratory Lead positions are filled:
    - Sandra is now able to focus on her Microbiology Lead position and has been busy validating updated testing procedures.
    - John Carlo (JC) Santiago has filled the Point of Care Testing Lead position (interim). He is taking on more of those responsibilities and the transition is going very well.
    - Molly Motos is our interim Transfusion Service (Blood bank) Lead and has been very involved with nursing staff and lab staff to improve our transfusion services and the relationship between the lab and the nursing staff.
    - John (Chemistry) and Matt (Hematology) continue to provide quality services in their areas as well
- "Team Fun" is planning holiday activities and has been doing monthly birthday celebrations for which the staff has expressed appreciation. There was also a BBQ in September
- Hannah and Jessica have identified several opportunities for improvement in our outpatient phlebotomy services and are working hard with the team to revise workflows and perform customer service recovery.

OLD BUSINESS

Cardiopulmonary:

No old business for Cardiopulmonary

Diagnostic Imaging:

No old business for Imaging

Laboratory Services:

No old business for Laboratory Services

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DATE: November 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Scott Hooker, Director of Facilities

RE: Department Update

REPORT DETAIL

MAINTENANCE/FACILITIES

New Business:

Colombo Construction has contractors on site working on the chiller plant upgrade and the Pharmacy Project. Some framing has been completed along with all underground plumbing and electrical conduits.

HCAI Projects

- **Pharmacy Project** – The Pharmacy Project is moving along smoothly; not fast, but steady. No big hurdles recently.

Here are some of the tasks that are taking place:

- Fire sprinkler work last week; relocation of sprinkler heads to be compliant with the new floor plan in the area.
- All underground plumbing has been completed.
- Rebar has been installed and inspected in some large structural grade beams.
- Received approval from HCAI to pour the concrete for these new grade beams, as well as other areas.
- Cement pour took place on 10/28/2022.
- The reason we had to reroute around the old ED corridor is because the cement pump was not available. We had to get cement to the bathroom waiting area using wheelbarrows. We didn't want the public walking past this area (safety).
- Framers will be onsite 10/31/2022 to perform some prep work, (install bolts and other hardware for walls in the near future).
- Mechanical will be onsite 10/31/2022 coordinating with the framers.
- Electrical – conduit runs have been completed up to a point where a change order is at HCAI for review.

- Roofers will be onsite 11/2/2022 to perform some demo work for the structural portion of the work taking place down in the project. Structural attachments are required from the roof down the new structural support walls.

Temporary Chiller Project – This project is monitored by HCAI until we get rid of the temporary chiller. That will happen after the chiller plant upgrade (or condenser plant upgrade).

Chiller Plant Upgrade / Condenser Plant Upgrade – Work is ongoing, condensers are scheduled to arrive at the end of October. This is later than we expected due to supply chain issues. Electrical rough-in is complete, mechanical lines to be placed the week before the condensing units are craned in (end of October first of November).

SECURITY

New Business:

Security is running smoothly with no open positions. We are fully staffed with one out on LOA. Security Officer Steve Thompson has started working shifts solo, Mike White has gone through orientation and will start working alongside the other officers soon.

There have been several shootings at Healthcare Facilities across the nation. We are going to introduce the Security Team to NIHD staff through our Strategic Communications Department. We want our staff to be aware of who our officers are, what they do, and when they are here. With the help of Cori Stearns, we are also rotating security-related safety tips in the Safety Huddle Report. This is very helpful information for our NIHD team.

Old Business:

Security is currently operating with 6 officers. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

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DATE: November 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Lynda Vance, Manager of Project Management

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Collaborating with the Executive Team, we have reviewed all projects to ensure we are fiscally responsible. We are looking forward to using the new standard ROI form created by our new CFO, Stephen DelRossi. Along with the financial review, we also review staffing resources as we have short-staffed areas. This makes scheduling tricky for projects to ensure our teams have the time to be engaged. I enjoyed giving the board an overview report of the Phone Messaging project in October. Thank you for allowing me to provide this report.

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

Discovery – 7 (QliqSoft Secure Text Messaging, Tele-Pharm services, ORA/Argos Ophthalmic update, Infant RTLS Replacement system, Nuance PowerShare Hub update, OneContent upgrade, Patient Appointment Reminders)

Actively Working – 9 (ABI Machine for wound care, OR workflow optimization, ABG instrument, Hauge MedPlan, Hauge Interface Cerner project, MRI area update, Clinic Phone system Standard Setup, Redesign Quality/ Informatics, RHC Recovery Support, and Patient access area update)

Closing – 7 (State Mandate Tracking, Cerner Supply Ops Job Cleanup, Employee Health Management System Agility, i2i with Cerner, EMS radio and recording system Replacement, Stryker Mako Ortho Robot IDA, GHX - Provider Intelligence)

Moves Completed - 9 (RHC RN area addition, Interim Controller Relocation, Surgery/ PACU office changes, Case Manager office update, CFO office, Pharmacy Staff desk update, RHC clerk window update, AP Desk update, Accounting area update)

On Hold Projects - 15 (Omnicell Cabinets, eCase Reporting with Cerner, Qstress Test System, Perinatal Assistant Manager office, OB sleep room update, SmartSheet upgrade

for PHI compliance, OneContent athena upload, Copay workflow improvement, City of Hope Telehealth, SAP Concur, Onboarding Workflow Efficiency, Cerner Portal Relaunch, Internal Med Office update, LabCorp CHC price update athena, Ultrasound unit replacement)

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DATE: November 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Neil Lynch, Purchasing

RE: Department Update

REPORT DETAIL

NEW BUSINESS
Vendor performance issues with lab vendor Hardy, we are working with GPO and lab leadership to onboard higher performing vendor without negatively affecting bottom line. Problems with timely delivery and quality.

OLD BUSINESS
(Complete) Business as usual. Purchasing staff have been rotating vacation schedules causing resources to be tight.

(On Hold) Currently working with HR to fill vacancies in the Purchasing Department.

(Complete) Year-end fiscal inventory was rescheduled with a new completion date of 7/15/2022. We are very happy to be able to participate in weekend holiday activities around the 4th of July without inventory activities overwhelming the department.

Shipping delays have been minimal and PPE supply is more than sufficient. Purchasing will continue to monitor supply chain to ensure adequate supply.

(Complete) Purchasing is preparing for fiscal yearend inventory (6/30/2022). In preparation we will be analyzing inventory processes for Purchasing and Surgery departments, prepping the warehouse, and doing some item master maintenance. All of this is necessary to ensure an accurate fiscal year end valuation.

(Complete) Process review. Purchasing will be process mapping workflows to ensure accuracy and efficiency in supply chain processes with a focus on Cerner driven workflows.

(Complete) Back orders. We are experiencing significant delays across most supply chain categories. Covid-19, weather, shipping bottle necks, and manufacturing delays have made ordering difficult. Most resources are focused on minimizing delays.

(Complete) Purchasing continues to work on GPO (Group Purchasing Organization) transition. We are compiling data for analysis to determine contract compliance rate.

(Complete) GHX EDI integration has begun. IT continues has completed set up on the back end, purchasing staff is training and will be testing system through October.

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(760) 873-5811 Ext. 3415

DATE: November 2022
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Allison Partridge, RN, MSN, Chief Nursing Officer
RE: Department Update

REPORT DETAIL

COVID-19

The District continues to manage the daily challenges that COVID-19 has presented. We are closely monitoring the guidance from CDPH as the State deescalates the restrictions and requirements. NIHD continues to partner with Inyo County Public Health in administering COVID-19 vaccines and has created accessibility in the RHC and NIA clinics. The car clinic has also enhanced its workflow by establishing a process that allows patients to be seen and tested and leave with Paxlovid in hand when appropriate.

Recruitment

In collaboration with our Human Resource Team, we continue to focus on recruiting and retaining team members to fill open vacancies throughout the District. Recruitment and retention continue to be an area of daily focus and present challenges throughout the District with a significant impact on nursing.

New Team Members

We are excited to welcome six new RNs to the District. Three RNs will be joining our Emergency Department. In the Acute/SubAcute Unit, 2 RNs have joined us, with a third joining soon. We are also excited for our three RNs completing training programs. Two RNs are completing ICU training and one RN is completing OR training.

Survey Follow-up

Our District teams continue to collaborate in developing action plans to address our recent Joint Commission survey findings. I am very proud of our teams' continued collaboration and dedication to quality and safety.

Projects

STABLE/NRP Carts: The Perinatal Department has successfully implemented STABLE/NRP carts. These are emergency carts that are used during neonatal resuscitation. The carts allow all supplies to be stored and accessed in a standardized and efficient manner. The carts are located in the Perinatal Department and the Surgery Department.

Infant Security System Replacement: We are in the early planning phase to replace our infant security system. Our current infant security system is approaching the end of its life. We are projecting the completion of this project by the end of the fiscal year.

OR Optimization: The Perioperative Department is working to optimize workflows through all phases of the Perioperative process.

Department-specific reports to follow.

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(760) 873-5811 Ext. 3415

DATE: November 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Jenny Bates

RE: Department Update

REPORT DETAIL

Old Business

The community's health and well-being is our priority and the Emergency Department is always available and open to provide safe and essential emergency care. The ED continues to operate under the District's Covid emergency preparedness plan and we ensure the highest levels of safety are observed.

New Business

1. We have hired three permanent RNs to the ED. This has allowed us to cancel one traveler contract immediately, and three more traveler contracts will be cancelled by the end of the year.
2. ED leadership traveled to the Beta Conference in Los Angeles. The ED team received the Quest for Zero: Excellence in the ED, Tier 2 trophy at the Beta awards ceremony.

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DATE: November 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Julie Tillemans, *Perinatal Nurse Manager*

RE: Department Update

REPORT DETAIL

New Business

The Perinatal Unit recently received recognition from Beta Healthcare, signifying our continued excellence in Patient Safety.

We have implemented our Neonatal Resuscitation Carts to be utilized for neonatal resuscitation should the need arise. We have two NRP carts, one stationed in Perinatal and one in OR for c-section deliveries. These carts carry all necessary equipment to perform the steps of NRP.

We are diligently working on achieving our Prestigious Baby-Friendly Designation. I am proud to remind our community that Northern Inyo Healthcare District is the only Baby-Friendly Designated Hospital in the Eastern Sierra. This prestigious designation promotes the delivery of evidence-based feeding practices.

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DATE: November 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Robin Christensen Director Infection Prevention/Clinical Informatics

RE: Infection Prevention, Clinical Informatics, and Employee Health

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REPORT DETAIL

Infection Prevention: See CMO report

Clinical Informatics: Amanda Santana and Nicole Eddy continue to work with departments to optimize Cerner workflow. The team continues to provide onboarding training to all clinical staff, including providers, and offers ongoing support for all end-users.

The team monitors Cerner's multiple platforms (Ucern, flashes, and monthly global changes) for any changes impacting NIHD.

Nicole Eddy is working closely with the Hospitalists and Surgeon group on creating a Cerner workflow manual.

Amanda Santana is working closely with the Outpatient Patient nursing department and providers on streamlining the electronic outpatient ordering process within Cerner.

Employee Health:

Agility go-live went well in August. The team continues to optimize the system and improve workflow by converting it to an electronic workflow. In addition, Anastasia Beam continues to streamline employee health onboarding and communication with crucial NIHD stakeholders.

In late September, the team started the 2022-2023 influenza vaccine for all NIHD workforce. We continue open office hours twice a day, six days a week, for employees to get the vaccine. Influenza vaccines will be offered through March 2023. The team had assistance from nursing staff during low census. We want to thank those team members and the house supervisors for giving vaccines.

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150 Pioneer Lane
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(760) 873-5811 Ext. 3415

DATE: November 2022
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Justin Nott, Med/Surg and ICU Manager
RE: Department Update

REPORT DETAIL

Med/Surg and ICU

Over the last quarter, one of our areas of focus has been on addressing the joint commission findings pertaining to med/surg and the ICU and developing an action plan. Specifically, we have been working on addressing the findings in the area of pain reassessment, O2 protocol, and etched instruments. To address pain reassessments, we developed education regarding pain assessments, reassessments and documentation in Cerner, and we have assigned the education, through Relias, to all hospital RNs. Regarding O2 protocol, we have attached the O2 protocol, as an immediately available reference, to the O2 protocol order. Regarding etched instruments, a plan was developed and implemented for all etched instruments to be collected through sterile processing and replaced in a methodical manner.

We have begun holding multiple skills sessions to help get all clinical staff through their annual clinical competency training. Prior to Covid, our skills session was a two-day event that all clinical staff came to, but now, to meet social distancing requirements, it is broken up into multiple sessions that takes place over a number of months. We have completed skills training for the majority of med/surg and ICU staff, but are working on getting the last few staff members completed before the end of the year.

Med/Surg and ICU CSE is restarting tiered code blue drills, which start as a general overview for the first sessions but over time, the drills get much more detailed.

Staffing continues to be a focus on med/surg and in the ICU. We are still heavily staffed with travelers, but we have recently hired three new med/surg nurses. Two have already started working on med/surg and a third is going to be starting on 11/14/22. We have also hired three RNs in the ICU. Two of those RNs were able to join the ICU team through our NIHD ICU Training Program.

Northern Inyo Healthcare District

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www.nih.org

Date: 10/27/2022
To: Board of Directors
From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

The Medical Staff office is completing their annual recredentialing for half of the Medical Staff. Alison Bishop has done a wonderful job of taking this on despite being short staffed. Kudos to her!

Physician Recruitment update

As requested by the Board of Directors, the CMO report will contain activities related to Physician Recruitment and will outline the needs of the District.

- Urology: We have not had a full time local urologist in the Eastern Sierra for many years. The time has come and we will be welcoming Dr. Clayton Davis in August or September 2023! He will be moving to the area with his family. We will be partnering with him this spring and summer, making plans to establish his practice.
- General Surgery: We are in discussions with a general surgery candidate and have halted further recruitment at this time.
- Pediatrics: The pediatric department is assessing their clinical needs and are currently utilizing a locums physician, Dr. Donna Le until need can be established.
- Internal Medicine: Dr. Jennifer Lizcano will be transferring to be a full time hospitalist in 2023. We are not planning to backfill her position. The other providers in the Internal Medicine Clinic have handed off the Bishop Care Center patients to Dr. Todd Farrer who cares for nursing home patients in the area. This will provide the Internal Medicine clinic with more capacity to see primary care patients. We will keep an eye on this transition and if capacity becomes an issue, will reassess the need to fill the position.

Pharmacy Department update

The Pharmacy remodel continues at a steady pace. Even with some scheduling challenges, the entire project seems to be fairly on schedule. The pharmacy staff continues to do great work supporting the outpatient and inpatient areas.

The Pharmacy and Therapeutics committee is a Medical Staff committee with oversight of all things Pharmacy. Jeff Kneip has a large role as the Pharmacy Director. He partners closely with the chair of the committee, who has been Dr. Hathaway for many years. Dr. Hathaway has continued to chair this committee for over a year after her retirement from clinical practice. Recently she felt that it was time to pass on the torch. Dr. Atashi Mandal, a Med/Peds physician and hospitalist here at NIHD has agreed to step into position. Dr. Mandal brings with her 15 years of experience working in various hospitals in CA and has been at NIHD for over 4 years. We welcome Dr. Mandal into this important role!

Quality Department update

Several members from our team attended the BETA annual conference in October 2022, which was held in Palos Verdes, CA. NIHD received 2 accolades; one for work in the Emergency department and one for work in the Perinatal unit. There will be more detailed reports from each of these departments in your Board packet. Ali Feinberg, Manager of Quality and Survey Readiness also attended the conference. BETA presented ideas for improving patient quality and safety and we realized that this mirrored some of the great work we are already doing. It also gave us ideas for future projects.

The team continues to work diligently on QIP projects (Quality Incentive Program), partnering with many team members across the District. More details are forthcoming when projects become more concrete.

You heard details about the Joint Commission Survey at the last Board meeting. Correction action projects are occurring across the District, all being coordinated by the Quality Department.

Dietary Department

Our Registered Dietitians (RD) recently completed an Employee Wellness initiative called "Fall Into Healthy Habits." It was well attended by many staff members. Our RD's continue to provide inpatient and outpatient RD care and continue to look for ways to education members of our staff and community of best practices and good habit development.

Rehab Department

Our Rehab Department is still recruiting for a full time Speech and Language Pathologist (SLP). Our current traveler will be ending her time with us soon and the position continues to be vacant. When our traveler SLP leaves, we will utilize services through our per diem SLP and will continue to recruit for a local, fulltime SLP.

We have been helping Bishop Union Schools with Occupational Therapy (OT) support. Due to the high need of OT in the schools, the School District has chosen to hire their own full time OT starting in mid-November. At that time, our OT's will halt services at the school and will have more capacity at NIHD. This will allow Monica Jones, OT to expand her Cognitive Behavioral Therapy services. She has started to present her services to our providers and we anticipate increased referrals.

Infection Prevention

We welcomed our new Infection Prevention (IP) RN, Andrea Conley to NIHD last month! Andrea was with the District in the past and left to pursue her RN degree. We are delighted to have her back. She is partnering closely with Robin Christensen, RN.

<u>Covid 19</u>

We continue to run the RHC "Car Clinic" for acute illness needs. Paxlovid continues to be offered under the "Test to Treat" model. This means that if you test positive for Covid, we are able to supply you with the medication Paxlovid right there, negating the need for you to go to the pharmacy to pick up medication. There is a limitation for those patients with kidney issues. If you are a patient with kidney issues, you may be referred for monoclonal therapy with bebtolovimab, which is an IV medication given at the hospital. Bebtolovimab is now available for purchase (no longer provided through the state) so moving forward, we expect some out of pocket costs to our patients for this medication.

Local pharmacies and Inyo County HHS are offering the Covid bivalent vaccine booster from Pfizer and Moderna.

Monkey Pox

There have still been no cases reported in Inyo County. Inyo County Public Health now has a mechanism to obtain vaccine and treatment as appropriate.

Ebola

We are keeping an eye on Ebola around the world and thus far, no cases have been reported in the US. Of note, this report is being written in late October, so we may have further updates at the time of the Board meeting in mid-November.

Physician Compensation

Multiple meetings have taken place and joint discussions with myself, Stephen Delrossi, and the physicians are ongoing. We continue to adjust the physician compensation structure based on feedback from the physicians and our consultants, VMG. Our goal is to develop a mutually beneficial structure that is transparent and equitable. We feel that we are close to achieving this goal and hope to have new contracts in place starting Jan 1, 2023.

Community Health Needs Assessment (CHNA)

As noted in our CHNA, access to care is one of our community health needs. In response to this identified need, we are in the process of establishing a relationship with ConferMed. ConferMed is a network of specialists providing eConsults to primary care providers. The way it works is that a primary care provider (PCP) submits a consult for specialty care for their patient via the Electronic Health Record (EHR). The consult is transmitted to the ConferMED platform. Within 2 business days, the specialist sends the consult back to the primary care provider with specialty recommendations. The patient can then follow up with their PCP for further discussion and next steps. We think this is a great way to leverage technology to get specialty recommendations for patients while decreasing the need to travel out of the area. Per ConferMed, up to 69% of consults can be resolved virtually. There are times when a patient will need to see a specialist in person but it seems that a majority of the time, these specialty questions can be answered and discussed through a PCP.

We are awaiting our first implementation meeting so more details to come!

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

Date: October 29, 2022

Title: **Compliance Quarterly Board Report, Quarter 3 Calendar Year 2022**

Synopsis: The Compliance Department Quarterly Report updates the Board on the work of the Compliance Department. It provides information on audits, alleged breaches, contract work, and projects. All information in the report is summarized, however, any additional details will be provided to the Board of Directors upon request.

Prepared by: Patty Dickson
Patty Dickson
Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

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Quarterly Compliance Report –Quarter 3 (Q3) calendar year 2022
September 2022

1. Comprehensive Compliance Program review

A. A review of the NIHD Compliance Program will be on the agenda for the Q3 2022 Compliance and Business Ethics Committee meeting.
B. District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment to be completed before the end of the calendar year.
C. Penetration Testing Scheduled with IT (Information Technology) Security.
D. Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) in progress. Cooperative process between Quality, IT, Informatics, and Compliance.
E. Conflicts of Interest questionnaire responses are in review.

2. Audits

A. Employee Access Audits - The Compliance Department Analyst, Conor Vaughan, completes audits for access of patient information systems to ensure employees' access records only on a work-related, need-to-know, and minimum necessary basis.
    i. Cerner semi-automated auditing software tracks all workforce interactions and provides a summary dashboard for the compliance team. The dashboard provides "flags" for unusual activity. The following is Q3 activity
        a. New Employee Audits: 56
            I. Flags: 0
            II. Flags resulting in policy violations: 0
        b. For Cause Audits:5
            I. Flags: 0
            II. Flags resulting in policy violations: 0
        c. In "own" chart flags: 7
            I. Flags resulting in policy violations: 7
                i. Provided education and training: 7
                ii. Repeat violations: 0
        d. Same Last Name Search Flags: 223
            I. Resulted in follow up with employee: 24
            II. Flags resulting in disciplinary action: 0

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B. Business Associates Agreements (BAA) audit
    i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor meets the strict governmental regulations regarding how to handle, transmit, and store protected information to protect NIHD and NIHD patient information.
    ii. NIHD currently has approximately 190 BAAs.
        a. 5 are currently in negotiation
C. Contract and Agreement reviews/audit
    i. Contracts and agreements are in the following status:
        a. 235 contracts or agreement have been received for review by the Compliance Team in FY 2022
        b. ~60 are in the review process
        c. ~15 are awaiting fully executed copies
        d. ~5 are on hold
        e. ~25 existing contracts are also in the review process
D. Third Party Electronic Health System Access
    i. Policy is in development
    ii. Will include third party vendors (billing, coding, auditors, IT support, etc.)
    iii. Will include some partners in healthcare with specific needs to access mutual patient information
    iv. NIHD team is working in collaboration with Mammoth Hospital Compliance, HIMS, and ITS teams
E. HIMs (Health Information Management) scanning audit
    i. Scheduled for Q4 CY 2022
F. Email security audit/reviews
    i. Reviewed at least once a month
    ii. Review emails security systems for violations of data loss prevention rules
        a. Typically results in reminder emails to use email encryption sent to members of workforce.

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b. Occasionally results in full investigations of potential privacy violations.
    I. No investigations currently in progress

G. Language Access Services Audit
   i. Compliance is waiting for Cerner to develop a report to allow selection of English as a Second Language (ESL) patients.
   ii. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.

H. 340B program audits
   i. Annual 340B audit completed.
      a. Scheduled for 2023
   ii. DHCS (CA Department of Health Care Services) Self Audit – completed. Awaiting final determinations

I. Vendor Diversity Audit – NIHD has approximately 1350 vendors.
   i. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI, formerly OSHPD) to develop and administer a program to collect hospital supplier diversity reports including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
   ii. NIHD has 3 certified diverse vendors
      a. 0% spend for CY 2021 with diverse vendors
      b. CY 2022 report will be submitted to HCAI before the 07/01/2023 deadline.
      c. Diversity reports are now required annually in California. As of this time, there is no requirement to have a percentage of spend with diverse vendors; however, there is discussion of requiring plans for California organizations and businesses to develop plans to increase vendor diversity.

J. Provider Verifications
   i. More than 195 providers were verified and were checked for state and federal exclusions in quarter 3 of calendar year 2022
   ii. No exclusions were found for providers verified.

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iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

K. Claim/Charge Audits
   i. Cataract Surgeries – completed
   ii. Department of Transportation Physicals – completed
   iii. Low Dose Lung CT – completed
   iv. Colonoscopies – in progress

3. **HIPAA Security Risk Assessment (SRA)** – Due November 2022
4. **CPRA (California Public Records Act) Requests**
   A. The Compliance office has received seven (7) CPRA requests to date in 2022.
      i. All have been completed.
5. **Compliance Work Plan** – Updated October 2022, attached
6. **Conflicts of Interest**
   A. The Compliance department emailed the NIHD workforce the 2022 Conflicts of Interest (COI) form.
      i. Compliance Clerk is processing COI forms received and will notify the Business Compliance Team when ready to schedule a meeting to review the forms.
   B. No COI forms submitted to the compliance department noted any knowledge or concern for the following:
      i. Business transactions with an aim for personal gain.
      ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
      iii. Use of NIHD resources for purposes other than NIHD business, NIHD sponsored business activities, or activities allowed by policy.
      iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
      v. Use of NIHD money, goods, or services to influence government employees, or for special consideration or political contribution.
      vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.
7. **Unusual Occurrence Reports** (UOR)
   A. UOR report data for January 1, 2022 through September 30, 2022, is attached
      i. Notable trends out of 471 UORs received in CY 2022:

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a. UORs regarding complaints and requests to review billing and care are the highest volume
b. Safety and security issues are trending up
c. Specimen issues are trending down following implementation of a new training and competency plan implemented in the phlebotomy area.
d. 32 UORs have resulted in systemic changes in the organization thus far in 2022.

ii. NIHD has added tracking for alarm fatigue – examples: disabled alarms, alarms noted to have the volume turned off, ignored alarms

B. NIHD has now been tracking UORs with Complytrack software since May 2019.
i. In 42 months, 2,085 unusual occurrences have been reported. Trend data attached.
ii. There is a slight overall downward trend line, but this is most likely due to changes in critical indicators as designated by the Medical Staff, and an updated reporting process in the laboratory.
iii. Top three areas of concern for additional focus overall – patient complaints/review requests, procedure/test/specimen occurrences, and privacy concerns.

C. The UOR process involves significant work and time from the Compliance team.
i. All UORs in Complytrack are received by the Compliance Team.
a. Many patient complaint and concern phone calls are transferred to the Compliance team for intake and assistance.
ii. UORs are triaged and assigned to appropriate department leaders for review. Emails and phone calls are placed to leaders for urgent UORs.
iii. The Compliance team reviews responses, ensures thorough responses and corrective actions, provides follow up letters to patients, and ensures the executive team is aware of all areas of concern.
iv. The Compliance team follows up with leaders who are having difficulty with timely responses and attempts to assist them with resolution.
v. The Compliance team ensures UORs are closed out after thorough review, corrective actions and, in most cases, resolved.

8. Privacy Investigations

A. Privacy investigations/potential breaches between January 1, 2022 – September 30, 2022 – total 43
i. Reported to CDPH/OCR – 5

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a. Two breaches were substantiated with no deficiencies
b. Three breaches in submitted/in progress status with CDPH

ii. Investigations still active in the Compliance Department - 0
iii. Investigations closed by the Compliance Department with no reporting required - 38

B. Privacy investigations from 2021
i. Reported to CDPH/OCR 2021– 4
a. Two potential breaches are in submitted status with CDPH

C. Privacy investigations from 2020 (outstanding with regulatory agency)
i. Reported to CDPH/OCR 2020
a. 8 potential breaches have no CDPH determination at this time.

D. Privacy investigations from 2019 (outstanding with regulatory agency)
i. Reported to CDPH/OCR 2019
a. 1 potential breach have no CDPH determination at this time.

9. Investigations

A. Compliance has conducted or assisted with 35 investigations/reviews that were not related to privacy/breach allegations.
i. Regulatory agency requests (examples below, not an inclusive list)
a. Department of Health Care Services (DHCS)
b. California Department Public Health (CDPH)
c. California Occupational Safety and Health
ii. Workplace Violence/Safety/Security issues
iii. Third party payer grievances or reviews
iv. Workforce compliance and ethics violations
v. Contractual obligation disputes
vi. Fraud, waste, and abuse concerns

10. Compliance and Business Ethics Committee (CBEC)

A. Meeting conducted July 2022
i. Reviewed Compliance Work plan, discussed OIG updates
ii. Tabled review of Compliance Program for Q4 CY2022 meeting

B. Next meeting will be scheduled in November 2022

11. Issues and Inquiries

A. Compliance has researched over several hundred issues for various District workforce members and leadership in 2022. They include COVID-19 mandates and

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changes, COVID-19 exceptions and exemptions, minor privacy regulations, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, Federal Motor Carrier Safety Administration regulations, adoption processes, confidentiality issues, release of information and information blocking regulations, physician departures, regulatory updates, and many other areas of interest and concern.

B. Compliance has partnered with NIHD workforce, local law enforcement agencies, and the District Attorney to address multiple areas of partnership.
    i. Education/training to NIHD and Law Enforcement Agencies regarding mandatory and permissive release of information.
    ii. Subpoena service process for subpoenas related to NIHD work-related activities.
    iii. Law enforcement presence on campus in non-emergent situations.
    iv. Sexual Assault Response Team (SART) regulations and information

12. Optimization, update, and audit of Policy Management software

A. Proper policies and policy management is a large component of an effective Compliance Program.
B. Tracy Aspel, Compliance Policy Management Administrator, continues to work with leadership to facilitate updated policies and leadership growth.
C. Ms. Aspel continues to facilitate policy updates for both Clinical Consistency Oversight Committee (CCOC) and Non-clinical Consistency Oversight Committee (NCOC).
D. Ms. Aspel continues to provide training and assistance to leadership teams, including scheduling training classes, writing drafts of multiple challenging policies for our leadership teams, and providing research assistance to ensure regulatory compliance for policies.

13. Rural Health Clinic Compliance Software

A. Following successful implementation of InQuiSeek software, the maintenance, users' updates, and policy updates are now handled by the clinic leadership team.

14.Optimization, update, and audit of Contract Management software

A. Updating contracts/agreements status is being facilitated by Katie Manuelito, Compliance Contracts Analyst

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B. Including automated reminders for appropriate lead time for District leadership to review and update contracts that are expiring or auto-renewing, to ensure the District is meeting the requirements for monitoring contracts
C. Hosts about 2000 contracts (including archived and current contracts/agreements)
D. Contract review process is tracked via Smartsheet spreadsheets.

15. Forms Committee

A. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. There are standardized templates, designated fonts, official translations, and mandatory non-discrimination and language access information.
B. All forms and public information documents used at the District for patient care, regulatory requirements, orders, down-time documentation, standardized workflows, and process improvement are submitted to the Forms Committee. Once approved they are maintained in a location on the NIHD Intranet (a quick link named "Approved Forms") for access by NIHD workforce.
C. More than 130 forms and documents have been developed or revised from January 1, 2022 through September 30, 2022

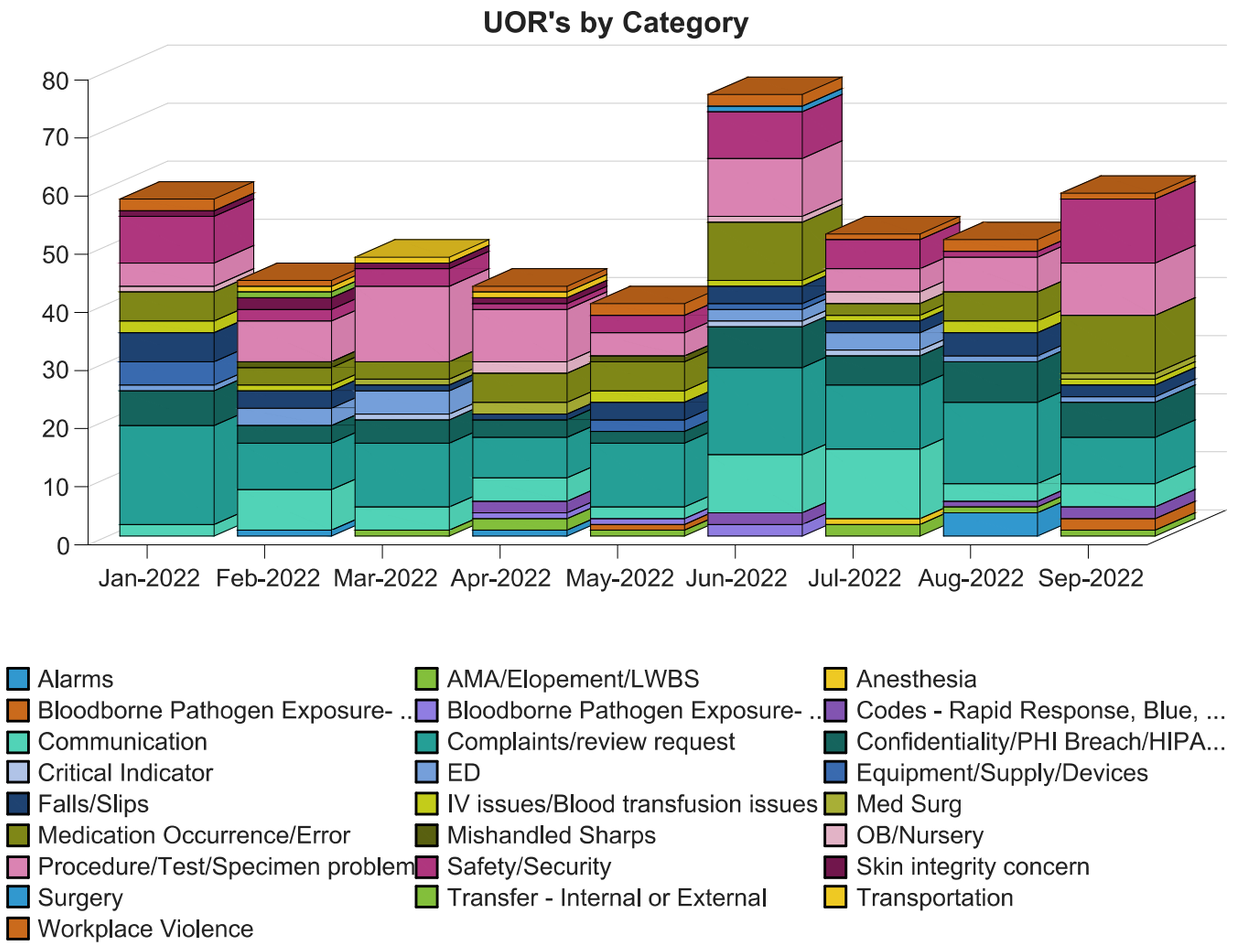
Compliance Work Plan – October 2022

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Review ongoing in 2022
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	ACHD/District Legal. Compliance can perform additional if requested.
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Completed May 2022.
4.	District Policy and Procedure management		Tracy Aspel continues to provide per diem support to leadership and has worked on many "heavy lift" policies for different leaders in the District.
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		87% Compliance with Relias training as 10/1/2022
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		Scheduled for 11/2022
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		In Progress – reviewed by 278 members of workforce
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.		Will be submitted to CBEC
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		Billing and Collections staff now performed by outside agencies, and NIHD campus support

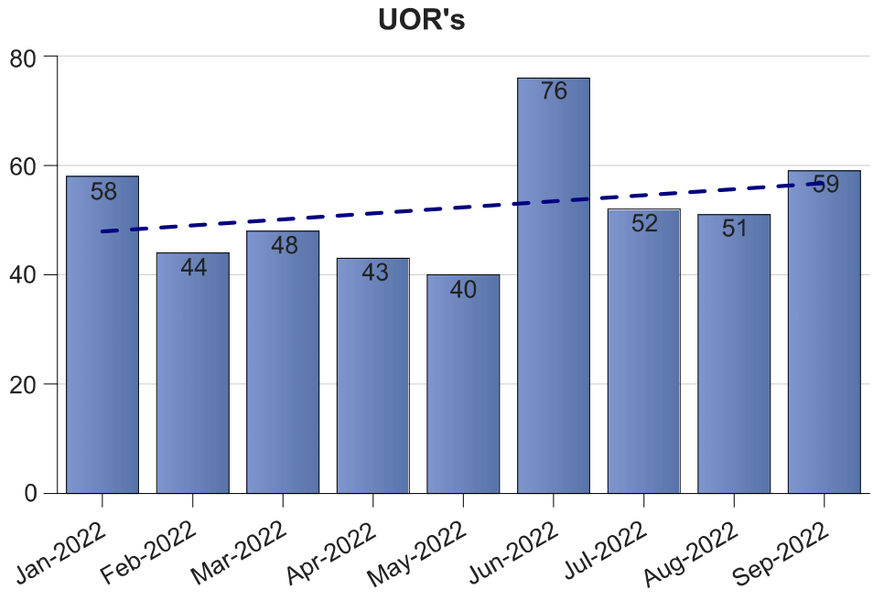
9.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		Role-based access. 3rd party EHR access policy in development
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.	Completed at Orientation and annually.	Completed at orientation – current through 10/1/2022. False Claims Act Policy assigned annually.
Compliance Communication			
11.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Q3CY22 in Q3 Board Report.
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Complytrack	UOR report developed 2021. TJC cited NIHD for non-compliant patient response. Corrective action plan developed.
13.	Document test and review of Compliance Hotline.		Completed 09/2022
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Verified 7/2022
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (OIG) List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new providers. Medical Staff Office (MSO) verifies all medical staff and credentialed providers. Accounting verifies all vendors.	Current through 10/1/2022
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Need to schedule time with HR and develop review process.
17.	Audits		
	a. Arrangements with physician (database)		Physician contract reviews in

			conjunction with CMO – ongoing 10/2022
	b. EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 10/1/2022
	c. Financial Audits	FY 2022	Eide Bailly Audit in progress
	d. Payment patterns		Review of denials, payment patterns, coding occurs in Revenue Cycle Admin Team (RCAT) meetings and other revenue cycle meetings. Updates to Billing and Coding Compliance Committee as needed.
	e. Bad debt/ credit balances, AR days		Reviewed billing processes, provider enrollments, continuous monitoring by CFO
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Scheduled security risk assessment November 2022 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due November 2022
	b. Periodic update to Security Risk Assessment		Update following penetration testing in December 2022
	c. Monthly employee access audits		Cerner provides semi-automatic continuous monitoring, reducing the need for a completely manual auditing process.
19.	Audit required signage		Scheduled 02/2023
20.	Audit HIMS (Health Information Management) scanned document accuracy		Scheduled for Q4 2022
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		Review OIG Compliance Guidance with Compliance and

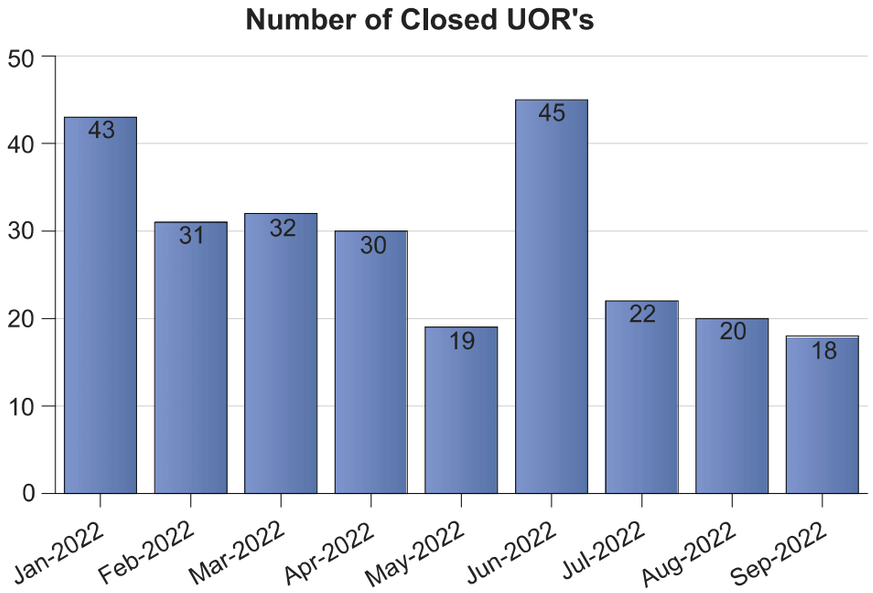
			Business Ethics Committee in 2022
22.	Implement automated access monitoring/auditing software		Semi-automated auditing in progress with manual follow up on all flags
23.	Review CMS Conditions of Participation		2022 TJC Survey and response being compiled by Quality and Survey readiness team.
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		ongoing
25.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Revenue Cycle has meeting weekly to track billing, overpayments and denials management.
26.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Board Report for Calendar year through quarter 3
	a. Provide trend feedback to leadership to allow for data driven decision-making		Quarterly
	I. Overall UOR process		Quarterly 2022
	II. Workplace Violence		Quarterly 2022
	III. Falls Committee		Quarterly 2022
	IV. Nursing Professional Practice Council		October 2022
27.	Pioneer Home Health and Hospice of the Owens Valley Contract(s) review		In Progress 10-2022
28.	Patient complaints		Currently working to determine most effective efficient workflow between Quality, Compliance, and Risk. Documented and tracked in Unusual Occurrence Reporting system
30.	Breach Investigations	On-going	On-going – see Compliance reports


UOR's by Category
80
70
60
50
40
30
20
10
0
Jan-2022
Feb-2022
Mar-2022
Apr-2022
May-2022
Jun-2022
Jul-2022
Aug-2022
Sep-2022
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ..
Bloodborne Pathogen Exposure- ..
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

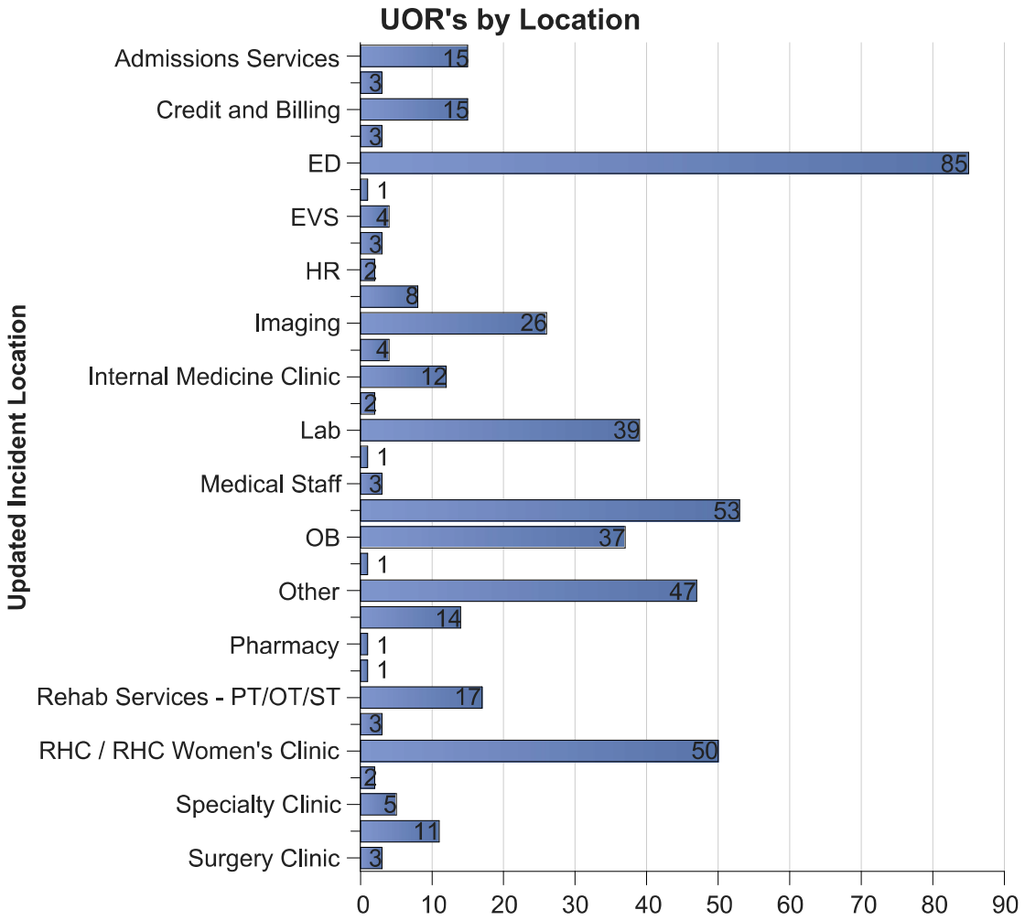
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Total
Alarms		1		1				4		**6**
AMA/Elopement/LWBS			1	2	1		2	1	1	**8**
Anesthesia							1			**1**
Bloodborne Pathogen Exposure- Sharps Injury					1				2	**3**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1	1	2				**4**
Codes - Rapid Response, Blue, Deescalation				2		2		1	2	**7**
Communication	2	7	4	4	2	10	12	3	4	**48**
Complaints/review request	17	8	11	7	11	15	11	14	8	**102**
Confidentiality/PHI Breach/HIPAA violation	6	3	4	3	2	7	5	7	6	**43**
Critical Indicator			1			1	1			**3**
ED	1	3	4			2	3	1	1	**15**
Equipment/Supply/Devices	4				2	1				**7**
Falls/Slips	5	3	1	1	3	3	2	4	2	**24**
IV issues/Blood transfusion issues	2	1			2	1	1	2	1	**10**
Med Surg			1	2					1	**4**
Medication Occurrence/Error	5	3	3	5	5	10	2	5	10	**48**
Mishandled Sharps		1			1					**2**
OB/Nursery	1			2		1	2			**6**
Procedure/Test/Specimen problem	4	7	13	9	4	10	4	6	9	**66**
Safety/Security	8	2	3	1	3	8	5	1	11	**42**
Skin integrity concern	1	2	1	1						**5**
Surgery						1				**1**
Transfer - Internal or External		1								**1**
Transportation		1	1	1						**3**
Workplace Violence	2	1		1	2	2	1	2	1	**12**
Total	**58**	**44**	**48**	**43**	**40**	**76**	**52**	**51**	**59**	**471**



Jan-2022	58
Feb-2022	44
Mar-2022	48
Apr-2022	43
May-2022	40
Jun-2022	76
Jul-2022	52
Aug-2022	51
Sep-2022	59
Total	**471**



	Closed
Jan-2022	43
Feb-2022	31
Mar-2022	32
Apr-2022	30
May-2022	19
Jun-2022	45
Jul-2022	22
Aug-2022	20
Sep-2022	18
Total	**260**



Admissions Services	15
Compliance	3
Credit and Billing	15
Dietary	3
ED	85
Employee Health	1
EVS	4
HIM/Medical Records	3
HR	2
ICU	8
Imaging	26
Infusion	4
Internal Medicine Clinic	12
IT Services	2
Lab	39
Med Surg Unit	1
Medical Staff	3
Medical Surgical Unit	53
OB	37
Ortho Clinic	1
Other	47
Peds/Allergy Clinic	14
Pharmacy	1
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1
Rehab Services - PT/OT/ST	17
Respiratory/Cardiopulmonary	3
RHC / RHC Women's Clinic	50
Rural Health Clinic / Rural Health Women's Clinic	2
Specialty Clinic	5

Surgery	11
Surgery Clinic	3
Total	**471**

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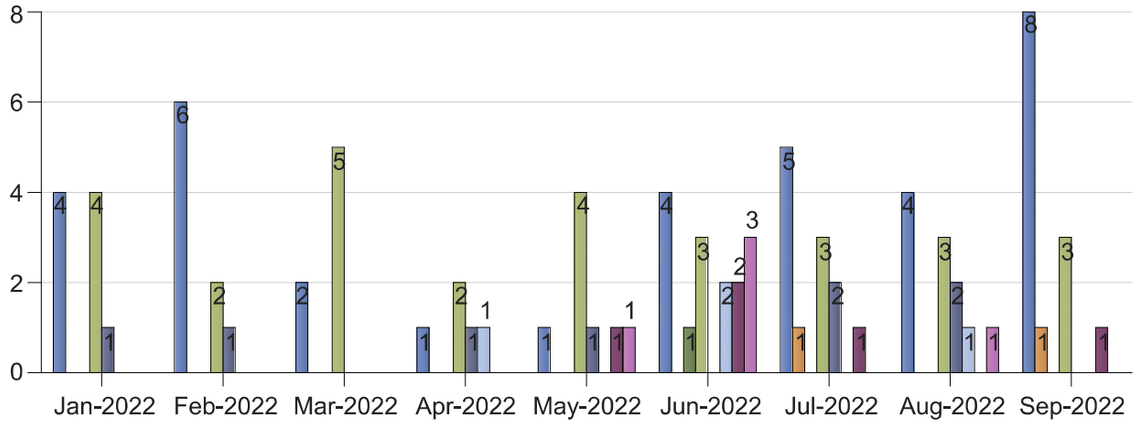
UOR's Related to Nursing by Nursing Unit Involved

(only when Nursing Unit Involved = Yes)



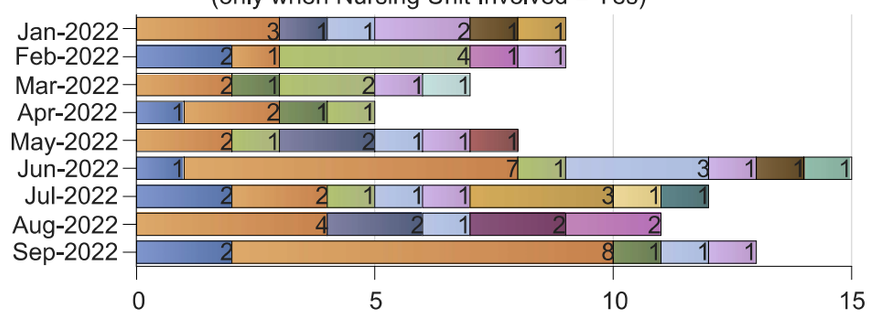
	Yes
Emergency	35
ICU	2
Infusion	1
Medical/Surgical	29
OB	8
OR	4
PACU	5
RHC	5
Total	**89**

Updated Nursing Unit Involved

Emergency, ICU, Infusion, Medical/Surgical, OB, OR, PACU, RHC

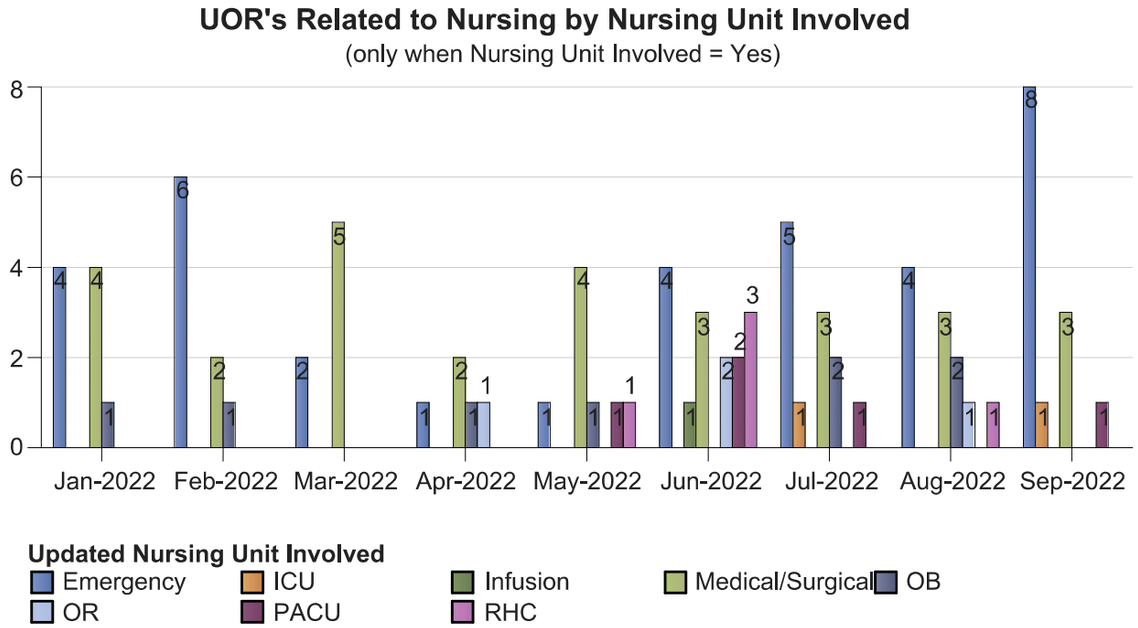
UOR's Related to Nursing

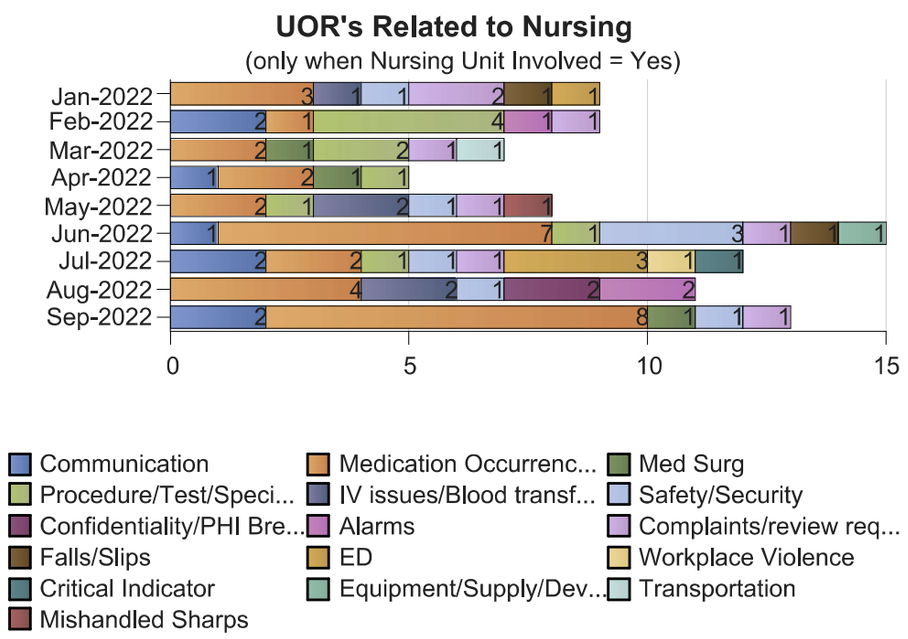
(only when Nursing Unit Involved = Yes)



Communication, Medication Occurrenc..., Med Surg, Procedure/Test/Speci..., IV issues/Blood transf..., Safety/Security, Confidentiality/PHI Bre..., Alarms, Complaints/review req..., Falls/Slips, ED, Workplace Violence, Critical Indicator, Equipment/Supply/Dev..., Transportation, Mishandled Sharps

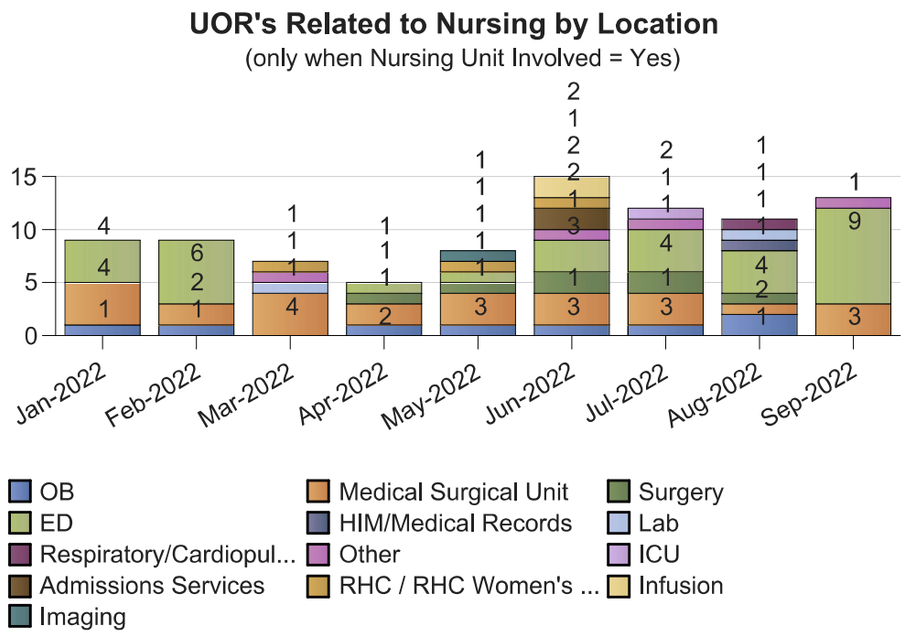
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Communication		2		1		1	2
Medication Occurrence/Error	3	1	2	2	2	7	2
Med Surg			1	1			
Procedure/Test/ Specimen problem		4	2	1	1	1	1
IV issues/Blood transfusion issues	1				2		
Safety/Security	1				1	3	1
Confidentiality/ PHI Breach/HIPAA violation							
Alarms		1					





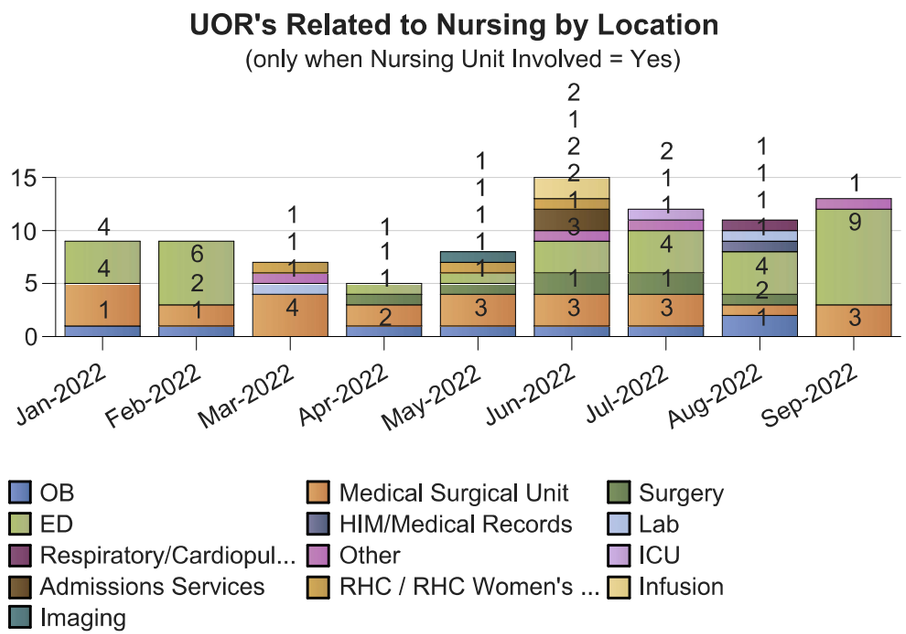
	Aug-2022	Sep-2022	Total
Communication		2	**8**
Medication Occurrence/Error	4	8	**31**
Med Surg		1	**3**
Procedure/Test/ Specimen problem			**10**
IV issues/Blood transfusion issues	2		**5**
Safety/Security	1	1	**8**
Confidentiality/ PHI Breach/HIPAA violation	2		**2**
Alarms	2		**3**

	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Complaints/ review request	2	1	1		1	1	1
Falls/Slips	1					1	
ED	1						3
Workplace Violence							1
Critical Indicator							1
Equipment/ Supply/Devices						1	
Transportation			1				
Mishandled Sharps					1		
Total	**9**	**9**	**7**	**5**	**8**	**15**	**12**



	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
OB	1	1		1	1	1	1
Medical Surgical Unit	4	2	4	2	3	3	3
Surgery				1	1	2	2
ED	4	6		1	1	3	4
HIM/Medical Records							
Lab			1				
Respiratory/ Cardiopulmonary							
Other			1			1	1
ICU							1
Admissions Services						2	
RHC / RHC Women's Clinic			1		1	1	
Infusion						2	

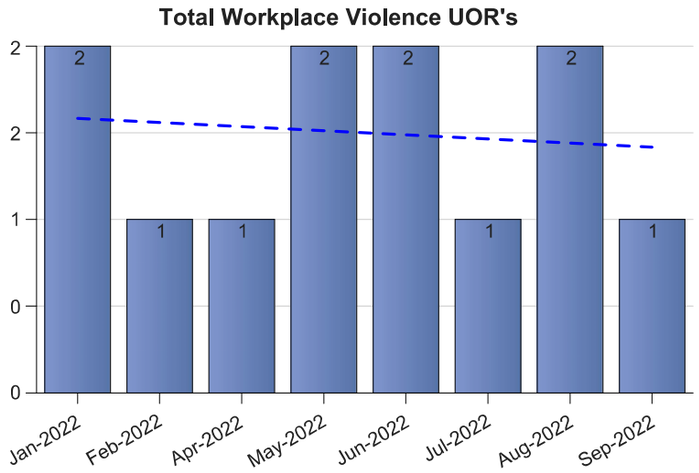
	Aug-2022	Sep-2022	Total
Complaints/ review request		1	**8**
Falls/Slips			**2**
ED			**4**
Workplace Violence			**1**
Critical Indicator			**1**
Equipment/ Supply/Devices			**1**
Transportation			**1**
Mishandled Sharps			**1**
Total	**11**	**13**	**89**



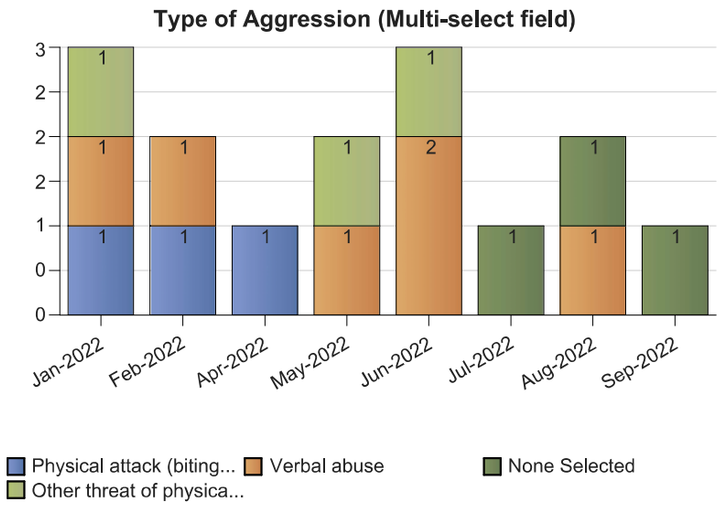
	Aug-2022	Sep-2022	Total
OB	2		**8**
Medical Surgical Unit	1	3	**25**
Surgery	1		**7**
ED	4	9	**32**
HIM/Medical Records	1		**1**
Lab	1		**2**
Respiratory/ Cardiopulmonary	1		**1**
Other		1	**4**
ICU			**1**
Admissions Services			**2**
RHC / RHC Women's Clinic			**3**
Infusion			**2**

	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Imaging					1		
Total	**9**	**9**	**7**	**5**	**8**	**15**	**12**

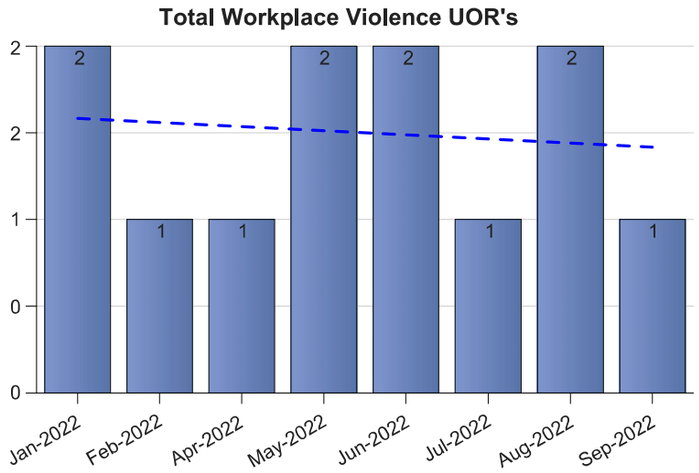
	Aug-2022	Sep-2022	Total
Imaging			1
Total	**11**	**13**	**89**



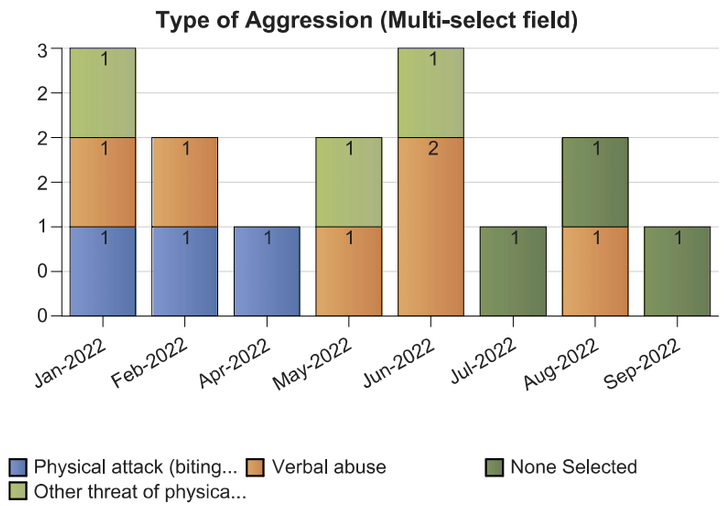
	Jan-2022	Feb-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Workplace Violence	2	1	1	2	2	1
Total	**2**	**1**	**1**	**2**	**2**	**1**



	Jan-2022	Feb-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1	1	1			
Verbal abuse	1	1		1	2	
None Selected						1
Other threat of physical force	1			1	1	
Total	**3**	**2**	**1**	**2**	**3**	**1**

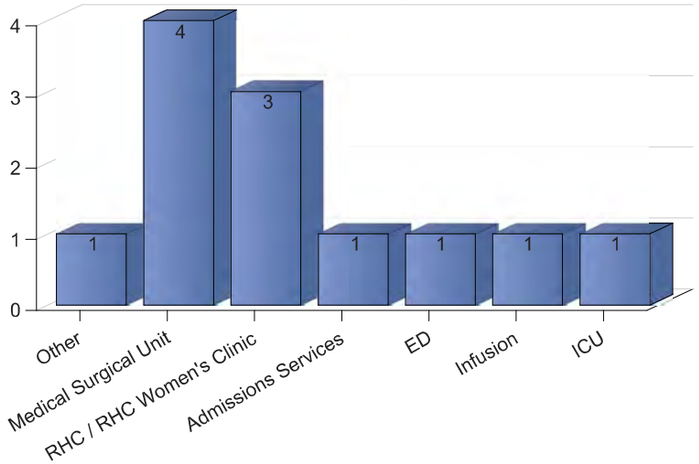


	Aug-2022	Sep-2022	Total
Workplace Violence	2	1	**12**
Total	**2**	**1**	**12**



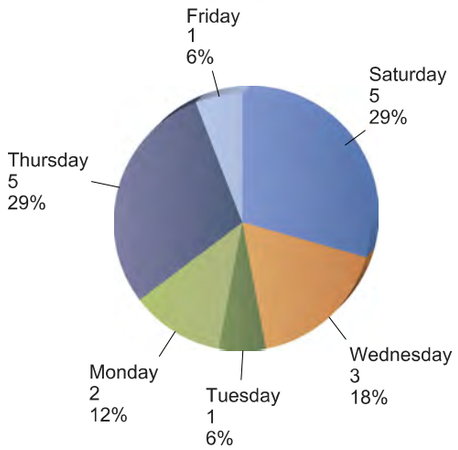
	Aug-2022	Sep-2022	Total
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)			**3**
Verbal abuse	1		**6**
None Selected	1	1	**3**
Other threat of physical force			**3**
Total	**2**	**1**	**15**

Total WPV Incidents by Location

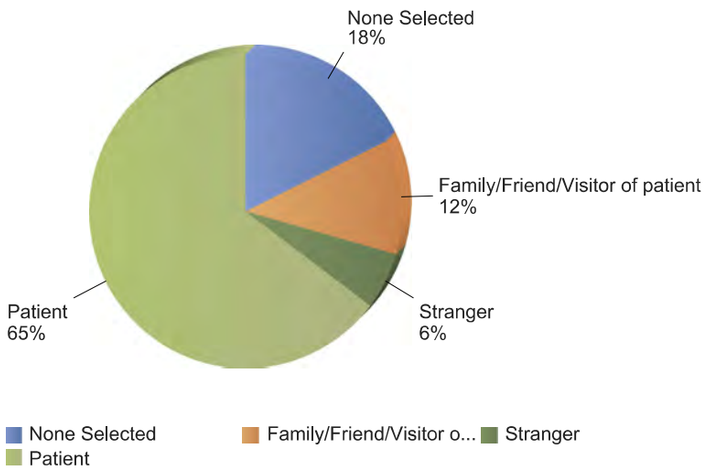


Other	1
Medical Surgical Unit	4
RHC / RHC Women's Clinic	3
Admissions Services	1
ED	1
Infusion	1
ICU	1
Total	**12**

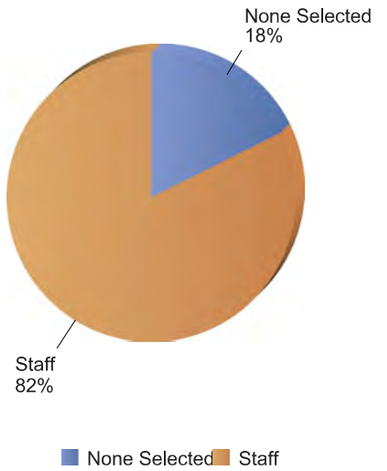
Total Incidents by Day of the Week

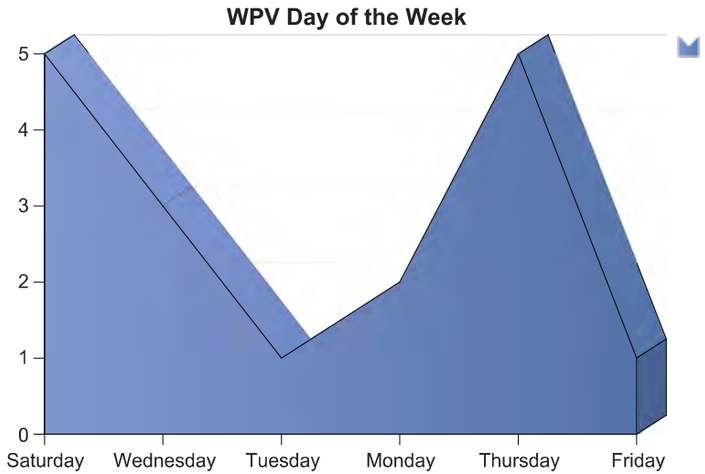


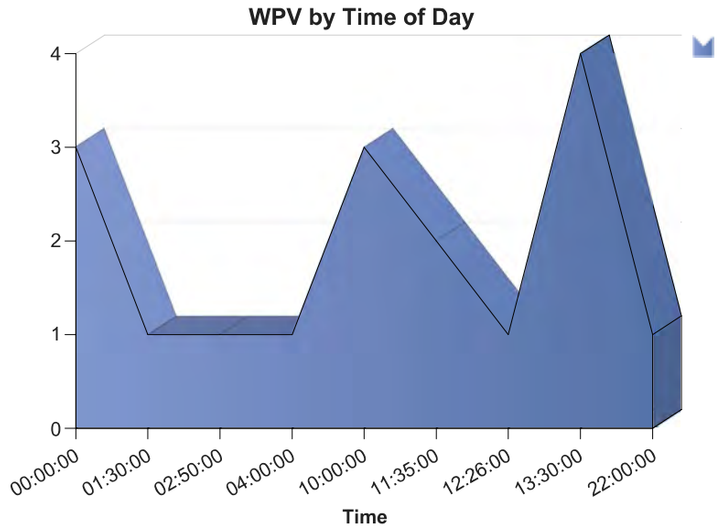
Assailant

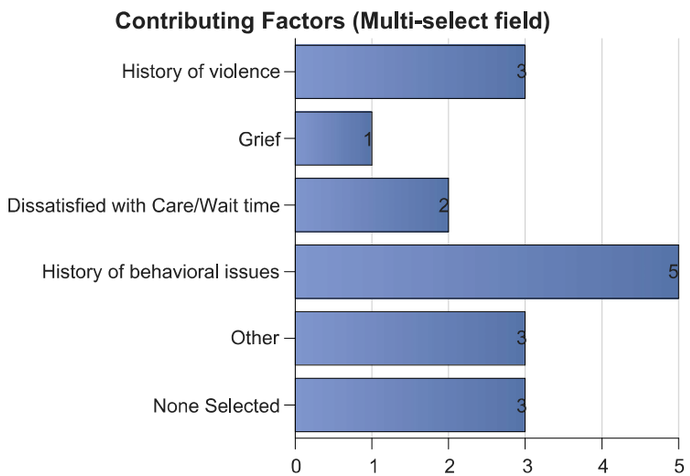


Victim





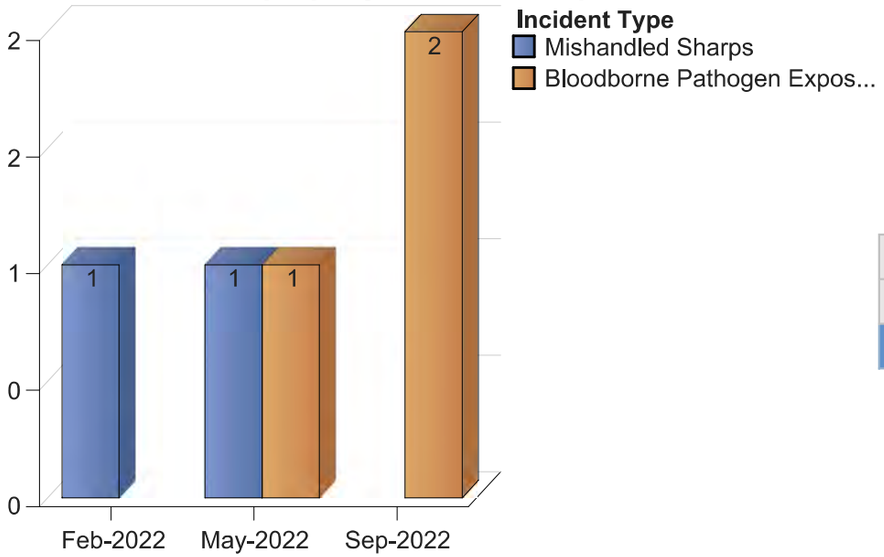




None Selected	3
Dissatisfied with Care/Wait time	1
Grief	1
History of behavioral issues	3
History of violence	2
Other	3
Total	**13**

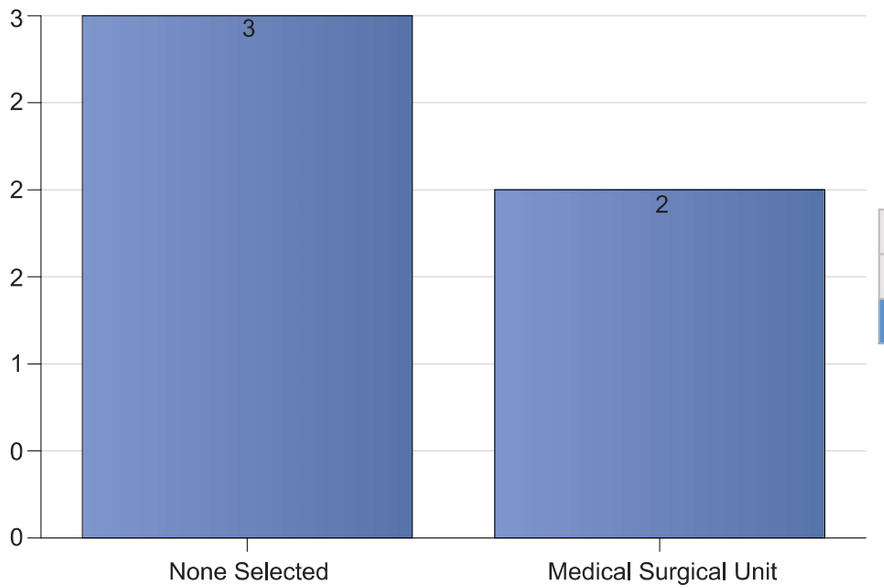
RHC Incidents by Day of the Week - No Data Available

Improperly Handled Sharps



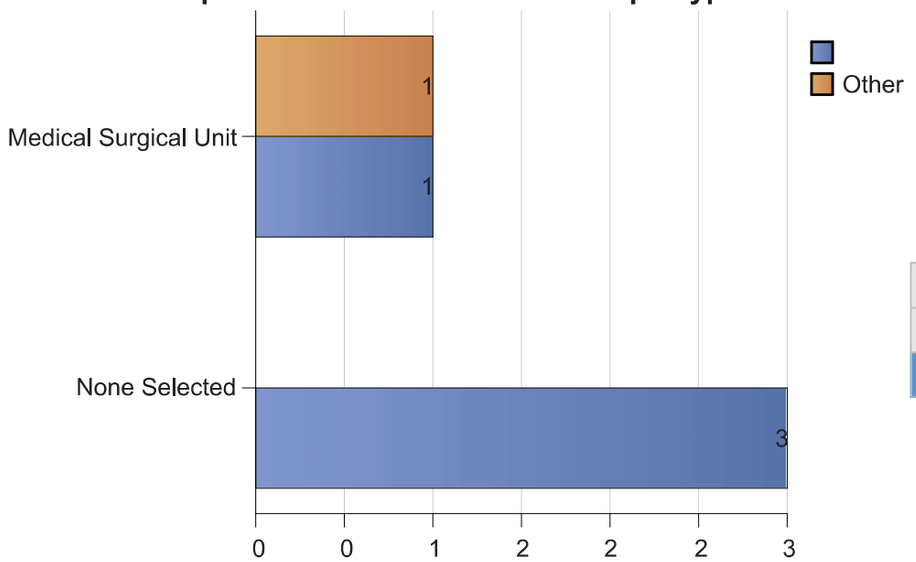
	Feb-2022	May-2022	Sep-2022	Total
Mishandled Sharps	1	1		**2**
Bloodborne Pathogen Exposure- Sharps Injury		1	2	**3**
Total	**1**	**2**	**2**	**5**

Departments affected by improperly handled sharps



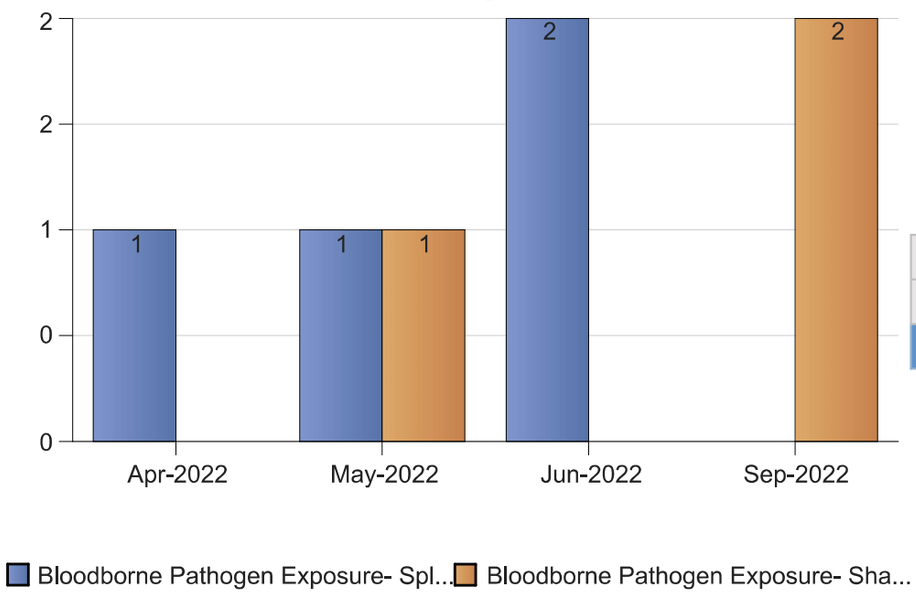
None Selected	3
Medical Surgical Unit	2
Total	**5**

Department and Mishandled Sharps Type

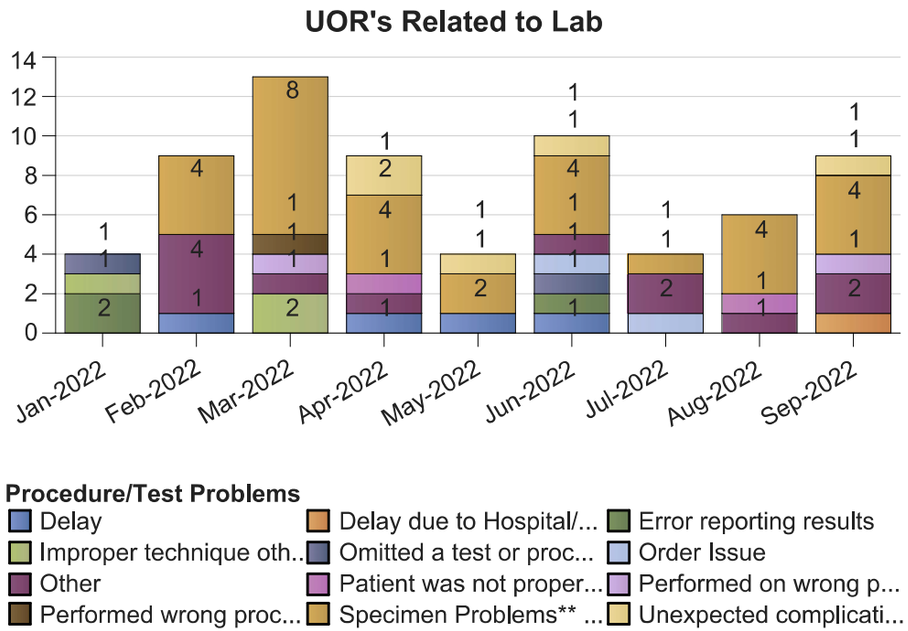


	Mishandled Sharps Type		Total
	None Selected	Other	
None Selected	3		**3**
Medical Surgical Unit	1	1	**2**
Total	**4**	**1**	**5**

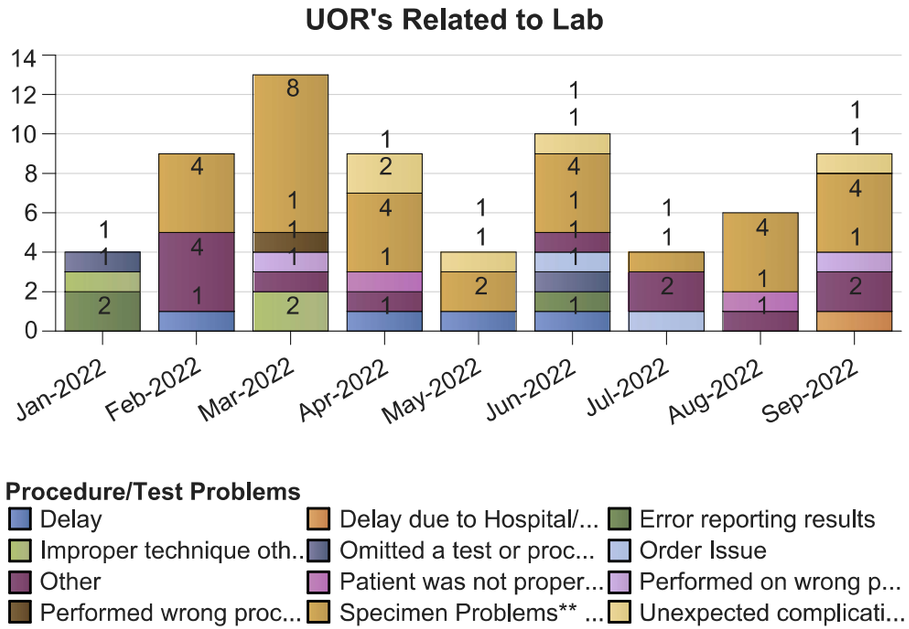
Bloodborne Pathogen Exposure



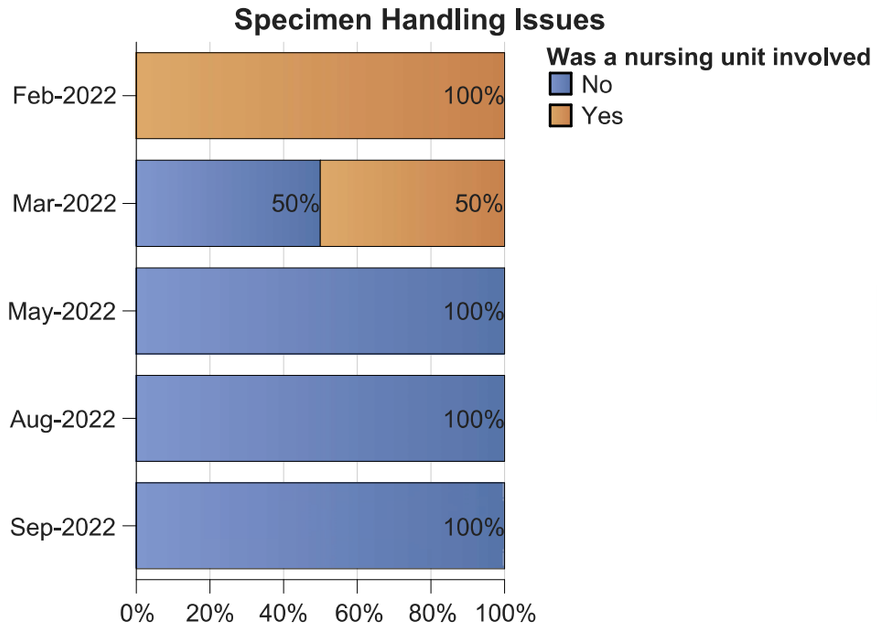
	Apr-2022	May-2022	Jun-2022	Sep-2022	Total
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane	1	1	2		**4**
Bloodborne Pathogen Exposure- Sharps Injury		1		2	**3**
Total	**1**	**2**	**2**	**2**	**7**



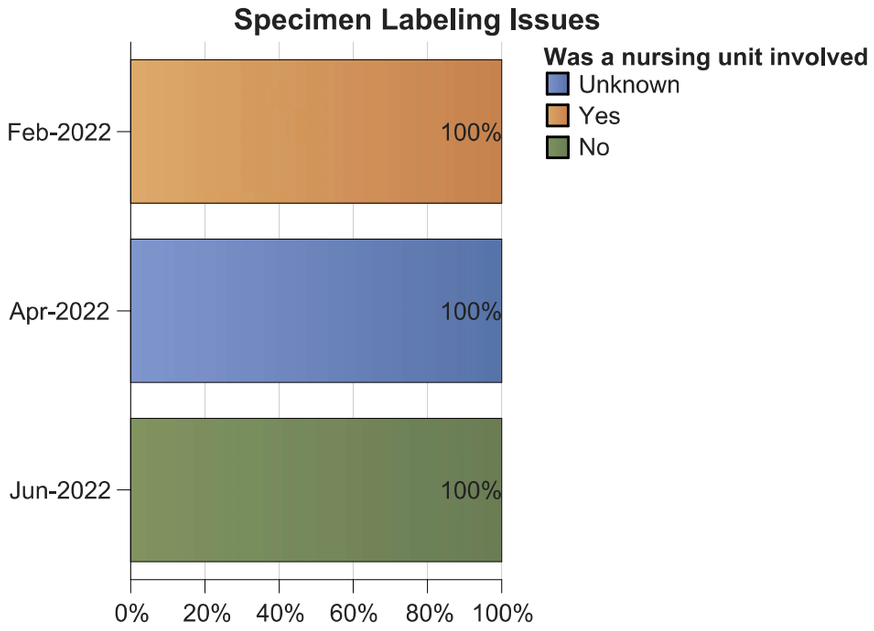
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022
Delay		1		1	1	1			
Delay due to Hospital/ Radiology systems problems or communication issues									1
Error reporting results	2					1			
Improper technique other than a break in sterile technique	1		2						
Omitted a test or procedure	1					1			
Order Issue						1	1		
Other		4	1	1		1	2	1	2
Patient was not properly prepared for the procedure or test				1				1	
Performed on wrong patient			1						1
Performed wrong procedure			1						
Specimen Problems** LAB ALWAYS SELECT THIS ONE***		4	8	4	2	4	1	4	4
Unexpected complications				2	1	1			1
Total	**4**	**9**	**13**	**9**	**4**	**10**	**4**	**6**	**9**



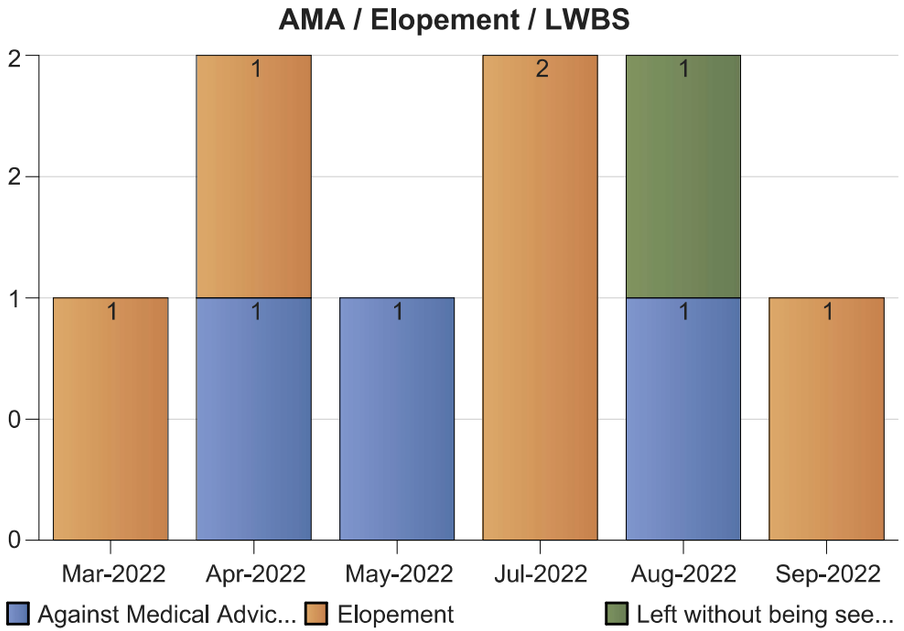
	Total
Delay	4
Delay due to Hospital/ Radiology systems problems or communication issues	1
Error reporting results	3
Improper technique other than a break in sterile technique	3
Omitted a test or procedure	2
Order Issue	2
Other	12
Patient was not properly prepared for the procedure or test	2
Performed on wrong patient	2
Performed wrong procedure	1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	31
Unexpected complications	5
Total	**68**



	Feb-2022	Mar-2022	May-2022	Aug-2022	Sep-2022	Total
No		1	1	1	2	**5**
Yes	2	1				**3**
Total	**2**	**2**	**1**	**1**	**2**	**8**

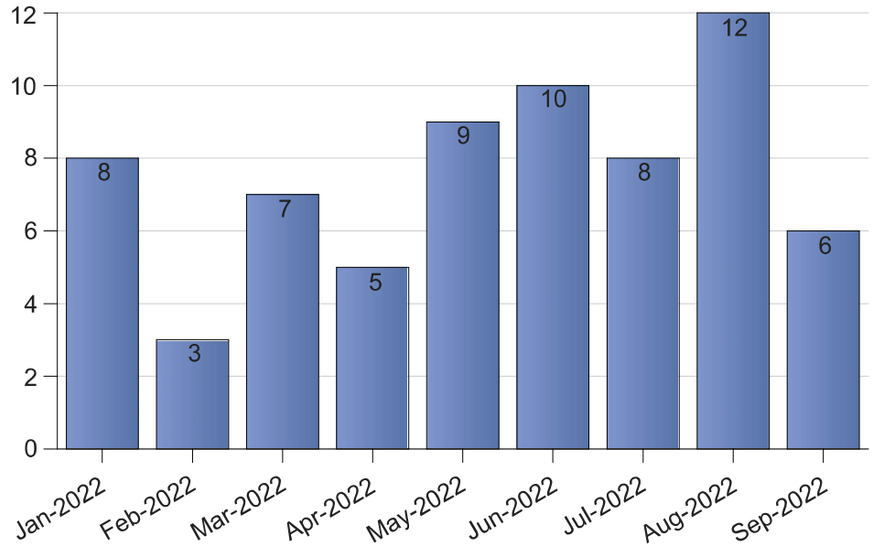


	Feb-2022	Apr-2022	Jun-2022	Total
Unknown		1		**1**
Yes	4			**4**
No			1	**1**
Total	**4**	**1**	**1**	**6**



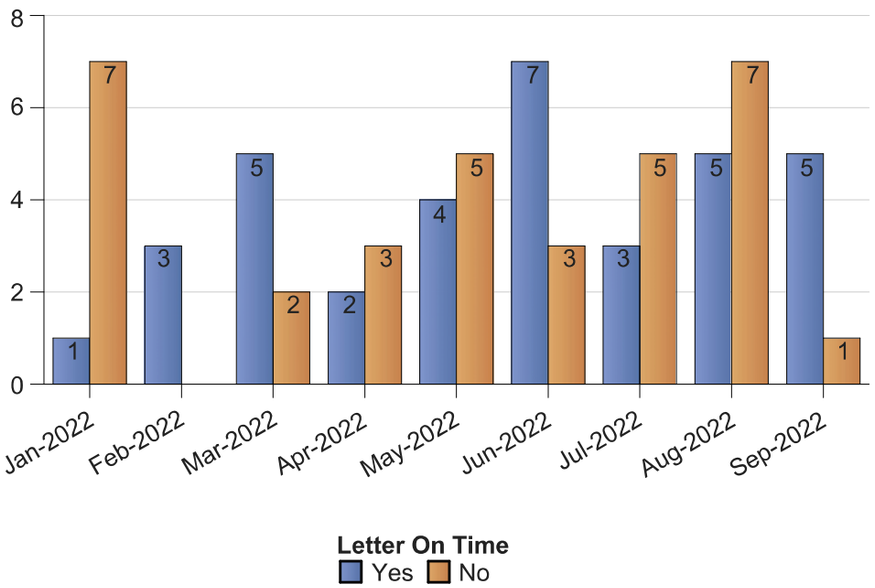
	Mar-2022	Apr-2022	May-2022	Jul-2022	Aug-2022	Sep-2022	Total
Against Medical Advice (AMA)		1	1		1		**3**
Elopement	1	1		2		1	**5**
Left without being seen (LWBS)					1		**1**
Total	**1**	**2**	**1**	**2**	**2**	**1**	**9**

UOR's with Complaint Response Required



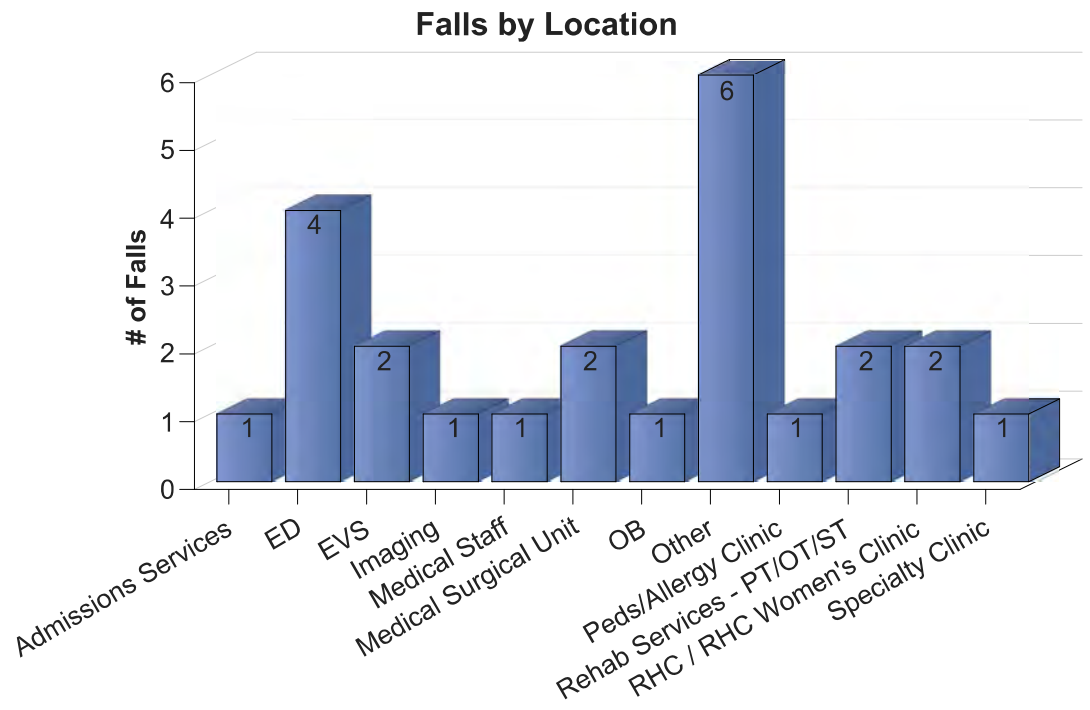
Jan-2022	8
Feb-2022	3
Mar-2022	7
Apr-2022	5
May-2022	9
Jun-2022	10
Jul-2022	8
Aug-2022	12
Sep-2022	6
Total	**68**

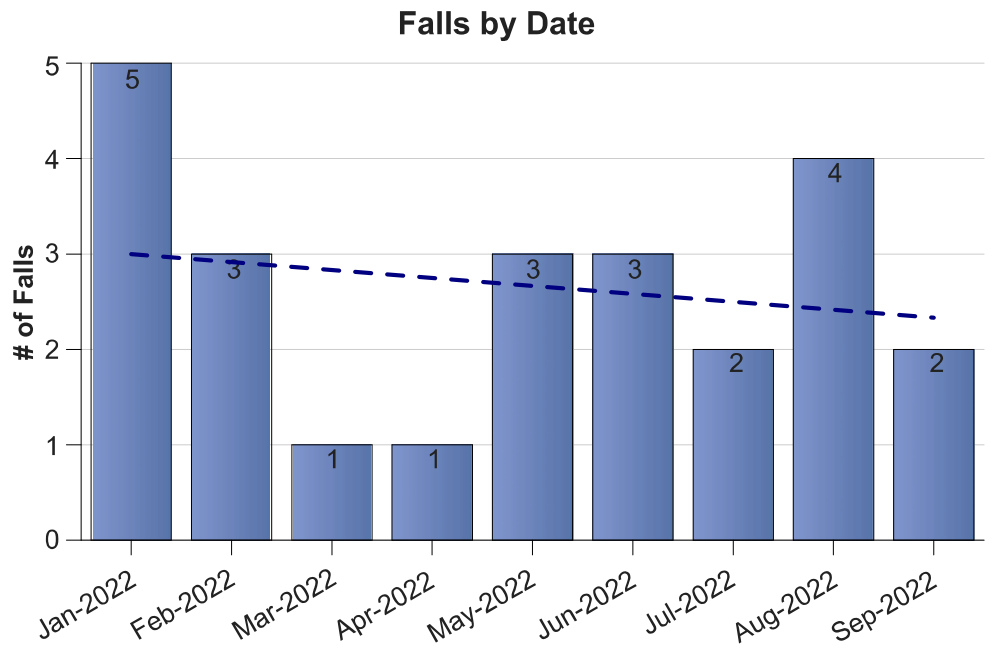
UOR's with On Time Responses



	Yes	No	Total
Jan-2022	1	7	**8**
Feb-2022	3		**3**
Mar-2022	5	2	**7**
Apr-2022	2	3	**5**
May-2022	4	5	**9**
Jun-2022	7	3	**10**
Jul-2022	3	5	**8**
Aug-2022	5	7	**12**
Sep-2022	5	1	**6**
Total	**35**	**33**	**68**

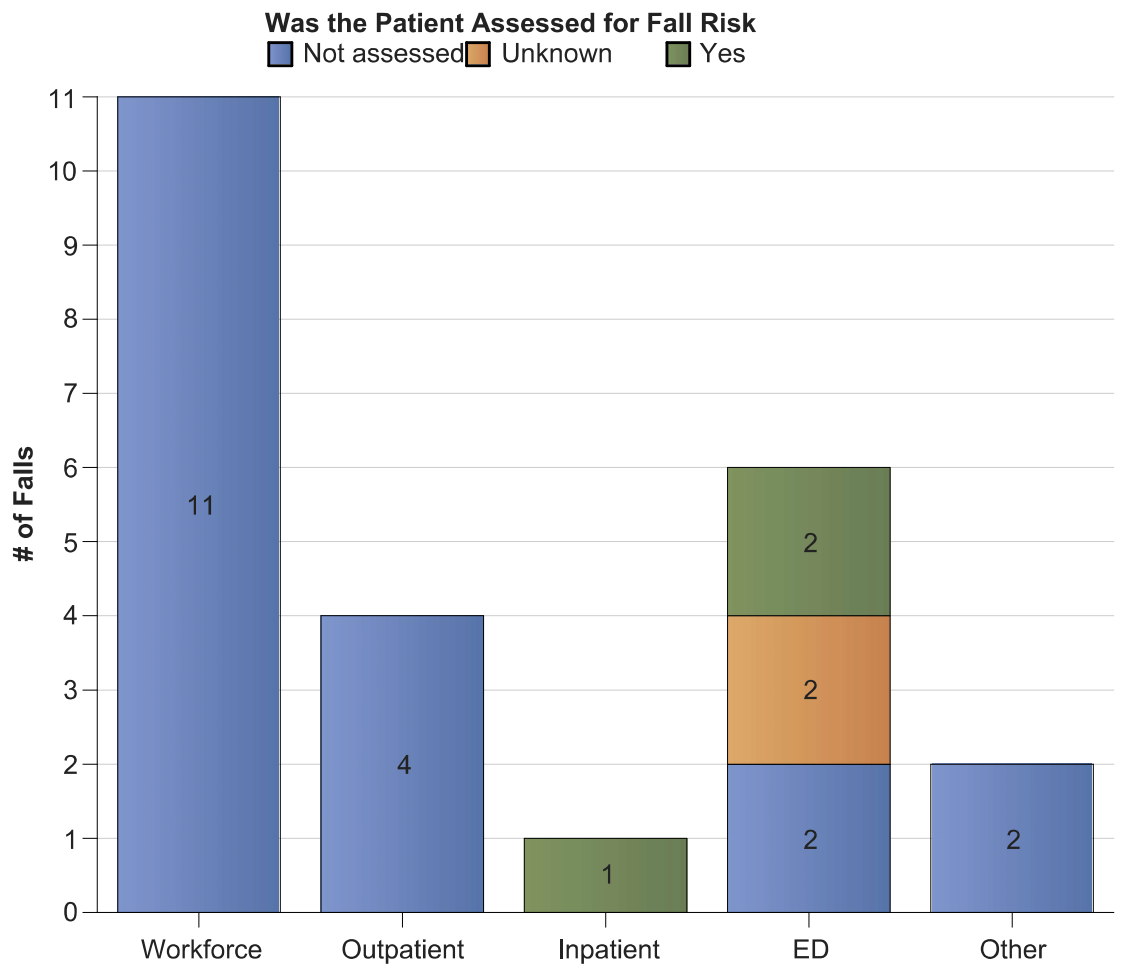
# of Falls	Falls/Slips	Total
Admissions Services	1	**1**
ED	4	**4**
EVS	2	**2**
Imaging	1	**1**
Medical Staff	1	**1**
Medical Surgical Unit	2	**2**
OB	1	**1**
Other	6	**6**
Peds/Allergy Clinic	1	**1**
Rehab Services - PT/OT/ST	2	**2**
RHC / RHC Women's Clinic	2	**2**
Specialty Clinic	1	**1**
Total	**24**	**24**



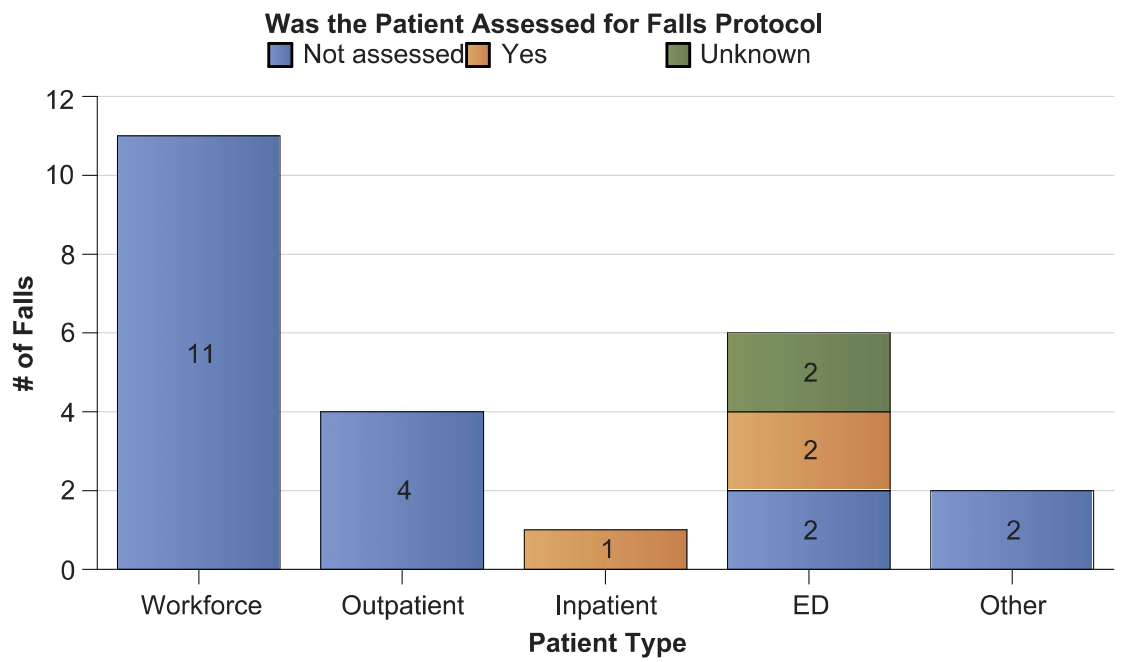


# of Falls	Falls/Slip Problem(s)									Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Ice/weather related	Other	Other Person	
Not Identified	4	4			2	1	1	7	1	**20**
Oriented		3	1	1		1		1		**7**
Total	**4**	**7**	**1**	**1**	**2**	**2**	**1**	**8**	**1**	**27**

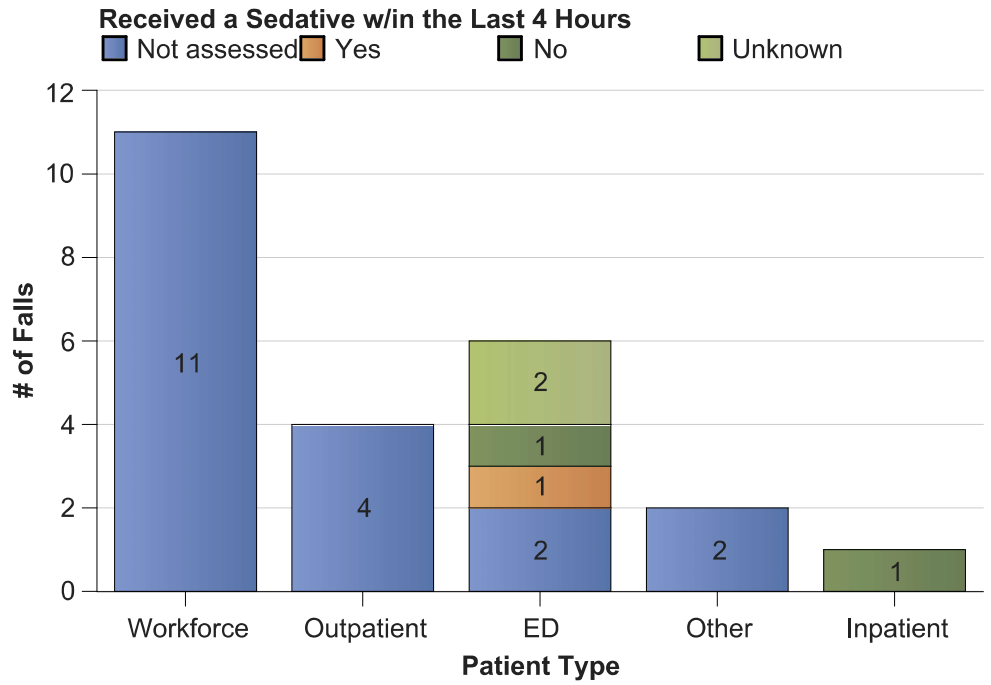
# of Falls	Was there any injury?				
	Not Identified	Unknown	Yes	No	Total
Not Identified	11				**11**
ED	3	1	1	1	**6**
Inpatient	1				**1**
Other	2				**2**
Outpatient	4				**4**
Total	**21**	**1**	**1**	**1**	**24**



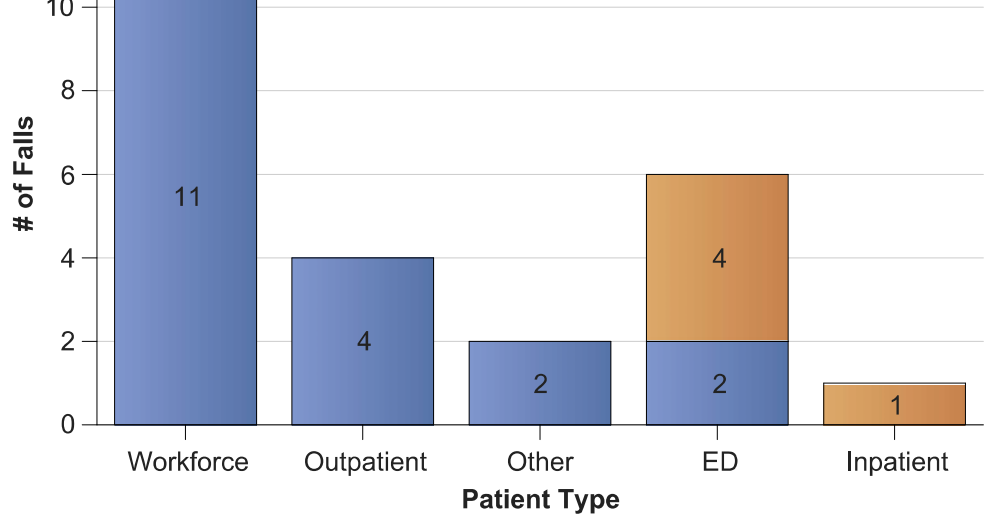
# of Falls	Was the Patient Assessed for Fall Risk			
	Not assessed	Yes	Unknown	Total
Workforce	11			**11**
Outpatient	4			**4**
Inpatient		1		**1**
Other	2			**2**
ED	2	2	2	**6**
Total	**19**	**3**	**2**	**24**



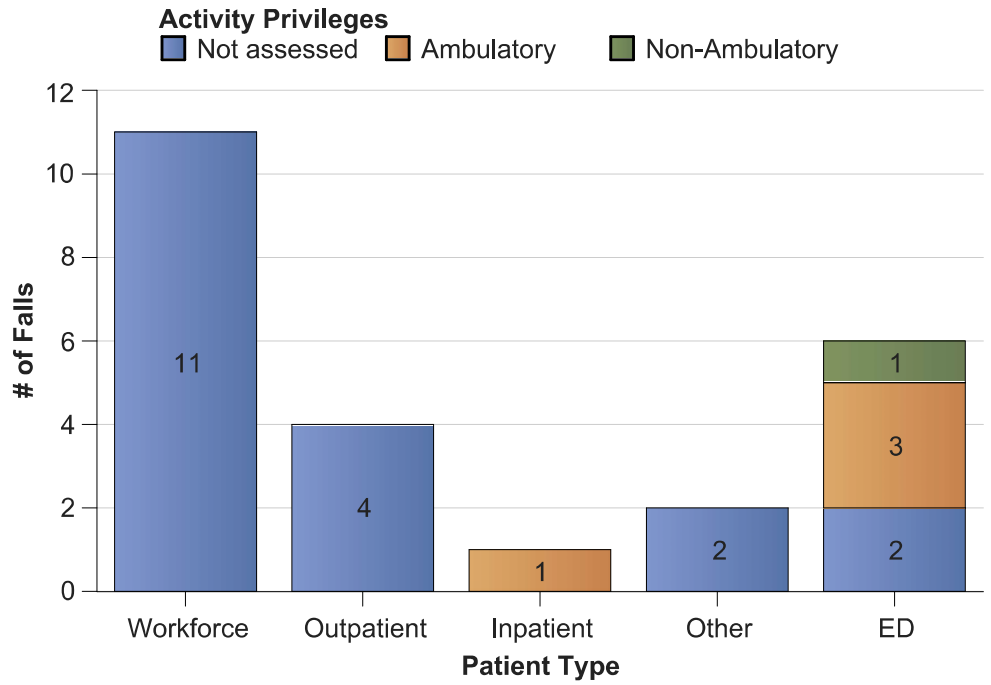
# of Falls	Was the Patient Assessed for Falls Protocol			
	Not assessed	Yes	Unknown	Total
Workforce	11			**11**
Outpatient	4			**4**
Inpatient		1		**1**
Other	2			**2**
ED	2	2	2	**6**
Total	**19**	**3**	**2**	**24**



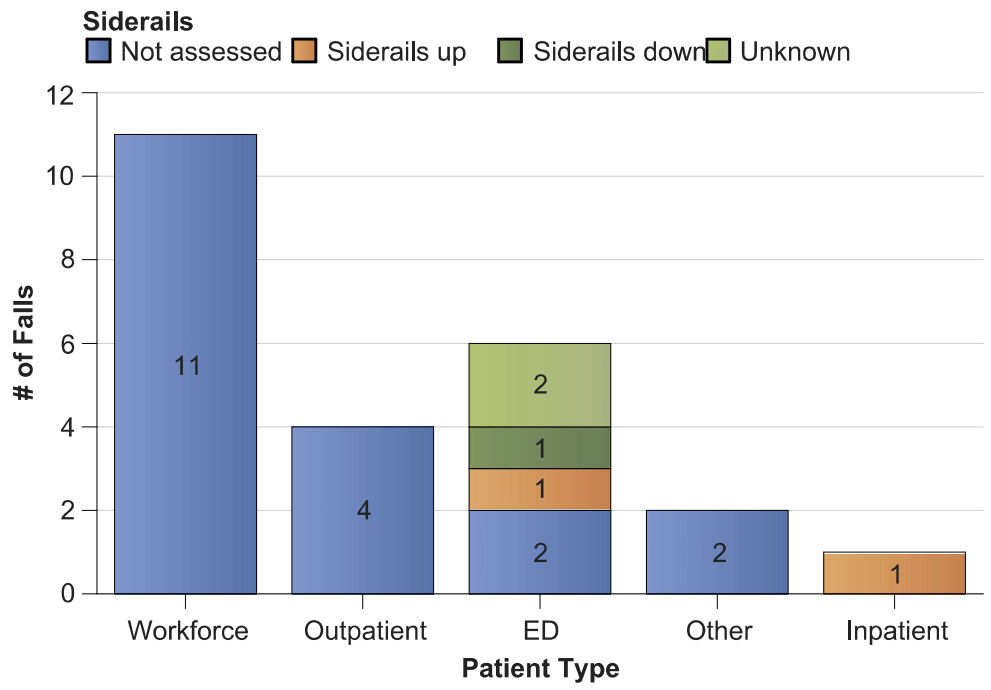
# of Falls	Received a Sedative w/in the Last 4 Hours				
	Not assessed	Unknown	Yes	No	**Total**
Workforce	11				**11**
Outpatient	4				**4**
Other	2				**2**
ED	2	2	1	1	**6**
Inpatient				1	**1**
Total	**19**	**2**	**1**	**2**	**24**



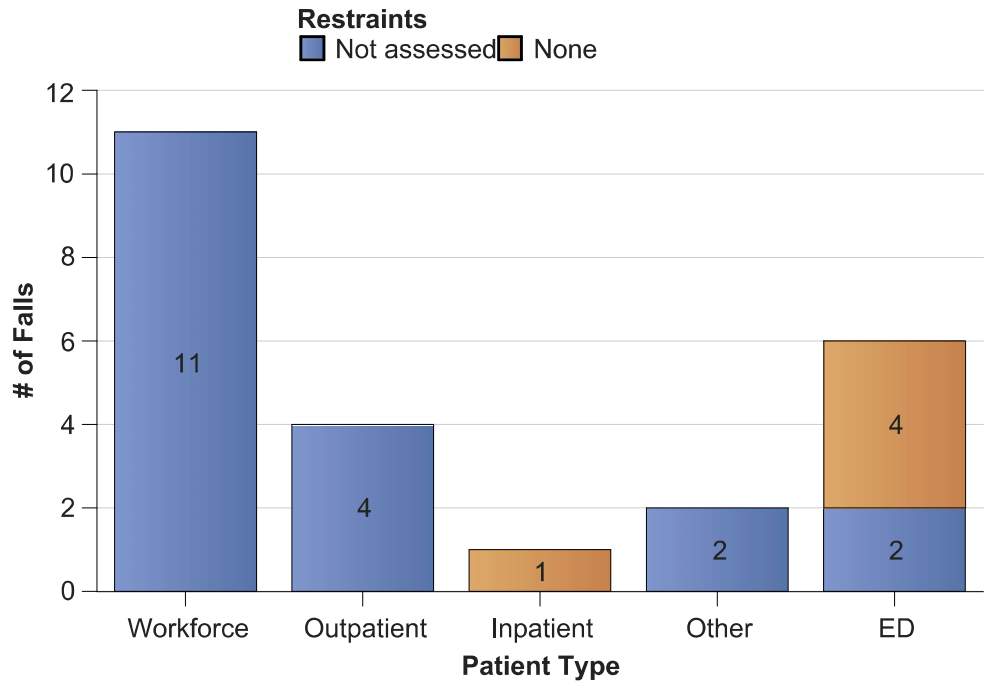
# of Falls	The Patient Is		
	Not assessed	Oriented	**Total**
Workforce	11		**11**
Outpatient	4		**4**
Other	2		**2**
ED	2	4	**6**
Inpatient		1	**1**
Total	**19**	**5**	**24**



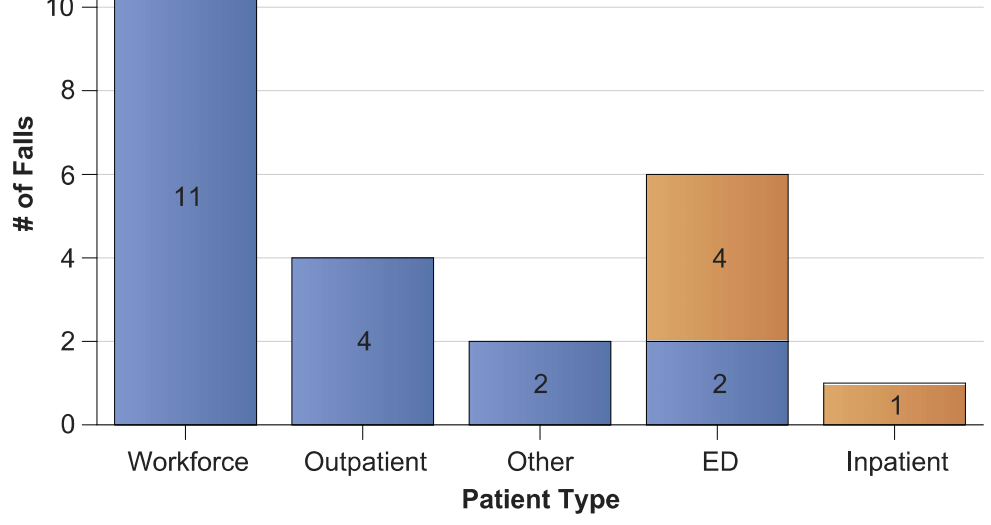
# of Falls	Activity Privileges			
	Not assessed	Ambulatory	Non-Ambulatory	Total
Workforce	11			**11**
ED	2	3	1	**6**
Inpatient		1		**1**
Other	2			**2**
Outpatient	4			**4**
Total	**19**	**4**	**1**	**24**



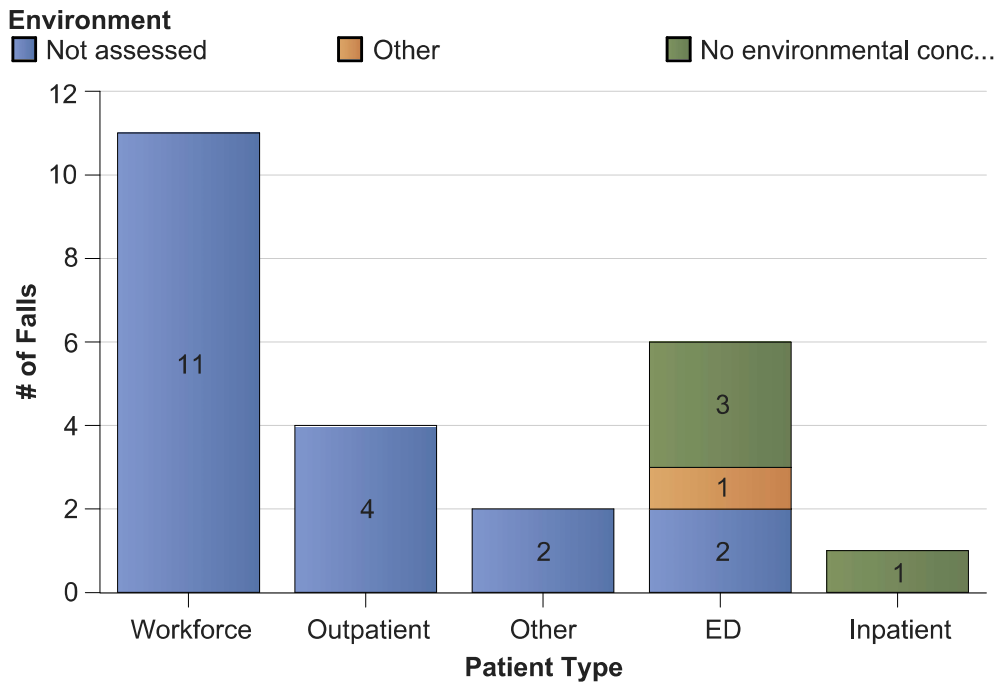
# of Falls	Siderails				
	Not assessed	Unknown	Siderails down	Siderails up	Total
Workforce	11				**11**
Outpatient	4				**4**
Other	2				**2**
ED	2	2	1	1	**6**
Inpatient				1	**1**
Total	**19**	**2**	**1**	**2**	**24**



# of Falls	Restraints		
	Not assessed	None	Total
Workforce	11		**11**
Outpatient	4		**4**
Other	2		**2**
Inpatient		1	**1**
ED	2	4	**6**
Total	**19**	**5**	**24**



# of Falls	Patient Attendent		
	Not assessed	No	Total
Workforce	11		**11**
Outpatient	4		**4**
Other	2		**2**
ED	2	4	**6**
Inpatient		1	**1**
Total	**19**	**5**	**24**



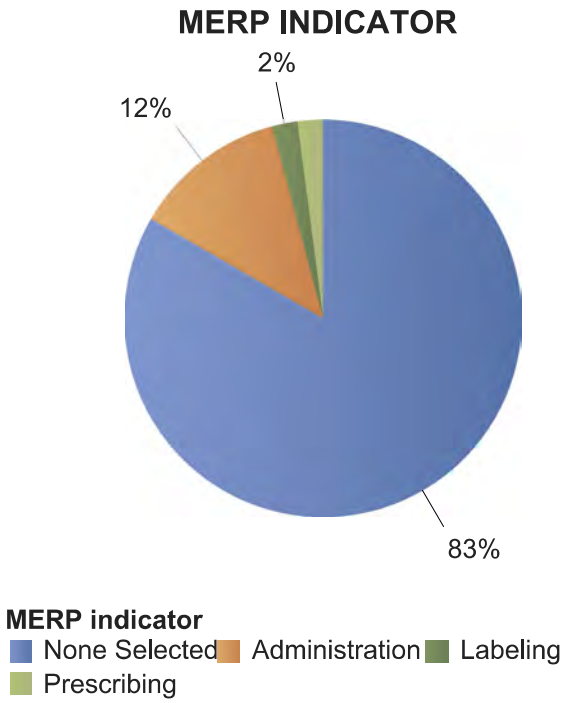
# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	11			**11**
Outpatient	4			**4**
Other	2			**2**
Inpatient		1		**1**
ED	2	3	1	**6**
Total	**19**	**4**	**1**	**24**

# of Falls	Fall Witnessed				Fall Alleged		Assisted to Floor			Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	Total	Not Identified	Yes	Total	Not Identified	No	Yes	Total
Not Identified	11			**11**	11	**11**	11		**11**	11			**11**
ED	4		2	**6**	6	**6**	5	1	**6**	4	1	1	**6**
Inpatient		1		**1**	1	**1**	1		**1**			1	**1**
Other	2			**2**	2	**2**	2		**2**	2			**2**
Outpatient	4			**4**	4	**4**	4		**4**	4			**4**
Total	**21**	**1**	**2**	**24**	**24**	**24**	**23**	**1**	**24**	**21**	**1**	**2**	**24**

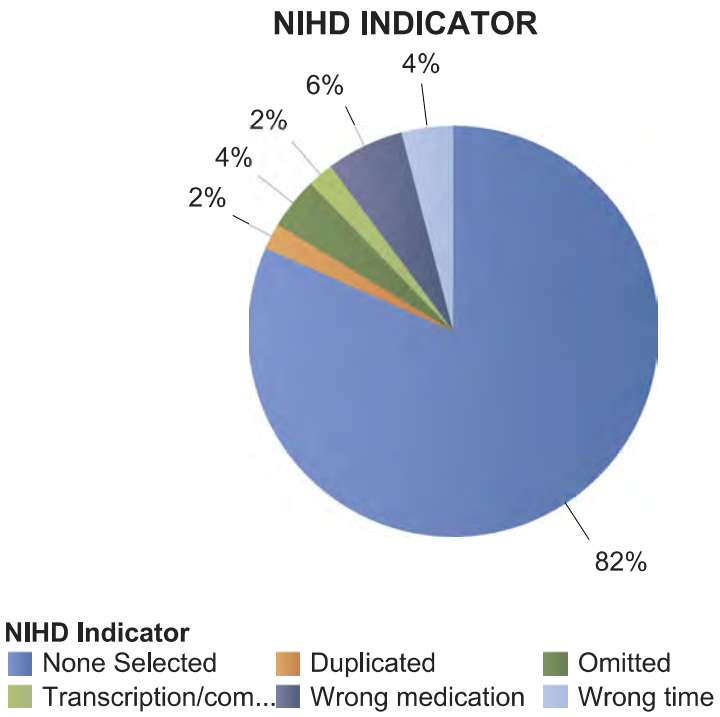
Medication Occurrences are medication issues that did not reach the patient. They were caught prior to administration.

Medication Errors are those issues that did reach the patient.

	# of Errors	# of Occurrences	Total
Jan-2022	4	1	**5**
Feb-2022	2	1	**3**
Mar-2022	3		**3**
Apr-2022	4	1	**5**
May-2022	3	2	**5**
Jun-2022	4	6	**10**
Jul-2022	2		**2**
Aug-2022	5	0	**5**
Sep-2022	10		**10**
Total	**37**	**11**	**48**

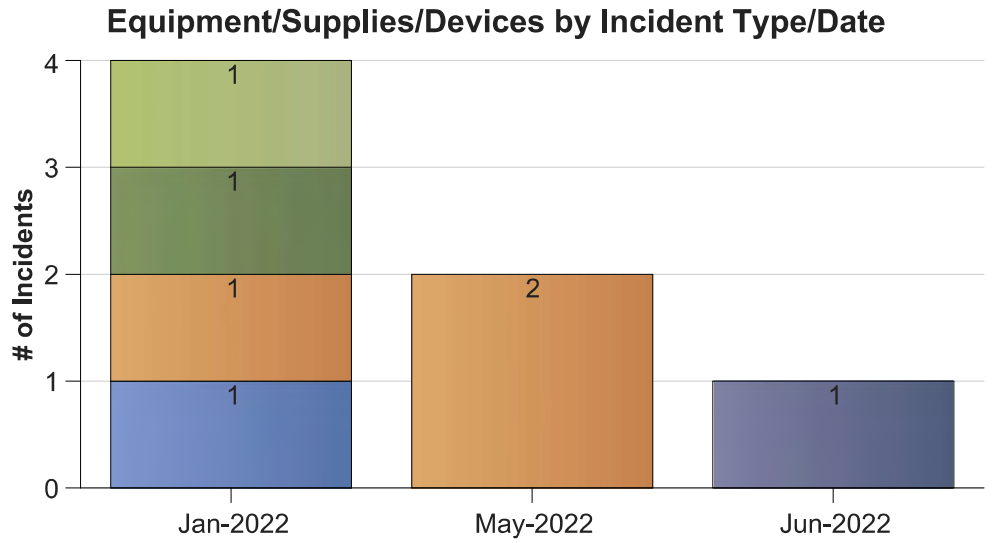


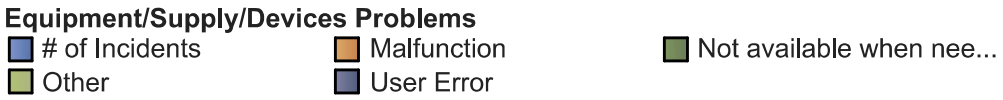
None Selected	40
Administration	6
Labeling	1
Prescribing	1
Total	**48**

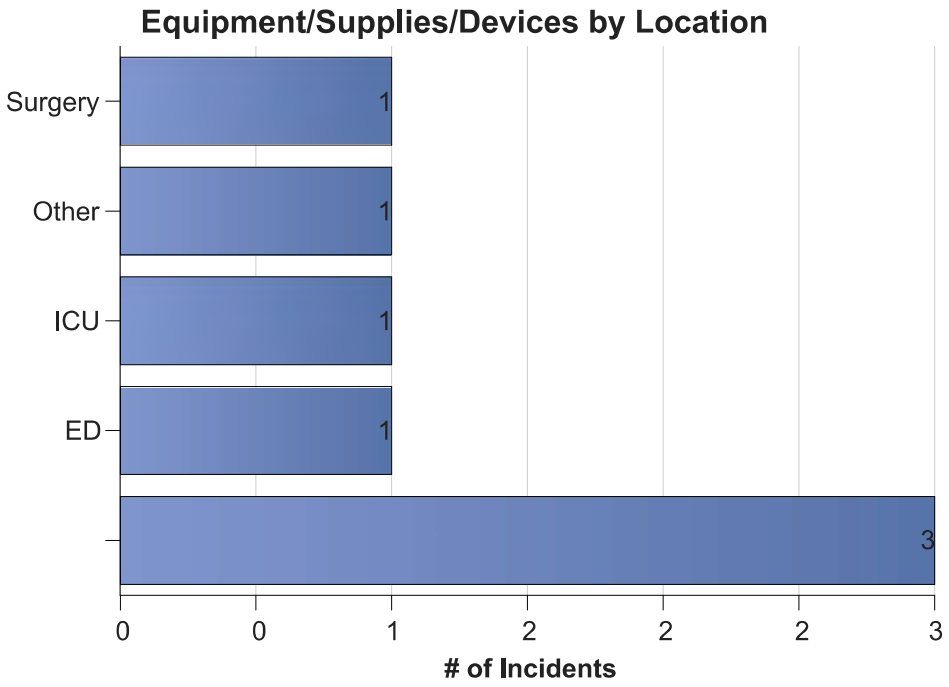


None Selected	40
Duplicated	1
Omitted	2
Transcription/computer entry errror	1
Wrong medication	3
Wrong time	2
Total	**49**

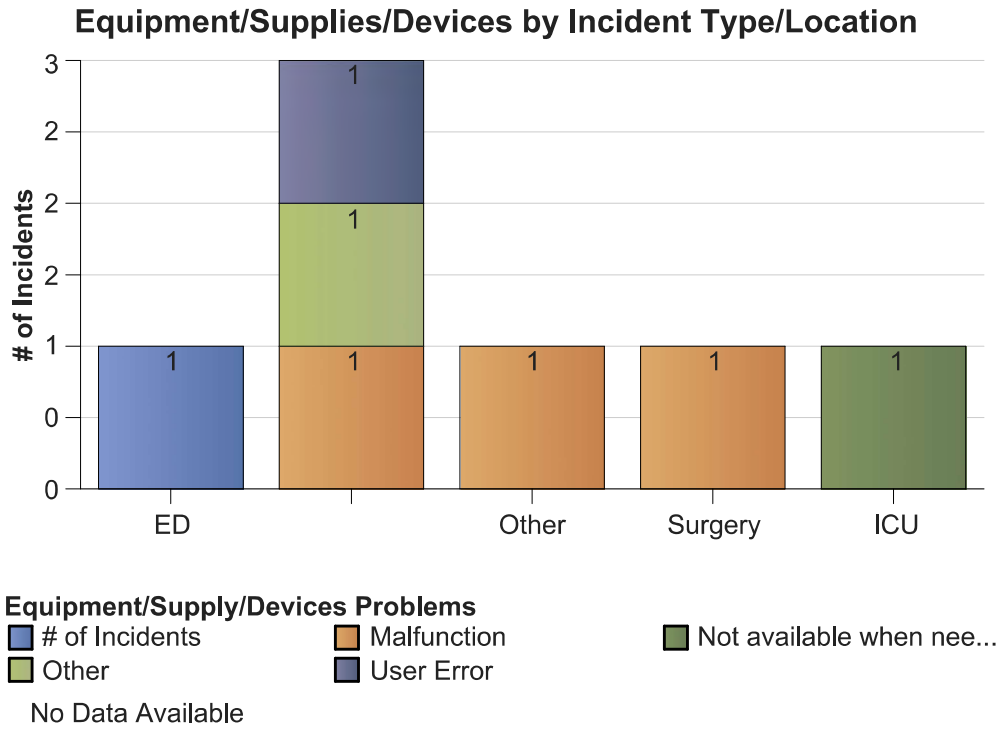
2022

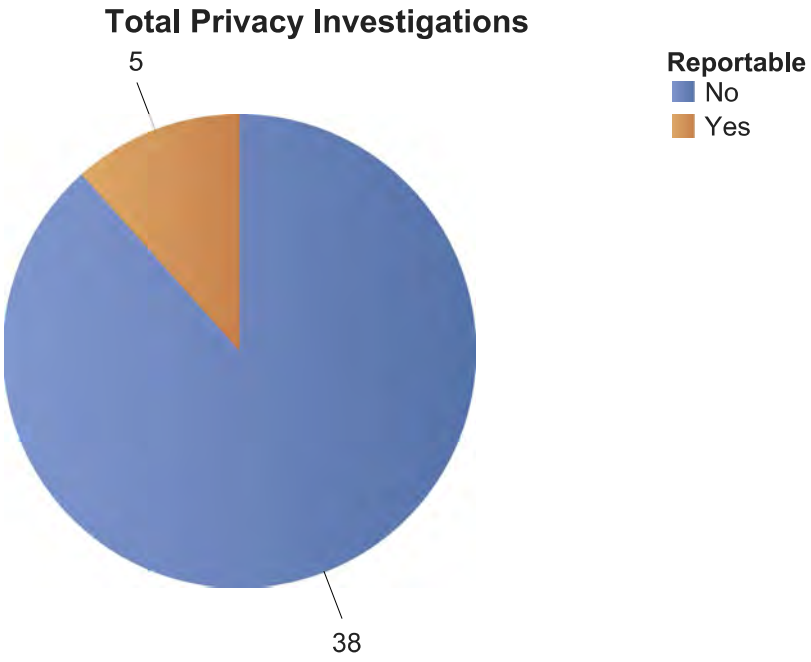


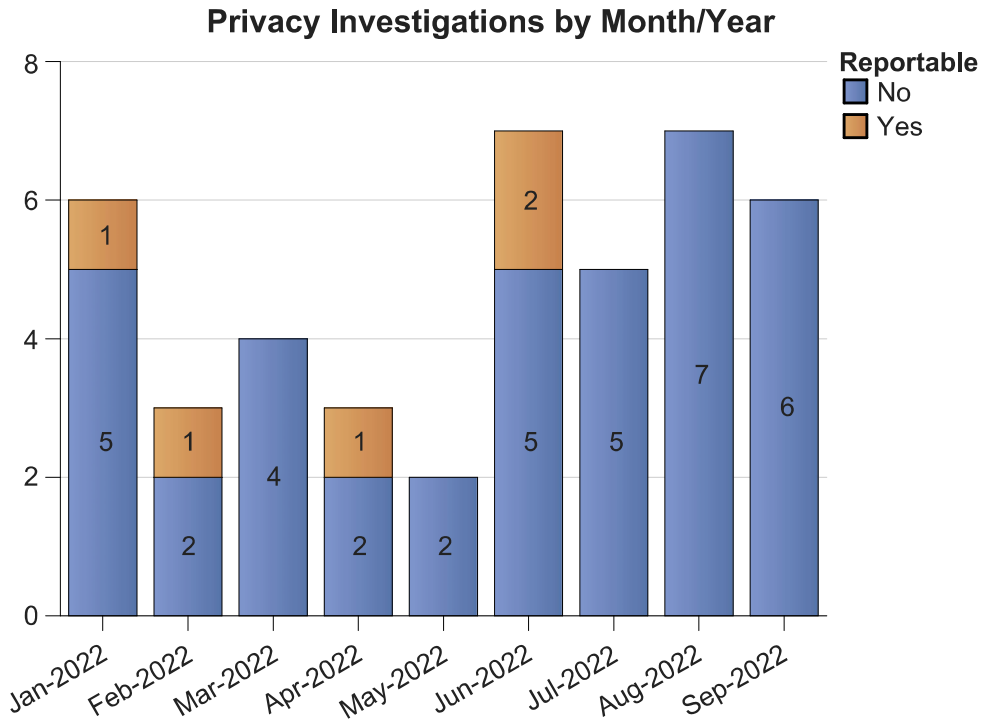




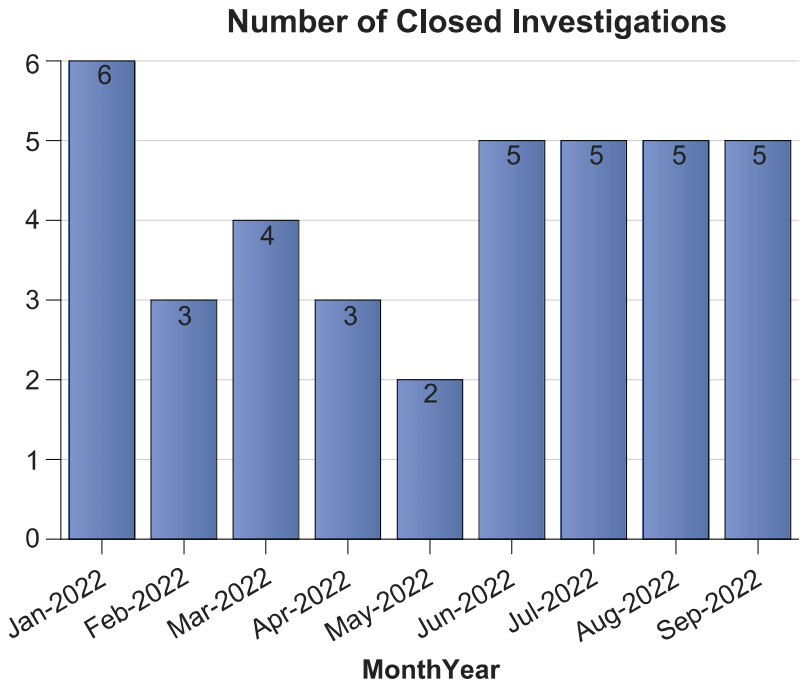
No Data Available


Equipment/Supplies/Devices by Incident Type/Location
# of Incidents
3
2
2
1
0
0
1
1
1
1
1
1
1
1
ED
Other
Surgery
ICU
Equipment/Supply/Devices Problems
# of Incidents
Malfunction
Not available when nee...
Other
User Error
No Data Available


Total Privacy Investigations
5
38
Reportable
No
Yes

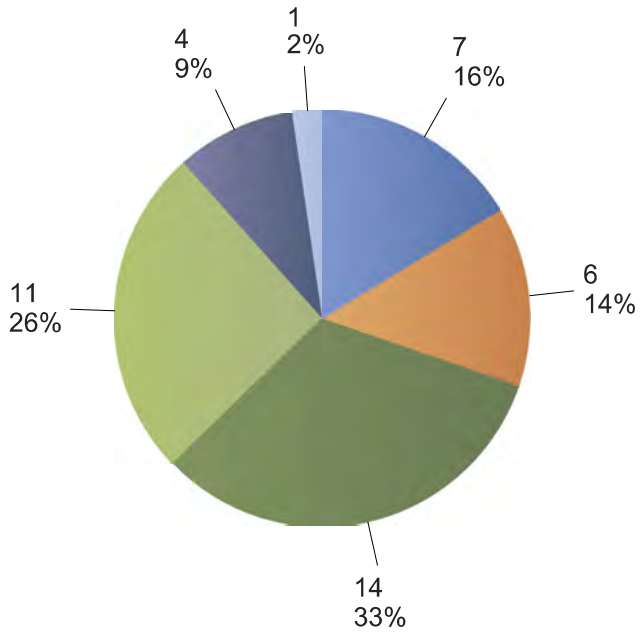


	No	Yes	Total
Jan-2022	5	1	**6**
Feb-2022	2	1	**3**
Mar-2022	4		**4**
Apr-2022	2	1	**3**
May-2022	2		**2**
Jun-2022	5	2	**7**
Jul-2022	5		**5**
Aug-2022	7		**7**
Sep-2022	6		**6**
Total	**38**	**5**	**43**



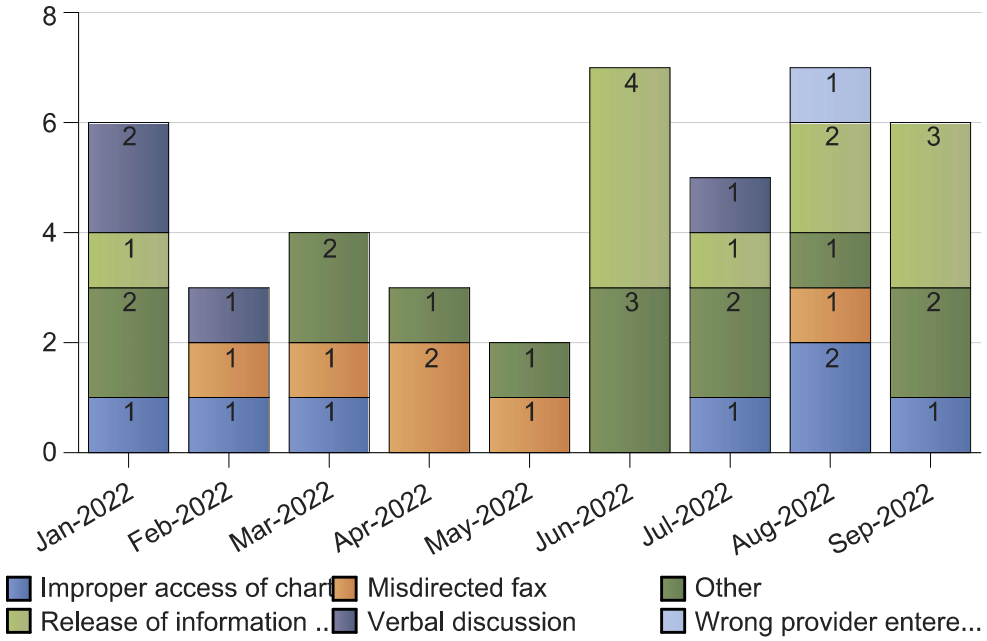
	Closed	Total
Sep-2022	5	**5**
May-2022	2	**2**
Mar-2022	4	**4**
Jun-2022	5	**5**
Jul-2022	5	**5**
Jan-2022	6	**6**
Feb-2022	3	**3**
Aug-2022	5	**5**
Apr-2022	3	**3**
Total	**38**	**38**
Total	**38**	**38**

Privacy Investigations by Violation Type

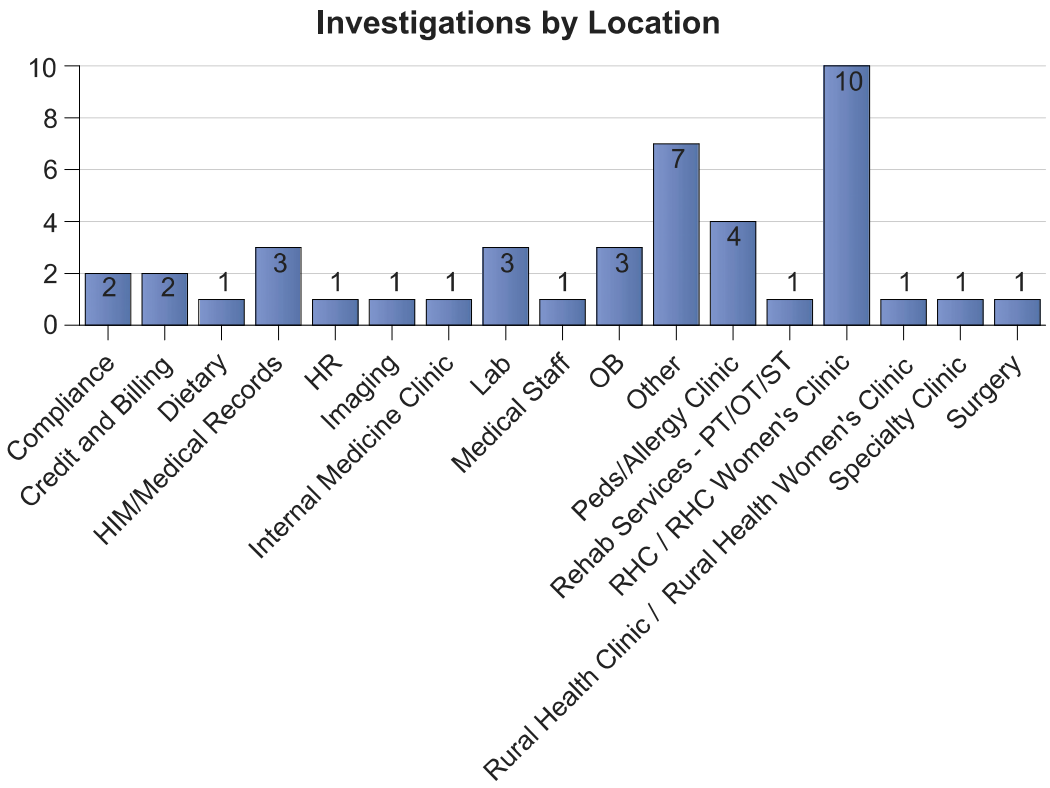


Improper access of chart	7
Misdirected fax	6
Other	14
Release of information concern	11
Verbal discussion	4
Wrong provider entered/selected	1
Total	**43**

Privacy Investigations by Type and Date

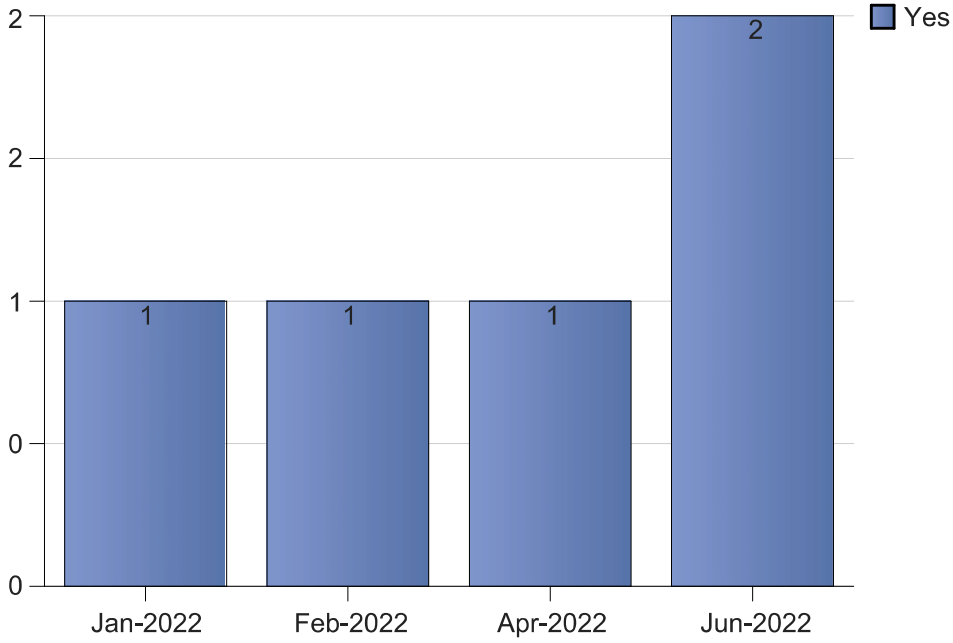


	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Total
Improper access of chart	1	1	1				1	2	1	**7**
Misdirected fax		1	1	2	1			1		**6**
Other	2		2	1	1	3	2	1	2	**14**
Release of information concern	1					4	1	2	3	**11**
Verbal discussion	2	1					1			**4**
Wrong provider entered/selected								1		**1**
Total	**6**	**3**	**4**	**3**	**2**	**7**	**5**	**7**	**6**	**43**



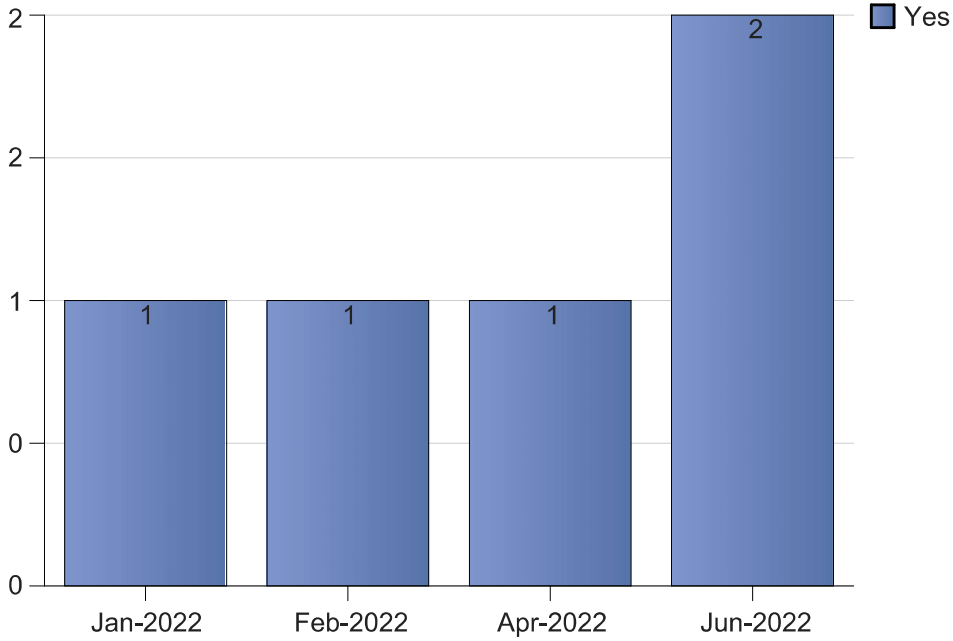
Compliance	2
Credit and Billing	2
Dietary	1
HIM/Medical Records	3
HR	1
Imaging	1
Internal Medicine Clinic	1
Lab	3
Medical Staff	1
OB	3
Other	7
Peds/Allergy Clinic	4
Rehab Services - PT/OT/ST	1
RHC / RHC Women's Clinic	10
Rural Health Clinic / Rural Health Women's Clinic	1
Specialty Clinic	1
Surgery	1
Total	**43**

Reported to OCR timely

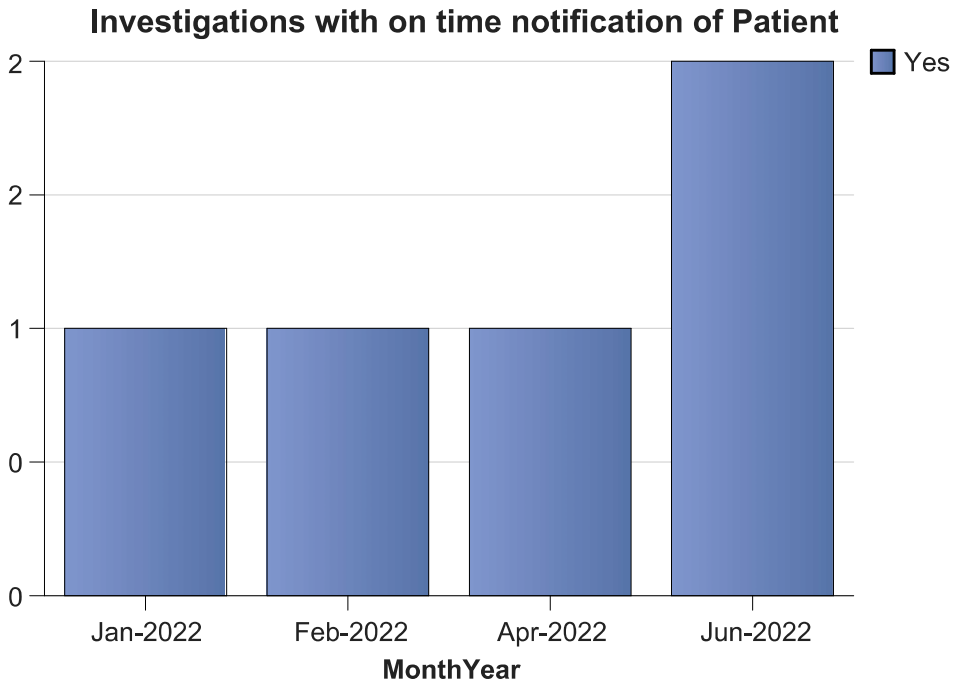


	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Total	**5**	**5**

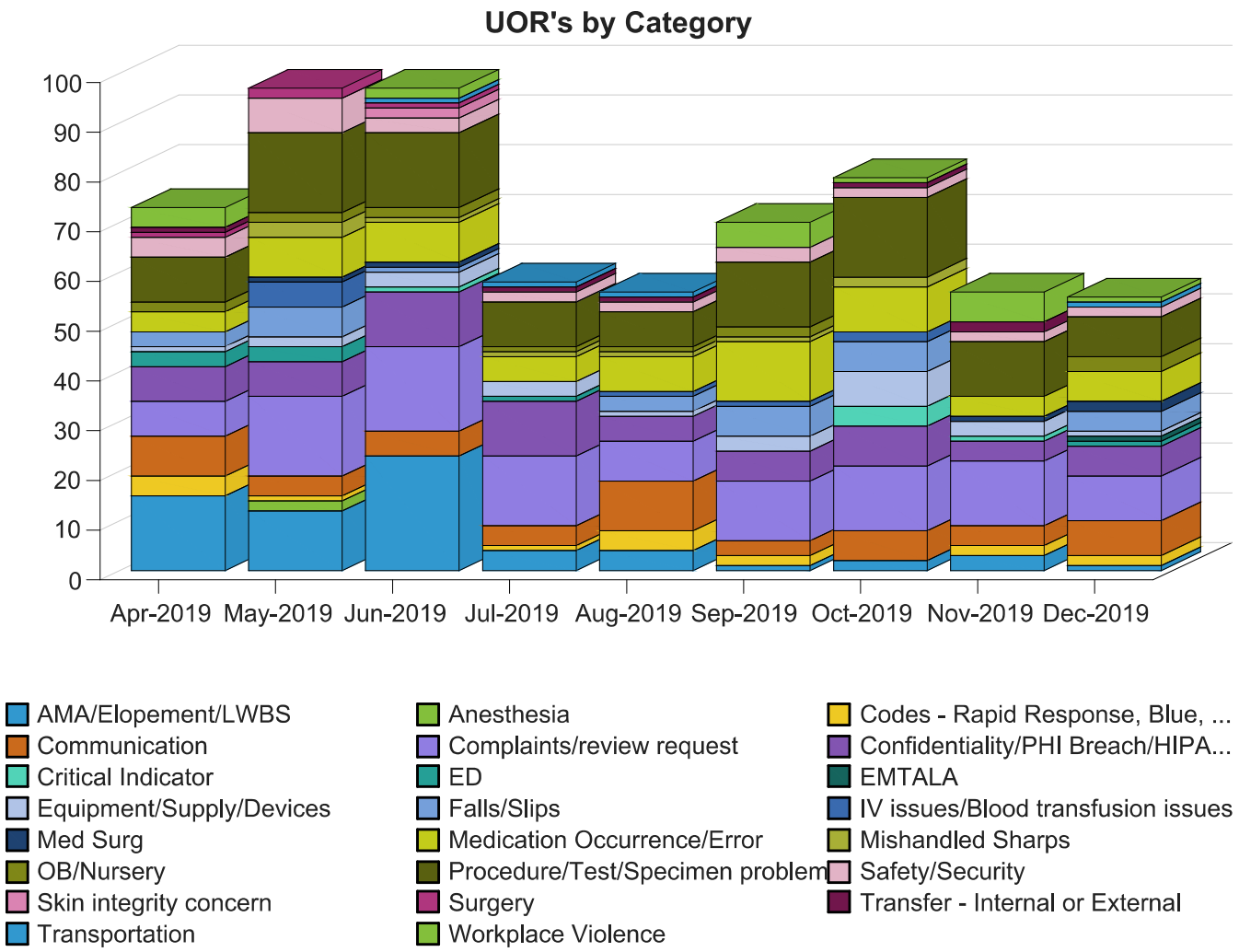
Reported to CDPH timely



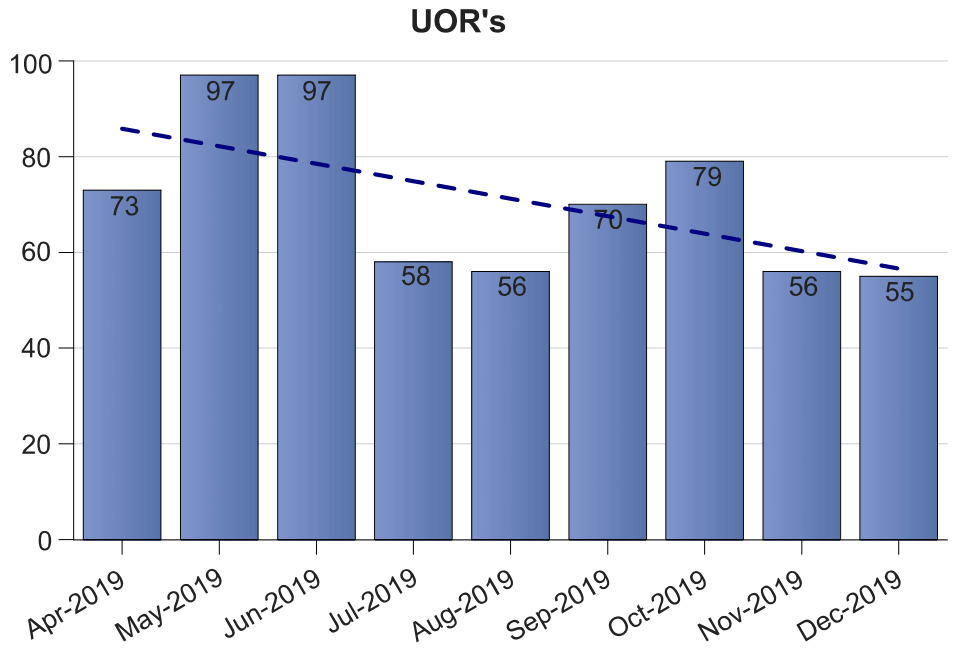
	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Total	**5**	**5**



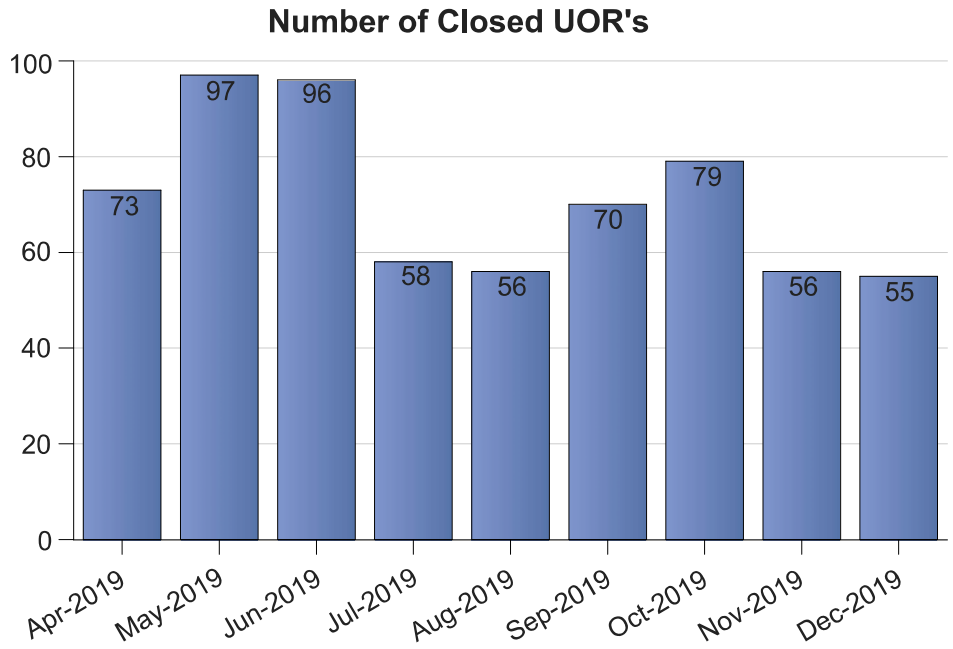
	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Total	**5**	**5**


UOR's by Category
100
90
80
70
60
50
40
30
20
10
0
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Dec-2019
AMA/Elopement/LWBS
Anesthesia
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
EMTALA
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Total
AMA/Elopement/LWBS	15	12	23	4	4	1	2	3	1	**65**
Anesthesia		2								**2**
Codes - Rapid Response, Blue, Deescalation	4	1		1	4	2		2	2	**16**
Communication	8	4	5	4	10	3	6	4	7	**51**
Complaints/review request	7	16	17	14	8	12	13	13	9	**109**
Confidentiality/PHI Breach/HIPAA violation	7	7	11	11	5	6	8	4	6	**65**
Critical Indicator			1				4	1		**6**
ED	3	3		1					1	**8**
EMTALA									1	**1**
Equipment/Supply/Devices	1	2	3	3	1	3	7	3	1	**24**
Falls/Slips	3	6	1		3	6	6		4	**29**
IV issues/Blood transfusion issues		5			1	1	2			**9**
Med Surg		1	1					1	2	**5**
Medication Occurrence/Error	4	8	8	5	7	12	9	4	6	**63**
Mishandled Sharps		3	1	1	1	1	2			**9**
OB/Nursery	2	2	2	1	1	2			3	**13**
Procedure/Test/Specimen problem	9	16	15	9	7	13	16	11	8	**104**
Safety/Security	4	7	3	2	2	3	2	2	2	**27**
Skin integrity concern			2							**2**
Surgery	1	2	1							**4**
Transfer - Internal or External	1			1	1		1	2		**6**
Transportation			1	1	1				1	**4**
Workplace Violence	4		2			5	1	6	1	**19**
Total	**73**	**97**	**97**	**58**	**56**	**70**	**79**	**56**	**55**	**641**

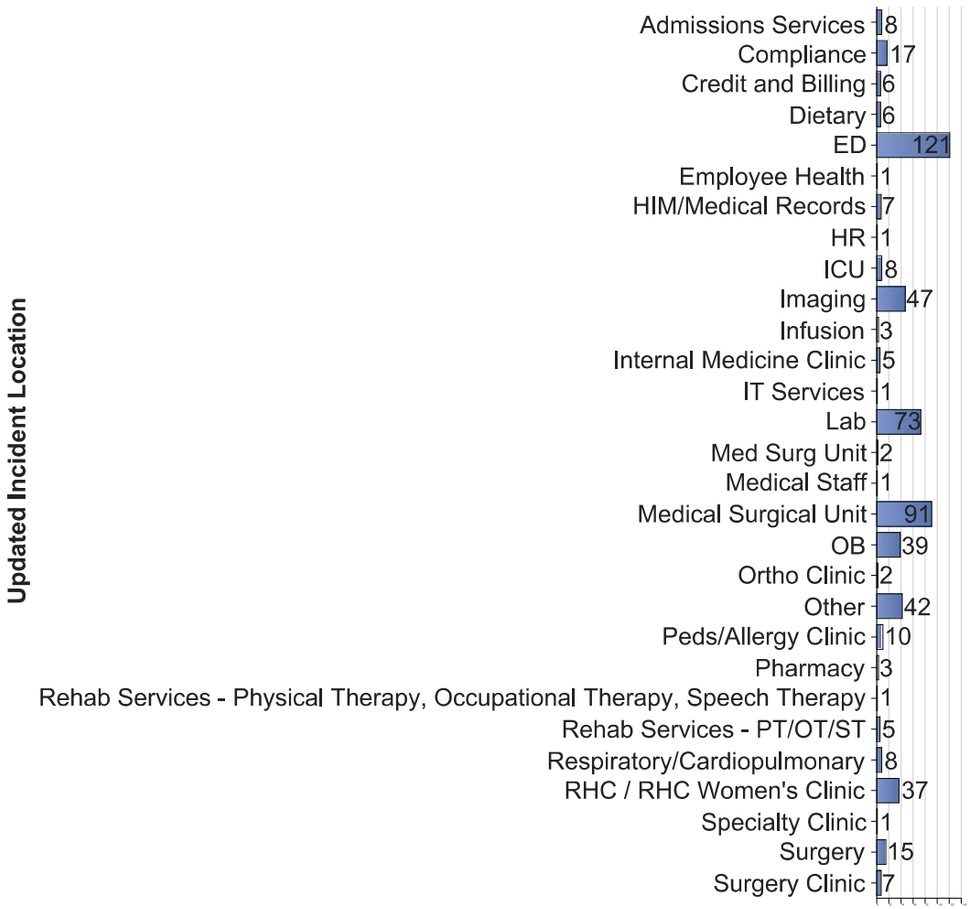


Apr-2019	73
May-2019	97
Jun-2019	97
Jul-2019	58
Aug-2019	56
Sep-2019	70
Oct-2019	79
Nov-2019	56
Dec-2019	55
Total	**641**



	Closed
Apr-2019	73
May-2019	97
Jun-2019	96
Jul-2019	58
Aug-2019	56
Sep-2019	70
Oct-2019	79
Nov-2019	56
Dec-2019	55
Total	**640**

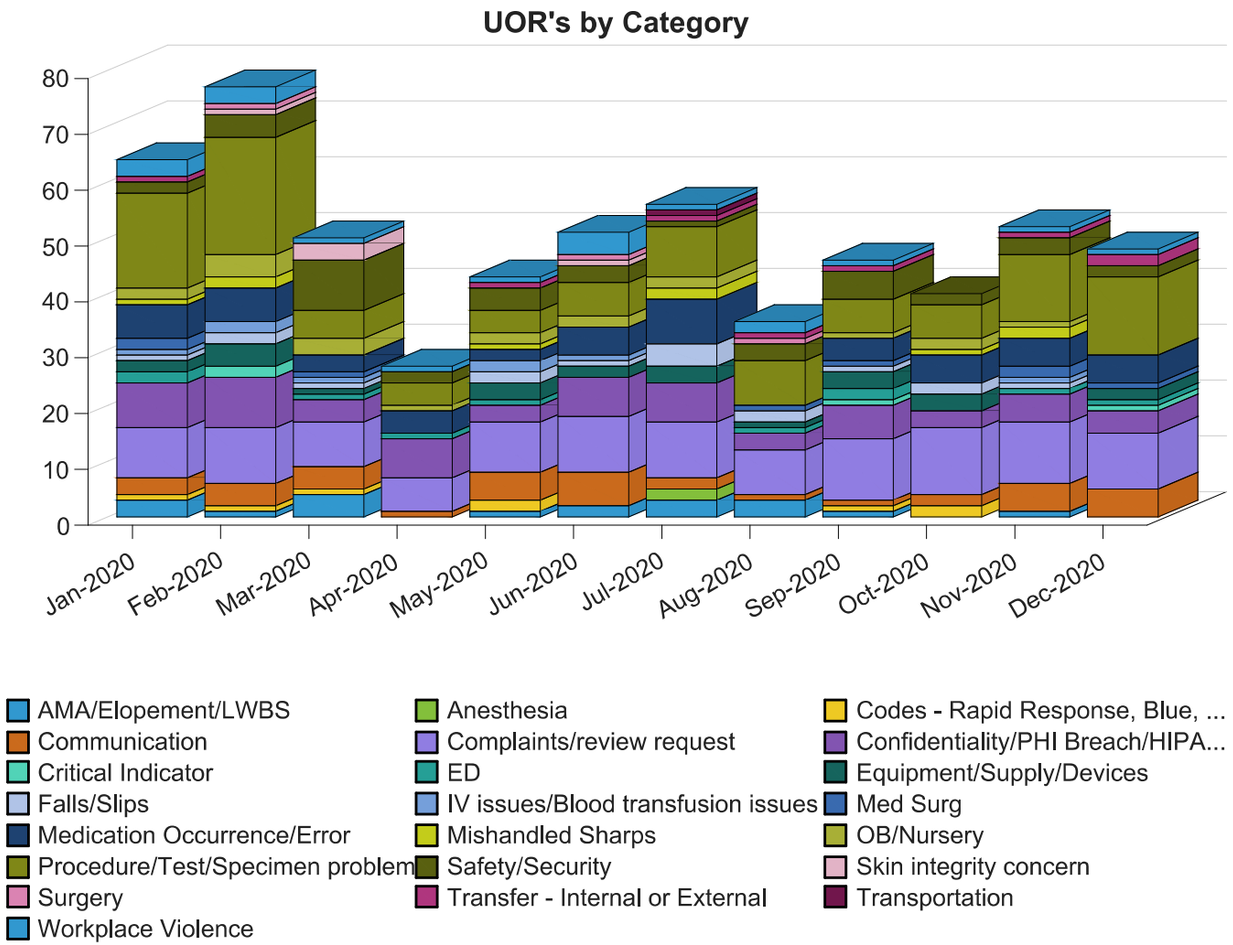
UOR's by Location



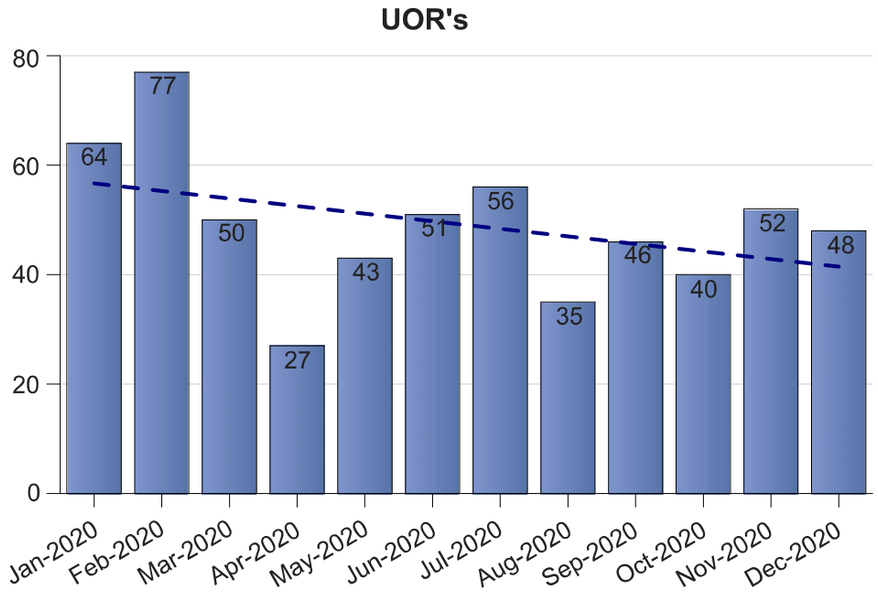
Admissions Services	8
Compliance	17
Credit and Billing	6
Dietary	6
ED	121
Employee Health	1
HIM/Medical Records	7
HR	1
ICU	8
Imaging	47
Infusion	3
Internal Medicine Clinic	5
IT Services	1
Lab	73
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	91
OB	39
Ortho Clinic	2
Other	42
Peds/Allergy Clinic	10
Pharmacy	3
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1
Rehab Services - PT/OT/ST	5
Respiratory/Cardiopulmonary	8
RHC / RHC Women's Clinic	37
Specialty Clinic	1
Surgery	15
Surgery Clinic	7

Total	**568**

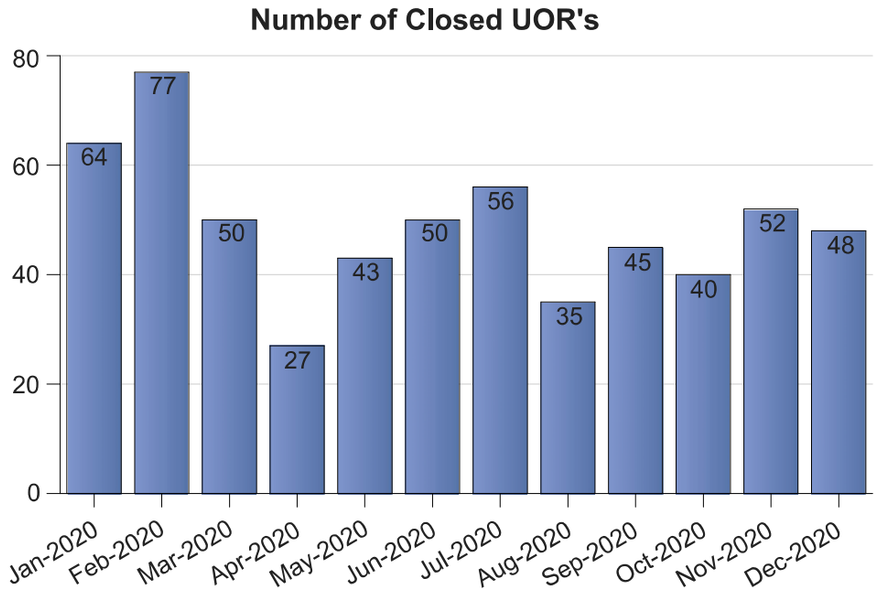
000002


UOR's by Category
80
70
60
50
40
30
20
10
0
Jan-2020
Feb-2020
Mar-2020
Apr-2020
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Nov-2020
Dec-2020
AMA/Elopement/LWBS
Anesthesia
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

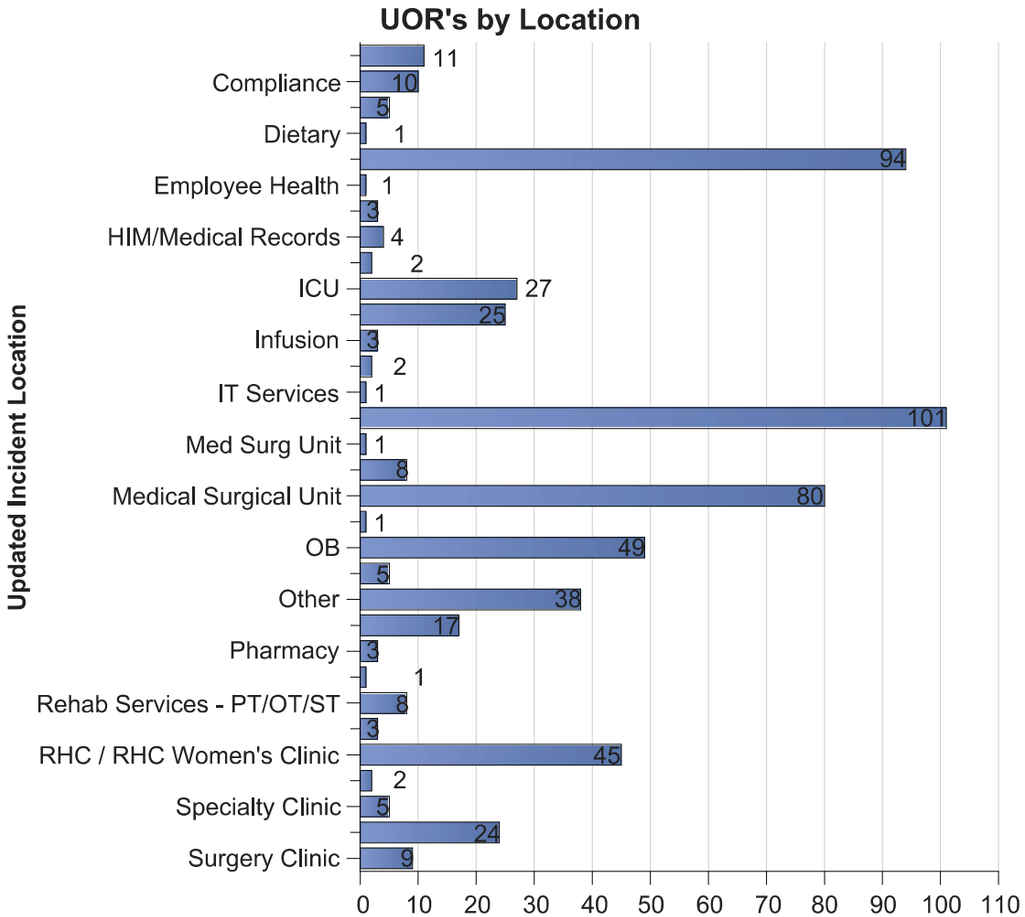
	Jan-2020	Feb-2020	Mar-2020	Apr-2020	May-2020	Jun-2020	Jul-2020	Aug-2020	Sep-2020	Oct-2020	Nov-2020	Dec-2020	Total
AMA/Elopement/LWBS	3	1	4		1	2	3	3	1		1		**19**
Anesthesia							2						**2**
Codes - Rapid Response, Blue, Deescalation	1	1	1		2				1	2			**8**
Communication	3	4	4	1	5	6	2	1	1	2	5	5	**39**
Complaints/review request	9	10	8	6	9	10	10	8	11	12	11	10	**114**
Confidentiality/PHI Breach/HIPAA violation	8	9	4	7	3	7	7	3	6	3	5	4	**66**
Critical Indicator		2							1			1	**4**
ED	2		1	1	1			1	2		1	1	**10**
Equipment/Supply/Devices	2	4	1		3	2	3	1	3	3		2	**24**
Falls/Slips	1	2	1		2	1	4	2	1	2	1		**17**
IV issues/Blood transfusion issues	1	2	1		2	1					1		**8**
Med Surg	2		1					1	1		2	1	**8**
Medication Occurrence/Error	6	6	3	4	2	5	8		4	5	5	5	**53**
Mishandled Sharps	1	2			1		2			1	2		**9**
OB/Nursery	2	4	3	1	2	2	2		1	2	1		**20**
Procedure/Test/Specimen problem	17	21	5	4	4	6	9	8	6	6	12	14	**112**
Safety/Security	2	4	9	2	4	3	1	3	5	2	3	2	**40**
Skin integrity concern		1	3			1							**5**
Surgery		1				1		1					**3**
Transfer - Internal or External	1				1		1	1	1		1	2	**8**
Transportation							1						**1**
Workplace Violence	3	3	1	1	1	4	1	2	1		1	1	**19**
Total	**64**	**77**	**50**	**27**	**43**	**51**	**56**	**35**	**46**	**40**	**52**	**48**	**589**



Jan-2020	64
Feb-2020	77
Mar-2020	50
Apr-2020	27
May-2020	43
Jun-2020	51
Jul-2020	56
Aug-2020	35
Sep-2020	46
Oct-2020	40
Nov-2020	52
Dec-2020	48
Total	**589**



	Closed
Jan-2020	64
Feb-2020	77
Mar-2020	50
Apr-2020	27
May-2020	43
Jun-2020	50
Jul-2020	56
Aug-2020	35
Sep-2020	45
Oct-2020	40
Nov-2020	52
Dec-2020	48
Total	**587**



Admissions Services	11
Compliance	10
Credit and Billing	5
Dietary	1
ED	94
Employee Health	1
EVS	3
HIM/Medical Records	4
HR	2
ICU	27
Imaging	25
Infusion	3
Internal Medicine Clinic	2
IT Services	1
Lab	101
Med Surg Unit	1
Medical Staff	8
Medical Surgical Unit	80
Nursing Informatics	1
OB	49
Ortho Clinic	5
Other	38
Peds/Allergy Clinic	17
Pharmacy	3
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1
Rehab Services - PT/OT/ST	8
Respiratory/Cardiopulmonary	3
RHC / RHC Women's Clinic	45
Rural Health Clinic / Rural Health Women's Clinic	2

Specialty Clinic	5
Surgery	24
Surgery Clinic	9
Total	**589**

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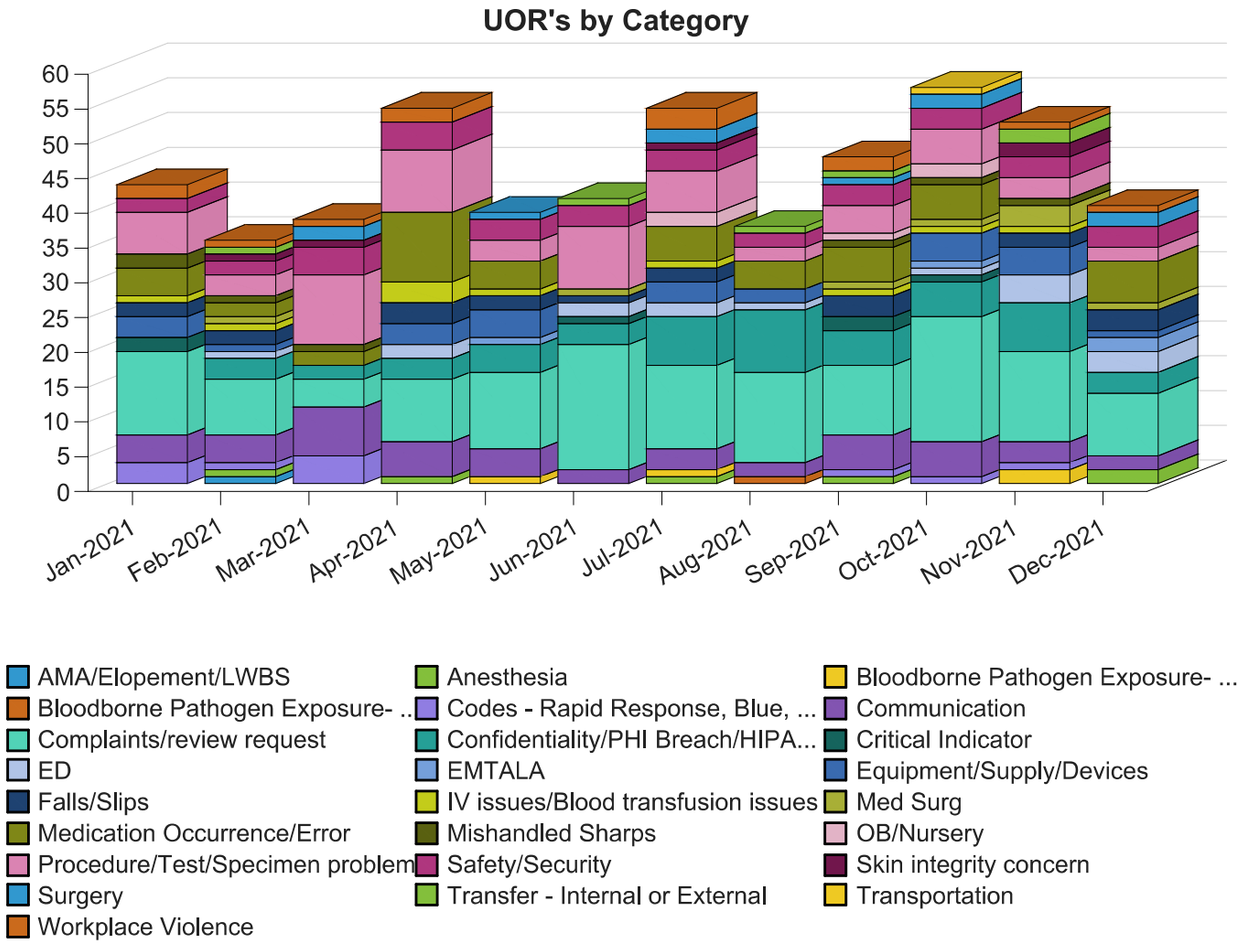
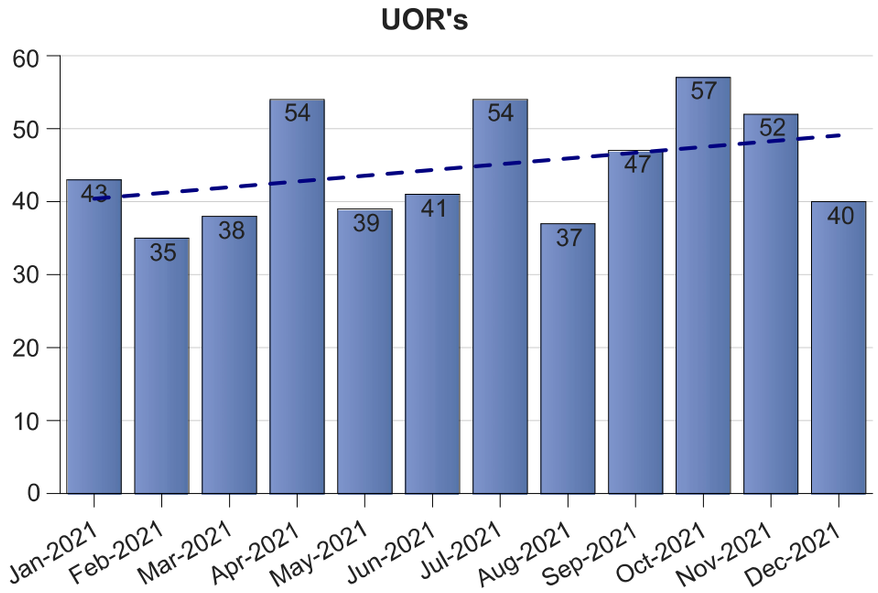
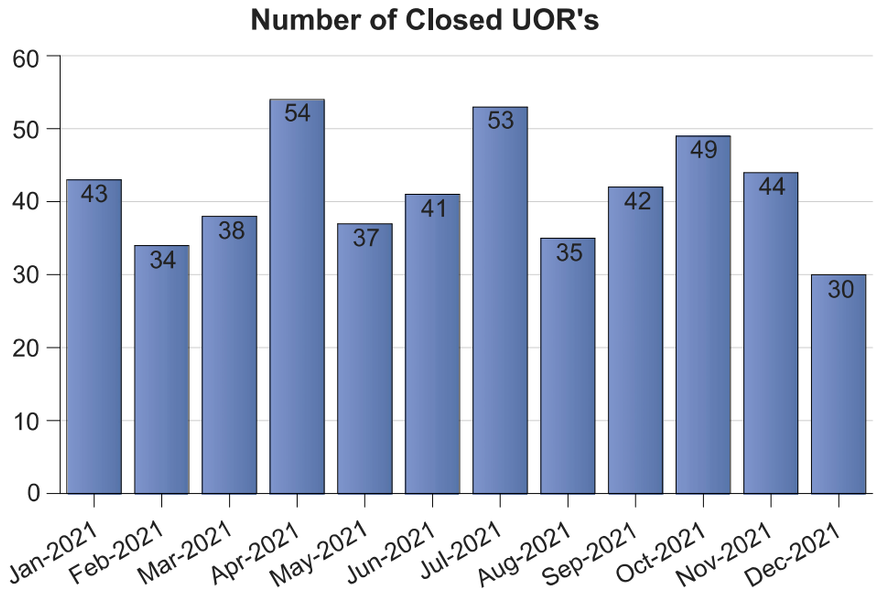

UOR's by Category
60
55
50
45
40
35
30
25
20
15
10
5
0
Jan-2021
Feb-2021
Mar-2021
Apr-2021
May-2021
Jun-2021
Jul-2021
Aug-2021
Sep-2021
Oct-2021
Nov-2021
Dec-2021
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
EMTALA
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

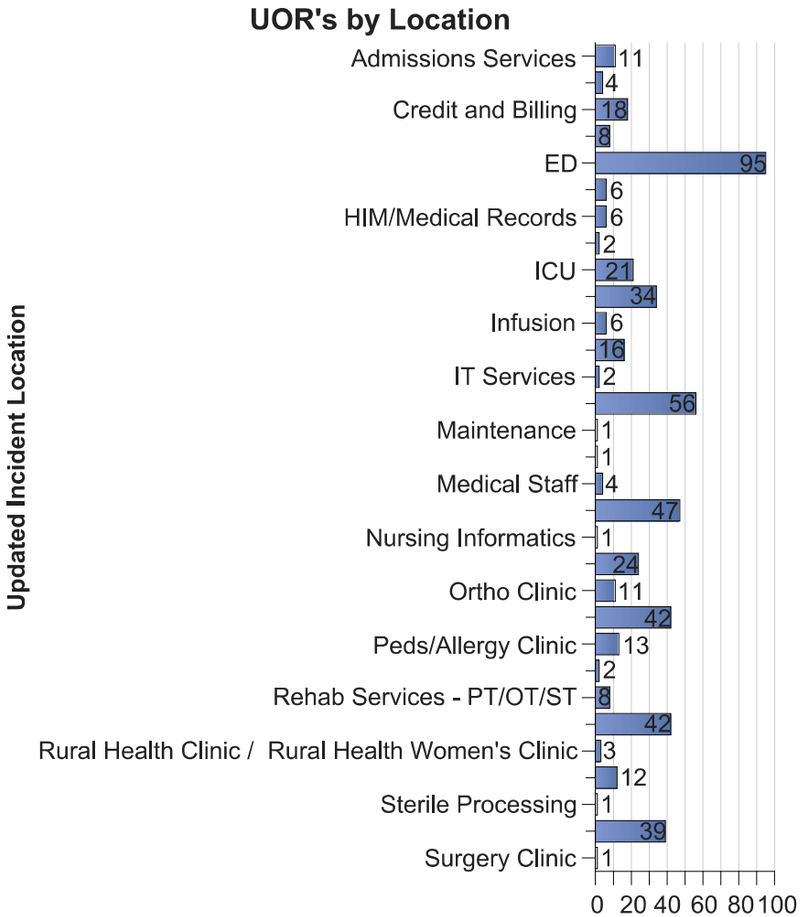
	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Total
AMA/Elopement/LWBS		1											**1**
Anesthesia		1		1			1		1			2	**6**
Bloodborne Pathogen Exposure- Sharps Injury					1		1				2		**4**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane								1					**1**
Codes - Rapid Response, Blue, Deescalation	3	1	4						1	1	1		**11**
Communication	4	4	7	5	4	2	3	2	5	5	3	2	**46**
Complaints/review request	12	8	4	9	11	18	12	13	10	18	13	9	**137**
Confidentiality/PHI Breach/HIPAA violation		3	2	3	4	3	7	9	5	5	7	3	**51**
Critical Indicator	2					1			2	1			**6**
ED		1		2		2	2	1		1	4	3	**16**
EMTALA					1					1		2	**4**
Equipment/Supply/Devices	3	1		3	4		3	2		4	4	1	**25**
Falls/Slips	2	2		3	2	1	2		3		2	3	**20**
IV issues/Blood transfusion issues	1	1		3	1		1		1	1	1		**10**
Med Surg		1				1			1	1	3	1	**8**
Medication Occurrence/Error	4	2	2	10	4		5	4	5	5		6	**47**
Mishandled Sharps	2	1	1						1	1	1		**7**
OB/Nursery							2		1	2			**5**
Procedure/Test/Specimen problem	6	3	10	9	3	9	6	2	4	5	3	2	**62**
Safety/Security	2	2	4	4	3	3	3	2	3	3	3	3	**35**
Skin integrity concern		1	1				1				2		**5**
Surgery			2		1		2		1	2		2	**10**
Transfer - Internal or External		1				1		1	1		2		**6**
Transportation										1			**1**
Workplace Violence	2	1	1	2			3		2		1	1	**13**
Total	**43**	**35**	**38**	**54**	**39**	**41**	**54**	**37**	**47**	**57**	**52**	**40**	**537**



Jan-2021	43
Feb-2021	35
Mar-2021	38
Apr-2021	54
May-2021	39
Jun-2021	41
Jul-2021	54
Aug-2021	37
Sep-2021	47
Oct-2021	57
Nov-2021	52
Dec-2021	40
Total	**537**



	Closed
Jan-2021	43
Feb-2021	34
Mar-2021	38
Apr-2021	54
May-2021	37
Jun-2021	41
Jul-2021	53
Aug-2021	35
Sep-2021	42
Oct-2021	49
Nov-2021	44
Dec-2021	30
Total	**500**



Admissions Services	11
Compliance	4
Credit and Billing	18
Dietary	8
ED	95
EVS	6
HIM/Medical Records	6
HR	2
ICU	21
Imaging	34
Infusion	6
Internal Medicine Clinic	16
IT Services	2
Lab	56
Maintenance	1
Med Surg Unit	1
Medical Staff	4
Medical Surgical Unit	47
Nursing Informatics	1
OB	24
Ortho Clinic	11
Other	42
Peds/Allergy Clinic	13
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	2
Rehab Services - PT/OT/ST	8
RHC / RHC Women's Clinic	42
Rural Health Clinic / Rural Health Women's Clinic	3
Specialty Clinic	12
Sterile Processing	1

Surgery	39
Surgery Clinic	1
Total	**537**

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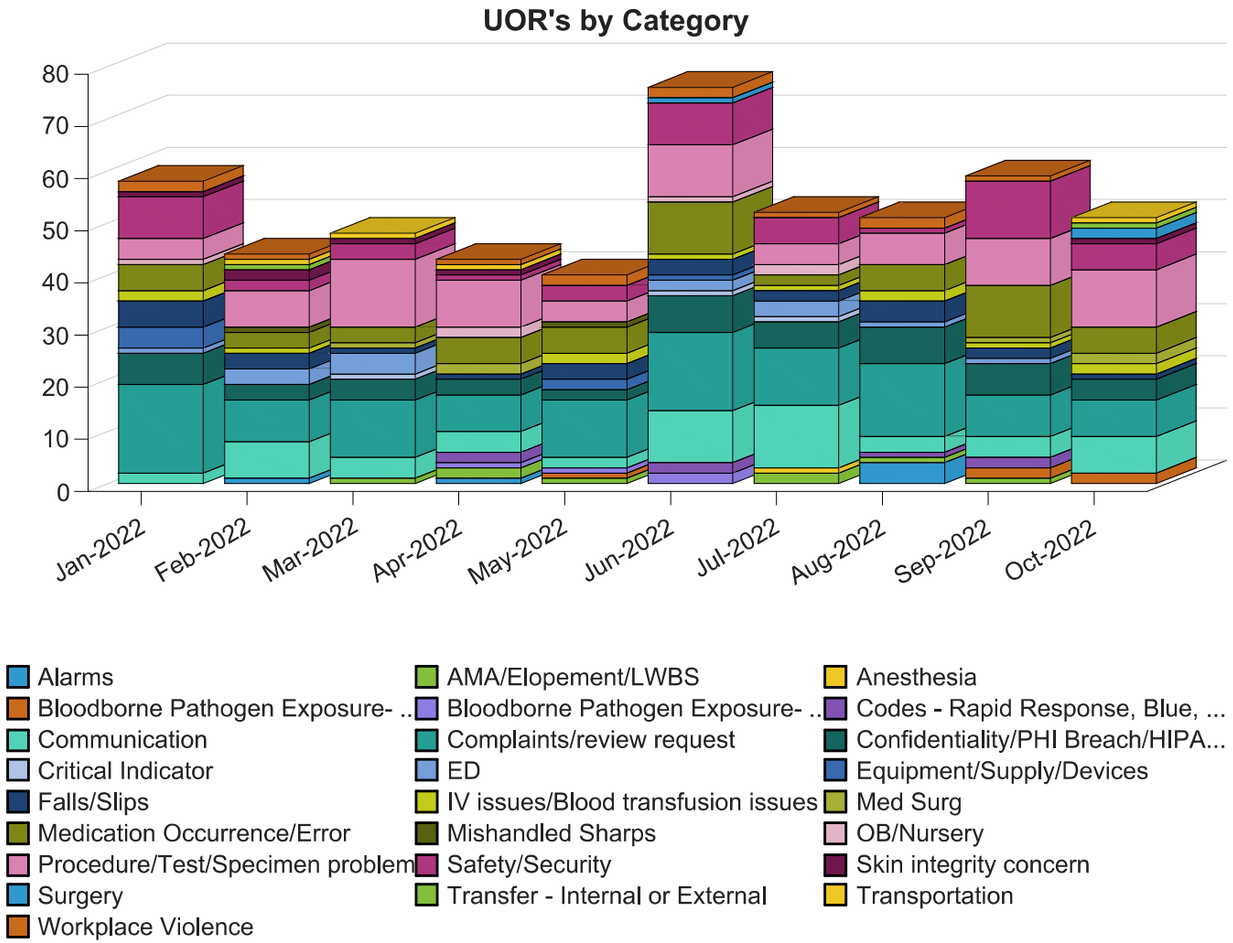
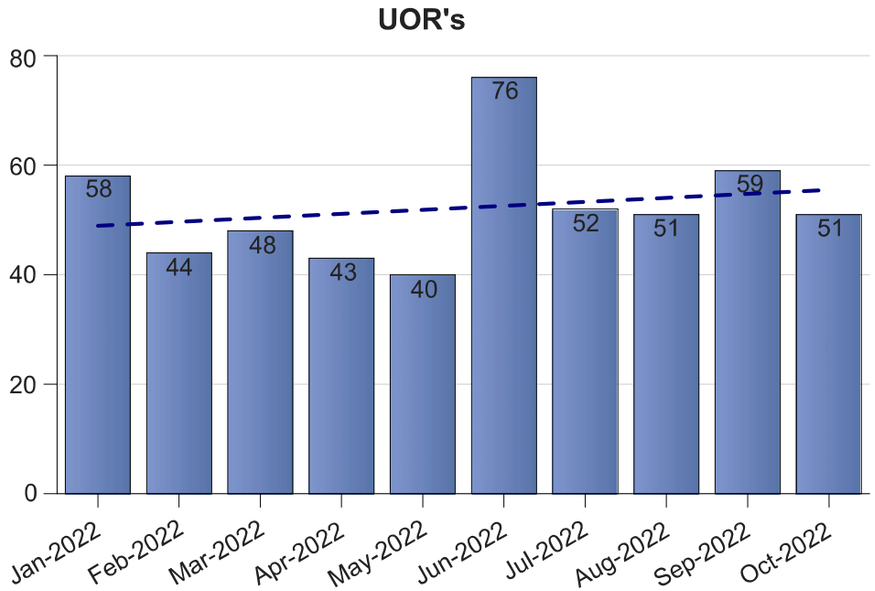
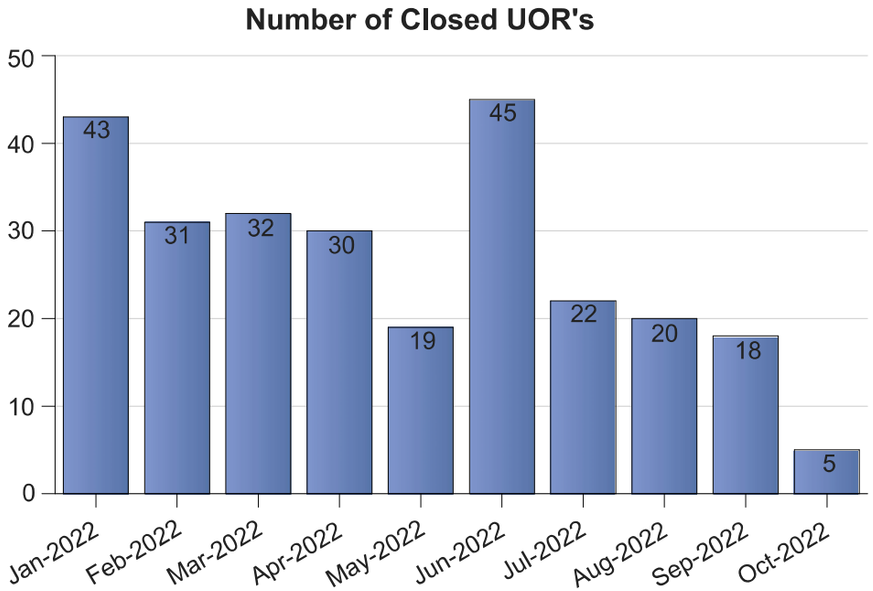

UOR's by Category
80
70
60
50
40
30
20
10
0
Jan-2022
Feb-2022
Mar-2022
Apr-2022
May-2022
Jun-2022
Jul-2022
Aug-2022
Sep-2022
Oct-2022
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ..
Bloodborne Pathogen Exposure- ..
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

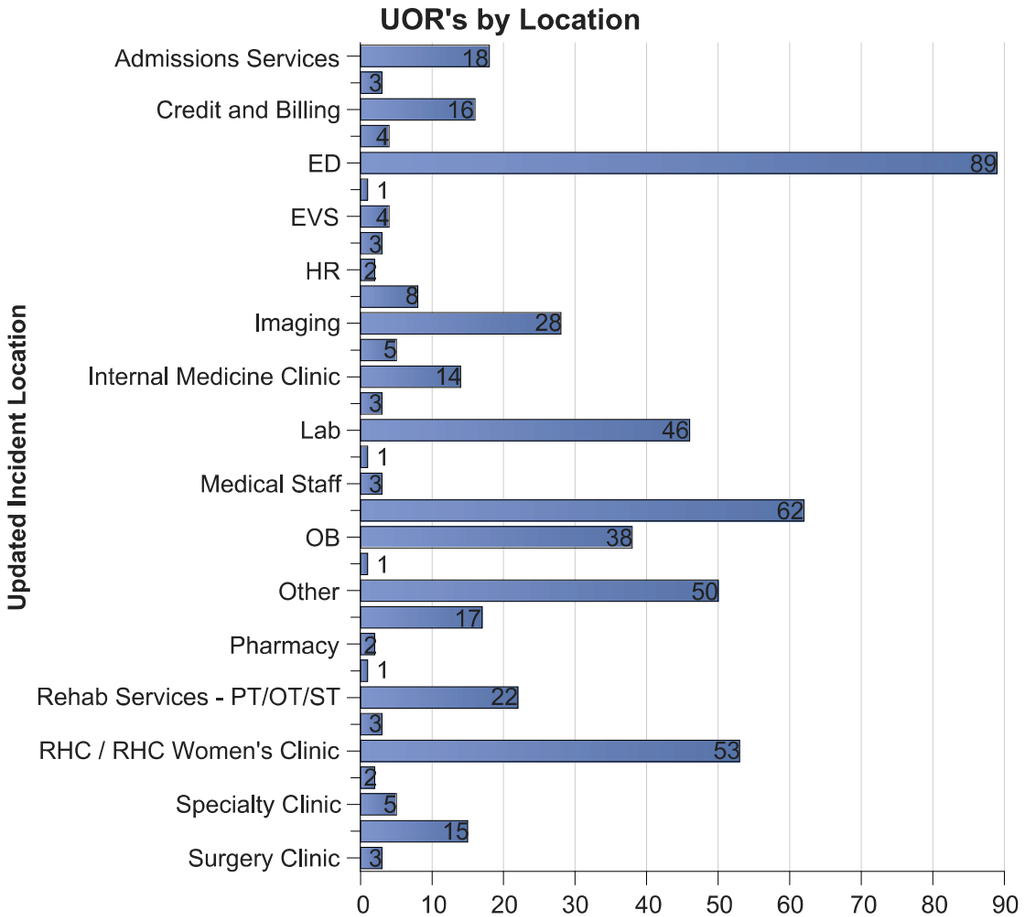
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Total
Alarms		1		1				4			**6**
AMA/Elopement/LWBS			1	2	1		2	1	1		**8**
Anesthesia							1				**1**
Bloodborne Pathogen Exposure- Sharps Injury					1				2	2	**5**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1	1	2					**4**
Codes - Rapid Response, Blue, Deescalation				2		2		1	2		**7**
Communication	2	7	4	4	2	10	12	3	4	7	**55**
Complaints/review request	17	8	11	7	11	15	11	14	8	7	**109**
Confidentiality/PHI Breach/HIPAA violation	6	3	4	3	2	7	5	7	6	4	**47**
Critical Indicator			1			1	1				**3**
ED	1	3	4			2	3	1	1		**15**
Equipment/Supply/Devices	4				2	1					**7**
Falls/Slips	5	3	1	1	3	3	2	4	2	1	**25**
IV issues/Blood transfusion issues	2	1			2	1	1	2	1	2	**12**
Med Surg			1	2					1	2	**6**
Medication Occurrence/Error	5	3	3	5	5	10	2	5	10	5	**53**
Mishandled Sharps		1			1						**2**
OB/Nursery	1			2		1	2				**6**
Procedure/Test/Specimen problem	4	7	13	9	4	10	4	6	9	11	**77**
Safety/Security	8	2	3	1	3	8	5	1	11	5	**47**
Skin integrity concern	1	2	1	1						1	**6**
Surgery						1				2	**3**
Transfer - Internal or External		1								1	**2**
Transportation		1	1	1						1	**4**
Workplace Violence	2	1		1	2	2	1	2	1		**12**
Total	**58**	**44**	**48**	**43**	**40**	**76**	**52**	**51**	**59**	**51**	**522**



Jan-2022	58
Feb-2022	44
Mar-2022	48
Apr-2022	43
May-2022	40
Jun-2022	76
Jul-2022	52
Aug-2022	51
Sep-2022	59
Oct-2022	51
Total	**522**



	Closed
Jan-2022	43
Feb-2022	31
Mar-2022	32
Apr-2022	30
May-2022	19
Jun-2022	45
Jul-2022	22
Aug-2022	20
Sep-2022	18
Oct-2022	5
Total	**265**



Admissions Services	18
Compliance	3
Credit and Billing	16
Dietary	4
ED	89
Employee Health	1
EVS	4
HIM/Medical Records	3
HR	2
ICU	8
Imaging	28
Infusion	5
Internal Medicine Clinic	14
IT Services	3
Lab	46
Med Surg Unit	1
Medical Staff	3
Medical Surgical Unit	62
OB	38
Ortho Clinic	1
Other	50
Peds/Allergy Clinic	17
Pharmacy	2
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1
Rehab Services - PT/OT/ST	22
Respiratory/Cardiopulmonary	3
RHC / RHC Women's Clinic	53
Rural Health Clinic / Rural Health Women's Clinic	2
Specialty Clinic	5

Surgery	15
Surgery Clinic	3
Total	**522**

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Pioneer Home Health Care
3rd Quarter Summary Report
November 16, 2022

I. Pioneer Home Health Care, Inc. 3rd Quarter Report

II. Statistics – Pioneer Home Health, Hospice and Personal Care Program

III. Brochures – Pioneer Home Health Care, Hospice and Personal Care Program

IV. Home Health Quality Assurance Performance Improvement (QAPI)

V. Hospice Quality Assurance Performance Improvement (QAPI)

VI. Community Outreach – Grief Support Group

VII. Fundraiser – See attached Flyers

Pioneer Home Health Care, Inc. (PHHC)

3rd Quarter Summary Report

November 16, 2022

Dear Distinguished NIHD Board Members,

Please see the attached summary of the services we have provided from January-September 2022:

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 July thru September 2022
58 admits
534 Visits
10,986 miles traveled – average 20.57 miles per HH visit
Present number of active patients = 28

Training is in progress for another layer of reimbursement introduced by Medicare, and is set to start January 1, 2023; Value Based Purchasing (VBP). Our internal services coordinator Sandra Johnson, and administrator Ruby Allen have been attending educational webinars and classes on the topic. Clinician training has started as well.

This reimbursement system will assign to the agency, either a bonus or a reduction of up to 5% of the total revenue per episode of care per patient. Medicare expects most agencies to end up in the middle, resulting in not much change in the reimbursement currently provided by the Patient Driven Grouping Model (PDGM) reimbursement system. VBP pits agencies across the country against one another, with not much differentiation between small or large companies.

The plus side of VBP is that it is more goal oriented, and patient satisfaction driven. The results will rely partially on patient satisfaction, via survey findings.

VBP will also be based on admit and discharge assessments on all home health patients with Medicare as the payer source. Patient progress must be shown in order to receive up to a 5% additional payment, however, if this is not demonstrated; up to 5% can be taken away.

One VBP goal is the reduction of Emergency Room visits and re-hospitalizations, therefore ER visits and unplanned hospital admissions will play a larger, negative role in home health care reimbursement through VBP.

An updated standardized assessment tool with standard data elements is also being introduced by Centers for Medicare and Medicaid Services (CMS): Oasis E, which is set to go live on January 1, 2023. It will replace the current OASIS D1, the current assessment tool used for home health services. According to CMS the comprehensive assessment tool was revised to increase standardization across post-acute care settings to uniformly collect social determinants of health data, and to have a standardized quality measure that can be used across different care settings. Our case managers are already training on the changes, and updates to our electronic medical record (EMR) are in progress as well.

SHP, our (new to us) OASIS "scrubber" analytic tool for home health services, is proving to be worth what it cost to change from our previous analytic tool; Home Health Gold. SHP has proven to allow much more accurate functional assessments of Medicare patients, and helps to identify needs, which results in appropriate reimbursement in order to meet those needs. This gives us the ability to plot out appropriate care for each individual, in order that we can provide the necessary care so that they can meet their home health goals.

The PHHC admission packet for home health services has been updated and it has been well received by patients. Its' "easy on the eye" look will hopefully encourage greater compliance in setting home health goals, participating in home exercise plans, medication compliance, medical provider follow up and follow through with disease management instructions.

Our program pamphlets which present each of our three programs; Home Health Care, Hospice and our Personal Care Program have been updated, with a softer, cleaner look as well. We are also currently working on our web site, which may possibly include a new logo and will echo the pamphlets' softer cleaner look.

Care Plan Updates: We are continuing to work on adding specific nursing care plans into our EMR; Ndoc. This will allow our nurses to be able to tailor their care plans to specific patient needs in order to provide quality care, improve efficiency and improve patient outcomes. Specific Speech Therapy and Occupational Therapy care plans are in progress as well.

We have been working with NIH, Medical Director Dr. Joy Engblade to have the proper documents in place in order to be able to accept Nurse Practitioner (NP) and Physician Assistant (PA) home health orders. Historically we have only been able to accept MD orders for home health care services, which has caused a lot of frustration and at times a delay in care. As of the last week of October, thanks to hard work from multiple people at NIH and PHHC administration, we are now able to accept NP and PA

home health orders, which is monumental. This is one positive change that came out of the Covid Emergency Temporary Standards.

Hospice of the Owens Valley Program

Statistics for July thru September 2022

14 Hospice Patients served with 91 home visits this quarter
Average length of stay (LOS) = 74.21 days
1562 miles traveled – average miles traveled per HOS visit = 17.16
Present number of HOS patients = 1

Our no-cost community grief support groups lasting 7-8 weeks at a time, have been provided to the community three times this year. Led by hospice chaplain Patrick Thompson, the support group has been very well received, and has been specifically sought out by those in need. We now keep a running waiting list of interested participants for the next time the support group is offered. We are proud to say this is our first year that our fund raising efforts have been successful in meeting our goal of being able to provide three support groups in a year.

In lieu of developing a brick and mortar thrift store to benefit hospice (per our strategic plan) we have developed a social media Facebook page called Hospice of the Owens Valley Virtual Thrift Store. To date we have received donations for several items we have offered on the site for sale. It is being managed internally, and has proven to be a small but successful endeavor. We are working toward more frequent postings in order to increase our followers.

We have been successful in holding multiple yard, garage and estate sales this year, thanks to the wonderful, strong but few hospice volunteers. We acknowledge their support and hard work in making the many wonderful things hospice provides possible. Here are upcoming Hospice fundraising events:

Light Up a Life Event

This special event will be held outdoors at our 363 Academy office location in Bishop, on December 1st, at 5:30 PM, and includes a special tree lighting ceremony. The entire community is invited to attend. This event provides the opportunity for those wanting to honor, remember or memorialize a loved one, while supporting the good works of hospice care. A donation of $10 will place a light on the tree in honor, or memory of your loved one. Weather permitting we will have music, a memory ornament craft, open fire pits for marshmallow roasting and more.

St. Nick's Christmas Craft Market

Hospice will be participating in the Tri-county Fairgrounds Christmas market, as part of their fundraising efforts. Held in the Heritage Arts Building, from 8:00 am to 3:00 pm on Saturday December 3rd, the event is open to all.

Polar Express

We invite you and your family to the Bishop Twin Theatre (wear jammies!) on December 18th at 1:00 pm, to enjoy the wonderfully, magical tale of the Polar Express train. Meet the conductor in person, and get a free magical bell if dressed appropriately for the occasion. Donation is $10 per person, and the snack bar will be open.

Christmas Gift Tree Raffle

One lucky winner will win a beautifully decorated tree, including all of the donated gift cards that "decorate" it. Last year the tree was valued at over $800, and this year, although we are still collecting donations to add to the tree, we are confident the tree will be valued over $1,000. We are already selling raffle tickets for a donation of $5 for one ticket, or $20 for five tickets. The winning tickets can be obtained at 363 Academy Ave, M-TH 0800-5:00, or Friday 0800-12:00 noon. The winner will be chosen on December 19th at noon.

Personal Care Program (PCP)

Statistics for July thru September 2022

Present number of active clients 22
Staffing: currently have 12 caregivers
2,135 hours of caregiving have been provided to the community members in the 3rd quarter

As the only licensed home care agency in the area, we pride ourselves in being the safest choice and the best choice for care in the home, in the area. Continuing education, and injury and illness prevention in-services are provided to PCP staff quarterly.

The staff of this program have each been provided with new uniform tops, which helps to distinguish them above the rest, and provides for a professional appearance. This is the first time our agency has splurged on uniforms, but considering our "under the table" competition, we felt it was wise to invest in our appearance and our staff. This also should help the staff with their uniform budgets, an added benefit to them.

Despite adding paid travel time and mileage between clients, and deminimis time to procure work, paid cell phone use to procure work, the program is still in high demand, with less loss shown compared to the last 2 years. We currently have a waiting list for our services, and hope that as staffing improves we will be able to meet the community need for this valuable service.

With the creation of PCP Per Diem positions, our current starting wage was increased, with a focus on the hourly rate vs providing benefits. However due to our overhead, it remains difficult to compete with "under the table" providers. Our $26/hr rate for home care is all that we feel the local market can bear.

We have not made much progress in procuring third party payers for the home care service. We will continue to work on this project.

Agency Wide:

Since successfully passing the Home Health California Department of Public Health (CDPH) survey, we are preparing for the upcoming Hospice survey expected later this year.

CPR certifications are being renewed and updated this November.

A 401K opportunity is now being offered to all staff, regardless of the amount of hours the employee works, in compliance with the new California state law enacted this year.

Multiple Quality Assurance Performance Improvement (QAPI) projects for both the Home Health and Hospice are in process.

Strategic planning for the agency will be delayed until next year.

Policy and Procedure manual review will begin in late November.

The agency continues to work short staffed and needs a full and/or part time nurse, Per Diem care givers, certified nursing assistants, and part time/Per Diem speech and physical therapists.

Respectfully submitted by

Ruby Allen RN, Administrator

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

for period ending 12/31/22

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
Acute Rehab - Carson													0
Acute Rehab - Renown Health			1			1							2
Acute Rehab - Other			1		1				1				3
Clinic - Mammoth Lakes Fam Med						1		1					2
Clinic - Rural Health NIH	3	2	1	2	1			4	7				20
Clinic - SIH				2									2
Clinic - Toiyabe	2	1	1		2	2	1	1	1				11
Family / Friend / Self													0
Hospital - Carson/Tahoe		2				2		1	1				6
Hospital - Glendale Adventist	1				1								2
Hospital - Loma Linda													0
Hospital - Mammoth Lakes	2		3		2			1					8
Hospital - Northern Inyo	13	8	7	6	3	3	6	5	2				53
Hospital - Renown Medical Center		2		2	1	1	3	2	2				13
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - NIH Observation			3	4	4	4	5	3	4				27
Hospital - UCLA Medical Center						1							1
Hospital - USC / Keck Med								1	1				2
Hospital - St Mary's							1						1
Hospital - other	1		1	1	1	3	3		2				12
Other													0
Physicians' Office Local	5	2	2	2	3	2		3					19
Physicians' Office Out-of-Counties		1											1
SNF - Bishop Care Center	1	4	4	7	4	2	5	4	3				34
SNF - Southern Inyo	1												1
SNF - Other			1	1	1	1							4
Another HH Agency													0
Workers Comp Insurance													0
Totals	29	22	25	27	24	23	24	26	24	0	0	0	224

Home Health Referral History

for period ending 12/31/22

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
2022	29	22	25	27	24	23	24	26	24	0	0	0	224
2021	21	19	23	25	1	16	18	18	16	19	15	15	206
2020	14	21	24	18	25	32	29	37	25	20	22	24	291
2019	16	21	19	15	1	19	14	20	12	22	23	16	198
2018	11	13	12	23		12	13	12	14	33	19	13	175
2017	16	12	14	21	2	15	12	16	13	13	12	11	157
2016	29	15	30	20	19	27	12	17	14	15	15	16	229
2015	22	27	19	27	21	30	26	21	17	18	18	18	264
2014	34	28	25	23	1	17	38	22	25	22	23	24	282
2013	34	27	26	28	15	29	17	17	36	27	21	27	304
2012	25	26	24	26	2	18	22	21	24	26	24	23	261
2011	26	25	34	6	3	33	26	22	23	16	21	23	258
2010	28	22	29	2	1	25	20	26	22	31	26	28	260
	305	278	304	261	115	296	271	275	265	262	239	238	3109
				4	4								
Average q mo:	25	23	25	22	10	25	23	23	22	22	20	20	
					3								
				7	4								
				1									

Pioneer Home Health Care
2022 Home Health Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Blue Cross													
SN					2	1	2	1	2				8
PT						2	2	4					8
OT					1	4	1	4	3				13
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	3	7	5	9	5	0	0	0	29
Supplies													0
Blue Shield													
SN													0
PT							2	3					5
OT													0
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	0	0	2	3	0	0	0	0	5
Supplies													0
Other Insurance													
SN													0
PT													0
OT													0
ST													
MSW													0
CHHA													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
Medicare													
SN	53	48	36	40	31	23	24	36	43				334
PT	40	61	79	67	53	62	66	68	49				545
OT	11	31	36	53	66	66	65	61	45				434
ST			2										2
MSW	2	6	4	4	8	4	5	2	4				39
CHHA													0
Totals	106	146	157	164	158	155	160	167	141	0	0	0	1354
Supplies	165	95	85	85	155	30	75	120	85				895

Pioneer Home Health Care
2022 Home Health Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
Workmans Comp													
SN					1								1
PT					1								1
OT					2								2
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	4	0	0	0	0	0	0	0	4
Supplies													0
Medi-Cal Managed Care													
SN	10	4	3	4	1	1							23
PT	8	4	6	5	5	1		1	5				35
OT	8	3		7	4	3							25
ST	1	3											4
MSW	2		2										4
CHHA													0
Totals	29	14	11	16	10	5	0	1	5	0	0	0	91
Supplies						20			20				40
Medicare Advantage													
SN	6		5	3	2	2	1	3					22
PT	2		8	2	2		1	7	4				26
OT			1	9	2	1	1	10	7				31
ST													0
MSW													0
CHHA													0
Totals	8	0	14	14	6	3	3	20	11	0	0	0	79
Supplies	105		20					120					245
Patient Pay													
SN		2	2			3	2	1					10
PT													0
OT													0
ST													0
MSW													0
CHHA													0
Totals	0	2	2	0	0	3	2	1	0	0	0	0	10
Supplies													0

Pioneer Home Health Care
2022 Home Health Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
PHHC HH Charity Care													
SN													0
PT													0
OT													0
ST													0
MSW													0
CHHA													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
2022 HHA VISIT TOTALS													
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
SN	69	54	46	47	37	30	29	40	45	0		0	398
PT	50	65	93	74	61	65	71	83	58	0	0	0	620
OT	19	34	37	69	75	74	67	75	55	0	0	0	505
ST	1	3	2	0	0	0	0	0	0	0	0	0	6
MSW	4	6	6	4	8	4	5	2	4	0	0	0	43
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**143**	**162**	**184**	**194**	**181**	**173**	**172**	**200**	**162**	**0**	**0**	**0**	**1572**
Supplies	270	95	105	85	155	50	75	240	105	0	0	0	1180
													1571

Pioneer Home Health Care
2022 Home Health Visits

Home Health Visits
through December 2022

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
SN	69	54	46	47	37	30	29	40	45	0	0	0	397
PT	50	65	93	74	61	65	71	83	58	0	0	0	620
OT	19	34	37	69	75	74	67	75	55	0	0	0	505
ST	1	3	2	0	0	0	0	0	0	0	0	0	6
MSW	0	6	6	4	8	4	5	2	4	0	0	0	39
CHHA	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**139**	**162**	**184**	**194**	**181**	**173**	**172**	**200**	**162**	**0**	**0**	**0**	**1567**
													1567
									Average visits per month =		**174**		
2021	141	143	128	167	133	116	133	137	146	129	114	110	**1597**
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**

Pioneer Home Health Care
2022 Home Health Miles

Average Miles and Visits through December 2022

		YTD # of Visits	YTD # of Miles	Ave MI Per Visit	
SN		397	7570	19.07	
PT		620	10841	17.49	
OT	0	505	7175	14.21	
ST		6	93	15.50	
MSW		39	725	18.59	
CHHA		0	0	0.00	
TOTALS		1567	26404	16.85	

	Prior Miles	New Monthly Miles	SUMS
SN	6726	844	7570
PT	9945	896	10841
OT	6451	724	7175
ST	93		93
MSW	683	42	725
CHHA			0
Totals	23898	2506	26404

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

for period ending 12/31/22

	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	1	2	3		2	1		1	3				13
Clinic - SIH													0
Clinic - Toiyabe						1	1						2
Family / Friend / Self													0
Hospital - Carson/Tahoe													0
Hospital - Glendale Adventist													0
Hospital - Loma Linda													0
Hospital - Mammoth Lakes													0
Hospital - Northern Inyo													0
Hospital - Renown Medical Center													0
Hospital - Sierra Surg - Carson													0
Hospital - Southern Inyo													0
Hospital - St. Mary's	1												1
Hospital - UCLA Medical Center													0
Hospital - USC / Keck Med													0
Hospital - VA													0
Hospital - Other			1										1
Other													0
Physicians' Office Local	1	1			1	1							4
Physicians' Office Out-of-Counties													0
SNF - Bishop Care Center								1					1
SNF - Southern Inyo													0
SNF - Other													0
Another Hospice Agency													0
Totals	3	3	4	0	3	3	1	2	3	0	0	0	22

S:\PHHC Secure Documents\EFINANCE\Referrals\Referrals 2022

Hospice Referral History

for period ending 12/31/22

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
2022	3	3	4	0	3	3	1	2	3	0	0	0	22
2021	0	6	1	3	1	3	3	2	3	1	4	2	29
2020	3	3	4	0	3	3	1	2	3	0	0	0	22
2019	5	2	3	2	1	2	3	3	2	0	5	1	29
2018	3	5	0	2		1	3	4	0	3	5	3	29
2017	1	1	0	0	2	6	0	2	3	0	2	3	20
2016	0	0	0	1	0	1	3	1	0	2	0	0	8
	15	20	12	8	1	19	14	16	14	6	16	9	150
Average q mo:	3	3	2	1	2	3	2	3	2	1	3	2	

17.33333 13

Pioneer Home Health Care
2022 Hospice Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
HOS Blue Cross													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain	0												0
Bereavement													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Regular Supplies													0
HOS Blue Shield													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
HOS Other Insurance													
SN													0
PT													0
OT													
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
HOS Medicare													
SN	20	24	47	21	31	40	32	21	12				248
PT													0
OT							1		1				2
MSW	4	3			1	5	1	1	3				18
Aide	3	3				2	1						9
Chaplain	14	15			15	14	12	2	4				76
Totals	41	45	47	21	47	61	47	24	20	0	0	0	353
Supplies	5					15			105				125

Pioneer Home Health Care
2022 Hospice Visits

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
HOS PHHC Charity Care													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies													0
HOS Medi-Cal Managed Care													
SN			6	1									7
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	6	1	0	0	0	0	0	0	0	0	7
Supplies													0
HOS Medicare Advantage													
SN													0
PT													0
OT													0
MSW													0
Aide													0
Chaplain													0
Totals	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies	105												105
2021 HOSPICE VISIT TOTALS													
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
SN	20	24	53	22	31	40	32	21	12	0	0	0	255
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	1	0	1	0	0	0	2
MSW	4	3	0	0	1	5	1	1	3	0	0	0	18
Aide	3	3	0	0	0	2	1	0	0	0	0	0	9
Chaplain	14	15	0	0	15	14	12	2	4	0	0	0	76
Bereavement	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**41**	**45**	**53**	**22**	**47**	**61**	**47**	**24**	**20**	**0**	**0**	**0**	**360**
Supplies	110	0	0	0	0	15	0	0	105	0	0	0	**230**

Pioneer Home Health Care
2022 Hospice Visits

Hospice Visits

through December 2022

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
SN	20	24	53	22	31	40	32	21	12	0	0	0	255
PT	0	0	0	0	0	0	0	0	0	0	0	0	0
OT	0	0	0	0	0	0	1	0	1	0	0	0	2
MSW	4	3	0	0	1	5	1	1	3	0	0	0	18
Aide	3	3	0	0	0	2	1	0	0	0	0	0	9
Chaplain	14	15	0	0	15	14	12	2	4	0	0	0	76
Bereavement	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**41**	**45**	**53**	**22**	**47**	**61**	**47**	**24**	**20**	**0**	**0**	**0**	**360**

Average visits per month = **41.0**

2021	3	16	36	37	29	33	27	33	22	16	49	42	**343**
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-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	YTD
													0

Hospice Visits - Volunteers

2021													
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
	165												

Pioneer Home Health Care
2022 Hospice LOS

Length of Service

through December 2022

MR#	INS	SOC Date	D/C or Death Date	LOS	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	TOTAL	LOS carry over
[redacted]	HOS MC	[redacted]	[redacted]	446	31	28	31	30	31	30	31	14					226	220
	HOS MC			300	31	28	31	30	31	30	26						207	93
	HOS MC			81	31	7											38	43
	HOS MC			14	14												14	
	HOS MC			4	4												4	
	HOS MC			6		4	2										6	
	HOS MC			107		28	31	30	18								107	
	HOS MC			232		18	31	30	31	30	31	31	30				232	
	HOS MC			47		25	22										47	
	HOS MC			103			18	30	31	24							103	
	HOS MC			6			6										6	
	HOS MCMC			11			6	5									11	
	HOS MC			27					6	21							27	
	HOS MC			57					15	30	12						57	
	HOS MC			85						23	31	31					85	
	HOS MC			118					26	30	31	31					118	
	HOS MC			55						30	25						55	
	HOS BX			3						3							3	
	HOS MC			17							17						17	
	HOS MC			12								12					12	
	HOS MC			5								5					5	
	HOS BX			1									1				1	
	HOS MC			2									2				2	
	HOS MC			14									14				14	
					111	138	178	155	189	251	204	124	47	0	0	0	1397	356

Redacted by NIHD Compliance

		YTD Active & Closed	
Closed only		This Yr Only	1397
Total LOS	1164	Total LOS	1706
# of Patients	22	# of Patients	24

Pioneer Home Health Care
2022 Hospice LOS

	52.91		**All Pts Ave.**	71.08														

Pioneer Home Health Care
2022 Hospice Mileage

Average Miles and Visits					
through December 2022					
		YTD	YTD		
		# of Visits	# of Miles	Ave MI Per Visit	
SN		255	3363	13.19	
PT		0	0	#DIV/0!	
OT	0	2	33	16.50	
MSW		18	148	8.22	
Aide		9	74	8.22	
Chaplain		76	1605	21.12	
Bereavement		0	0	#DIV/0!	
TOTALS		360	5223	14.51	
			Prior	New Monthly	SUMS
			Miles	Miles	
SN			3158	205	3363
PT					0
OT			30	3	33
MSW			136	12	148
Aide			74	0	74
Chaplain			1590	15	1605
Bereavement					0
		Totals	4988	235	5223

Pioneer Home Health Care
Personal Care Program Hours

For period ending January 31, 2022

	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	203.25	154.50	162.00	154.37	176.75	197.18	201.00	194.09	218.00	271.98	195.84	162.08
PCA Billable Hours @$26.00	42.33	49.00	52.00	67.25	110.25	119.50	206.54	91.00	115.00	114.17	109.33	111.59
PCA Billable Hours @$30.00	50.50	61.00	43.00	51.00	57.18	60.00	55.00	52.00	54.00	68.50	49.00	54.75
Total Billable Hours	296.08	264.50	257.00	272.62	344.18	376.68	462.54	337.09	387.00	454.65	354.17	328.42
PCA Billable Chgs @$25.00	5081.25	3862.50	4050.00	3859.25	4418.75	4929.50	5025.00	4852.25	5450.00	6799.50	4896.00	4052.00
PCA Billable Chgs @$26.00	1100.58	1274.00	1352.00	1748.50	2866.50	3107.00	5370.04	2366.00	2990.00	2968.42	2842.58	2901.34
PCA Billable Chgs @$30.00	1515.00	1830.00	1290.00	1530.00	1715.40	1800.00	1650.00	1560.00	1620.00	2055.00	1470.00	1642.50
Total Billable Chgs	7696.83	6966.50	6692.00	7137.75	9000.65	9836.50	12045.04	8778.25	10060.00	11822.92	9208.58	8595.84

	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	158.83	145.50	167.92	205.42	179.09	196.91							
PCA Billable Hours @$26.00	107.50	109.75	132.17	198.50	165.67	172.58							
PCA Billable Hours @$30.00	52.50	51.58	55.00	59.00	23.50	0.00							
Total Billable Hours	318.83	306.83	355.09	462.92	368.26	369.49	0.00	0.00	0.00	0.00	0.00	0.00	6316.35
PCA Billable Chgs @$25.00	3970.75	3637.50	4198.00	5135.50	4477.25	4922.75	0.00	0.00	0.00	0.00	0.00	0.00	
PCA Billable Chgs @$26.00	2795.00	2853.50	3436.42	5161.00	4307.42	4487.08	0.00	0.00	0.00	0.00	0.00	0.00	
PCA Billable Chgs @$30.00	1575.00	1547.40	1650.00	1770.00	705.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Total Billable Chgs	8340.75	8038.40	9284.42	12066.50	9489.67	9409.83	0.00	0.00	0.00	0.00	0.00	0.00	164470.43

Hours by Month:

January	560.58
February	529.62
March	720.86
April	799.63
May	841.65
June	682.59
July	625.66
August	818.01
September	737.75
October	0.00
November	0.00
December	0.00
	6316.35

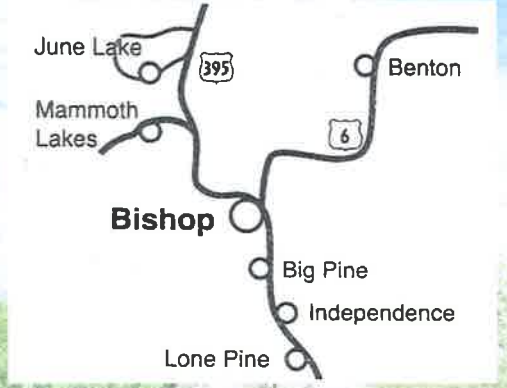
PCP Hours 22, 21, 20

Our Philosophy

We are a freestanding, community based, nonprofit 501(c)(3) organization. Our philosophy at Pioneer Home Health Care is to provide high quality, professional service which allows patients to remain in, or return to, their homes. We believe the home environment enhances wellness, speeds recovery and allows patients and families to participate in health maintenance, care and rehabilitation.

Where Services are Provided

Services are available from Lone Pine to June Lake



We do not discriminate on the basis of race, color, religion, age, gender, sexual orientation, disability, communicable disease, or place of national origin.

Pioneer Home Health Care, Inc.
363 Academy Avenue
Bishop, California 93514

Pioneer Home Health Care

We Bring Health Care Home

The Eastern Sierra's Only Licensed Home Health Care Agency

363 Academy Avenue
Bishop, California 93514
Phone: 760/ 872-4663

FAX: 760/872-4665
www.pioneerhomehealth.com

"There Is No Place Like Home"

When you are not feeling well, there is no place like home. Whether you are recovering from a short term illness or have chronic medical needs, Pioneer is there to provide compassionate, quality health care at home. We work hand-in-hand with your doctor and the health care community for a smooth care continuum.

"We Bring Health Care Home"

Pioneer is recognized as one of the top home health care agencies in the United States.

HomeCare Elite

We are…

- California State Licensed
- Medicare Certified
- Bishop Chamber Member

We are a member of…

- California Association for Health Services at Home

CAHSAH
Shaping the Future of Home Care

Ask your doctor if Home Health Care is the right care for you

Our services include, but are not limited to the following:

Skilled Nursing Care

- Skilled medical assessments and treatments
- Instruction in disease management
- Wound and ostomy care/teaching
- Intravenous and enteral therapy administration/teaching
- Pain management
- Medication education

Rehabilitation Therapists

- Home safety evaluation
- Identify appropriate durable medical equipment for safe completion of activities of daily living
- Develop a personalized home exercise plan, along with interventions to improve functional strength, mobility, and balance

Social Services

- Social and emotional support related to issues of illness and need for care
- Assistance to identify and implement community and financial resources

Home Health Aides

- Personal care and bathing assistance to facilitate medical recovery

Services are available

We are here seven days a week, including holidays, in most locations. A nurse is available by phone during non-office hours.

Our office hours are from:

8:00am to 5:00pm
Monday thru Thursday
And
8:00am to noon
on Fridays

Home health care is a covered benefit under Medicare and most private insurance plans. We will verify insurance coverage and bill the appropriate insurer on your behalf. The payment received from some government programs does not cover the cost of providing the care. For that reason, Pioneer also relies upon grant funding and community support for donations.

Hospice Services

Personalized healthcare, coordinated by your doctor and our hospice team of professionals

Medication, supplies and equipment related to the terminal illness

Nursing visits to the home for symptom management as needed with 24/7 phone access.

Specialized training for family members and caregivers on how to address comfort needs

Assistance with bathing and personal grooming

Volunteer assistance for compassionate support

Assistance with advance directives and memorial planning

Grief counseling and spiritual support for both the individual and the family

Insurance billing to Medicare, Managed Care Medi-cal and Private Insurance providers

We do not discriminate on the basis of race, color, religion, age, gender, sexual orientation, disability, communicable disease, or place of national origin.

Hospice…Compassionate Support for Life's Journey.

Leave a Legacy

As a non-profit charitable corporation, we raise funds from donations, memorials, grants and special events. Your contributions expand our care resources. Including us in your personal Will or Trust, supports our continued services and provides for your own remembrance.

Please call us for more information

760/872-4663

Pioneer Home Health Care, Inc.

Hospice of the Owens Valley

Compassion for the Journey

The Eastern Sierras' Only Licensed Hospice Care Agency

363 Academy Avenue
Bishop, California 93514
Phone: 760/ 872-4663

FAX: 760/872-4665
www.pioneerhomehealth.com

Life's Most Important Journey Starts Here…

What is Hospice?

When someone you love has an advanced life-limiting illness, our Hospice team is there to offer options that maximize comfort and maintain dignity. Hospice treats the person instead of the disease, focuses on the whole family, and emphasizes quality of life instead of quantity. Hospice care allows terminally ill individuals and their families to experience the end of life journey together, in the comfort and security of their home setting.

What is the Focus of Hospice Care?

The focus of our hospice care is to ensure comfort during life's final stages, by managing complex symptoms and offering consistent emotional, physical, spiritual and practical support. We provide this care in the comfort, privacy and familiarity of your home.

When Should Hospice Care Begin?

After receiving a terminal diagnosis, it can take 3-6 months to progress through distinct physical, emotional, and spiritual stages. It is better to begin Hospice care early rather than later in order to fully benefit from our services.

Ask your doctor if Hospice Care is the right care for you

Hospice is not a place; it's a philosophy of compassionate care when life changes.

Which Doctor do I work with?

Our hospice team works with each individual's primary care physician. Our Hospice Medical Director is available to your doctor and the hospice care team as a consultant and a resource. Our hospice team of experts will regularly review your case with the primary focus on controlling symptoms and improving your quality of life.

Is Grief Counseling Available?

Yes. Bereavement is the time of mourning we all experience following a loss. Our hospice team will work with surviving family members to help them through this time. Our experienced grief counselors and trained volunteers provide support and education by phone, personal visits, or support groups.

How are Hospice Services Paid?

Medicare and Managed Care Medi-Cal require the patient to meet specific qualifications in order to be eligible for hospice, along with their primary care physician, and our Hospice Medical Directors' confirmation. Once approved, hospice services can begin and any hospice related costs will be covered by these insurances. Most private insurance plans have some form of hospice coverage as well.

Providing you
and your loved ones
Peace of Mind

Pioneer Home Health Care, Inc.
Personal Care Program
363 Academy Avenue
Bishop, California 93514

Pioneer Home Health Care, Inc.

Personal Care Program

Supporting Safe and Independent Living

The Eastern Sierra's Only
Licensed
Home Care Agency

363 Academy Avenue
Bishop, California 93514
Phone: 760/ 872-HOME

Phone: 760/872-4663
www.pioneerhomehealth.com

"Home is Best"

We are a community based, non-profit agency that has been serving the Owens Valley for over 30 years, and we are a valued partner of Northern Inyo Health Care district. We are the only licensed home care agency in the area. Our philosophy is to provide caring, high quality, and professional care, with the goal of allowing our clients to remain independent in their homes for as long as possible.
If you believe "there's no place like home", then let us help you stay there!

Utilize our creative care solutions to create your own schedule, and design your own personalized care program!

A proud member of:
California Asso. for Health Services at Home

CAHSAH
Shaping the Future of Home Care

We do not discriminate on the basis of race, color, religion, age, gender, sexual orientation, disability, communicable disease, or place of national origin.

What do you need help with?

These are some of the tasks that our Personal Care Attendants can assist you with!

- Prep/serve meals or snacks
- Assist with eating meals and fluids
- Following medical diet restrictions
- Run errands, do grocery shopping
- Kitchen clean up, wash and dry dishes
- Refrigerator clean up
- Basic laundry
- Bathroom cleanup
- Linen change and bedroom cleanup
- Light housekeeping, dusting and vacuuming
- Assist with toileting/catheter assistance
- Assist with showering and bathing
- Assist with dressing
- Assist with indoor or outdoor ambulation
- Accompany on outings/medical appointments
- Companionship

How To Find Out More

We would like the opportunity to explain our service in more detail, help you define your care needs, and to answer all of your questions.

Call today to schedule your free in-home consultation:

(760) 872-4663

While most personal care services are self-pay, some services may be covered by a veterans' program or a long term care insurance. If so, we can assist you with both the authorization and the billing process. Services are billed twice per month.

Services are available

We are here seven days a week, including holidays, in most locations.

Our office hours are from:
8:00am to 5:00pm
Monday thru Thursday
And
8:00am to noon
on Fridays

Pioneer Home Health Care, Inc.

Home Health Quality Assurance Performance Improvement (QAPI)

2022 Annual Report

Projects closed for the year:

1. Transition of Care project
2. Depression PHQ2 evaluation project
3. Prevention of Hospitalizations: Utilization Review project
4. Quality of Care Improvement project (to be revisited in future)
5. Vaccination Compliance project

Current Open Projects:

1. Utilization Review Process

   The Form used for Utilization Review has been updated, made to be more concise and clear, it also directs the reviewer as to where to find the items we are reviewing.

   All clinicians participate in this process and while providing chart review it also will be used as an educational tool to learn more about our electronic medical record Ndoc.

   Our goal of reviewing 40 charts was achieved. We plan to use the new UR form next year when we begin reviewing charts again. The group opted to keep this project open until we are satisfied with how the new form is working, and if we feel it is meeting the chart review requirements adequately. This project is for both home health and hospice.

2. Infection Control Tracking

   This project continues to work with our electronic medical record Ndoc, in an effort to track infections, such as skin, wound, respiratory, urinary tract or blood infections, and work on streamlined ways to log, and track new infections, much like we did on the Fall Report/tracking.

   This project relies on us working with Ndoc for answers, and our Internal Services Coordinator is working on this project as well as all clinicians. This project will continue to be open.

3. Code Status Reporting/Updating

   The issue of not having updated information regarding patients' code status was identified last year. Since then as a part of our weekly team conference, we address the code status of all patients, home health or hospice. Our daily census log is updated weekly, and as new admissions are added.

If the patient is a Do Not Resuscitate, we follow through with documentation to support this decision prior to logging the patient in as DNR in their chart.

We have had our MSWA follow up with patient code status choices, often time utilizing medical records to confirm their decision, or if necessary taking a photo of the POLST which is often time not recorded in any patient records but is in force with MD signature, and posted in the home. This photo becomes part of their medical record.

Adding wording to the home Health Care Intake form has aided the staff, as a reminder to ask the patient for this information upon admission. We have also included a request for any Advanced Health Care Directive (AHCD) form. This in turn is shared with the patients' provider and their medical record department. The team decided to keep this project open a bit longer.

4. Clinician Orientation Project:

This has been an ongoing project for many years. The onboarding process of training and orienting a new employee is very difficult and time consuming, and it reduces current clinician productivity, as they take time out to train a new employee.

We have switched our educational tools from Home Care Institute to Home Care Pulse, and have added training tools to the prepackaged educational material a new employee must view. Our electronic Medical Record is no longer new to us, but we continue to learn new ways to utilize it.

An employee orientation manual has been compiled for any new clinician, and has yet to be fully trialed by anyone. This project will be kept open, until staff feel out onboarding process has been improved and is efficient. This is for both home health and hospice programs.

5. Fall Prevention Plan:

This is an ongoing project since 2020. It has resulted in improved patient education tools, which we provide to the patient, and template care plans we can put into our electronic medical record for physical and occupational therapy.

We have also worked with our electronic medical record on clear ways to document any falls, and how to retrieve the information, and track/count falls, to assess for a reduction or increase in these adverse events.

This year we have not yet provided an analysis of the number of falls we have yet, and how we compare to prior years.

This project will also continue, as we have yet to test our interventions for an improvement or decline in falls reported.

Hospice of the Owens Valley

Quality Assurance Performance Improvement (QAPI)

2022 Annual Report

1. Chart Completion Project:
    - Our Interdisciplinary Group (IDG) compiled 12 charts to identify specific portions of the chart that may be missing, or neglected, and examined them as part of a QAPI chart audit. 10 of 12 charts were found to be complete, however 2 charts were missing some portion of documentation or could be improved upon.

    - A plan was make to complete chart audits on a more regular basis, and we narrowed down the specific deficits we were looking for: IDG notes, MD notification of cancelled visits, and more specific discharge summaries that include notification of death or revocation of hospice services to pharmacies: Delta Care RX, Dwayne's' Pharmacy, DME companies: Airway Medical, VA etc. and designated provider and Hospice Medical Director notifications.

    - 12 more charts were reviewed since June of 2021, and the 12 charts were found to have IDG concerns addressed and were complete.

IDG met and decided it was safe to close this project at this time. May choose to look at this again in the future following the next CDPH survey.

2. Medical Social Worker (MSW) and Chaplain Service Use:

    We ran a total year data report for the number of visits for both service types, at varying times from 2021-2022

    January 1, 2021 thru February 4, 2022- 36 admissions

- MSW- ratio visits per patient: .75
- Chaplain- ratio visits per patient: 2.95

September 16, 2021 thru February 4, 2022-14 admissions

- MSW- ratio visits per patient: .58
- Chaplain-ratio visits per patient: 3.93

March 1, 2022 thru October 31, 2022-16 admissions

- MSW-ratio visits per patient: 3.3
- Chaplain ratio visits per patient: 5.0

IDG chose to close this project, as MSW and Chaplain service are now being utilized appropriately. Plan to use patient education to promote these service options.

3. Filling all Hospice Positions:
    - Every position is currently filled, however in order to grow the Hospice program, additional nurses and Certified Home Health Aides (CHHA's) are required. We submitted a request and were approved by the CDPH to provide the CHHA class at our facility, for another 2 years.

IDG chose to close this project at this point, will focus on recruitment for staff, and volunteers in future QAPI projects.

4. Bereavement Program Process:
    - Our bereavement service report was updated in 2022, as well as our plan of care for all bereaved clients. There was a timeliness issue in implementation of the plan for bereaved clients, which has since resolved.
    - We are still interested in a different Bereavement Risk Assessment tool, however due to a lack of validated tools available, and the fact

that the tool is used in our Electronic Medical Record Ndoc, we will continue to use it.

IDG is provided an updated report on the status of the Bereavement Program monthly. While it is running smoother now, the team decided to continue with this project until we all felt it met quality standards.

5. Managing Mono County deaths:
    - IDG has decided to keep this project open, despite drastic improvements in how Mono Co deaths are handled in conjunction with the Mono Co Sheriff's office. Since late 2020, the Mono Co Sheriff's office has allowed our hospice nurses to pronounce the patient, in lieu of an officer having to be on site. From there the hospice nurse can notify the Coroner's office and proceed with the body removal process without use of paramedics, and further drama, during what is a very difficult time for the family.
    - We now have a Mono County Coroner's Report, which can be filled out in advance, and be used as a tool to help prepare the family for the patients' comfortable death home. This expedites the difficult procedure on the day of death.

There have been minimal deaths in Mono County that we have been involved with since this change in process. IDG opted to keep this project open.

6. Potential Future QAPI Projects:

    - Narcotic Safety and destruction/disposal of medications in the home.
    - Dyspnea/use of Oxygen, symptom management interventions
    - Volunteer recruitment
    - Staff recruitment

Grief Support Group

Fall of 2022

Sept. 29th (7-8week course)

Thursdays @ 6:00 pm

Grief support handbook provided

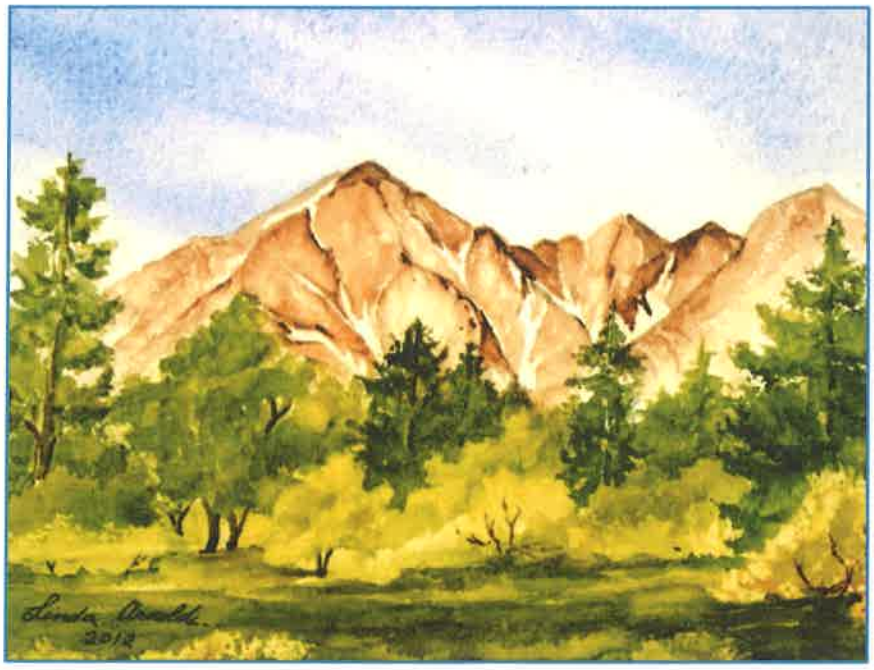
Contact: Patrick Thompson to sign up

760-872-4663

Space limited

Courtesy of Hospice of the Owens Valley

Donations Welcome



Light Up A Life

Hospice Tree Lighting Ceremony

Where friends and loved ones are honored, remembered or memorialized. Your gift of $10.00 will place a light on our tree in their honor while supporting the good works of hospice care.

Thursday, December 1st at 5:30pm
(dress warm!)

Pioneer Home Health Care, Inc.
363 Academy Street, Bishop

THE ENTIRE COMMUNITY IS WELCOME!

This event will include a memory slide show, make & take memory ornaments, music, fire pits,

Light Up A Life

Everyone is invited to the

Hospice Tree Lighting Ceremony

Where friends and loved ones are honored, remembered or memorialized. Your gift of $10.00 will place a light on our tree in their honor while supporting the good works of hospice care.

Thursday, December 1st, 2022 at 5:30pm (Dress Warm!)

at

Pioneer Home Health Care, Inc.
363 Academy Street, Bishop

Light refreshments will follow the ceremony

THE ENTIRE COMMUNITY IS WELCOME!

Donations for a light(s) on the Hospice Tree of Lights can be sent to

Hospice of the Owens Valley

363 Academy Avenue Bishop,
CA 93514

Enclosed is $ _____ for _____ lights (suggested donation of $10.00 per light)

Donated by: _____
Address: _____

In Memory of _____
Send acknowledgment to:

_____
_____
_____

In Honor of a living person:

_____

Send acknowledgment to:

_____
_____
_____

In Memory of _____
Send acknowledgment to:

_____
_____
_____

In Honor of a living person:

_____

Send acknowledgment to:

_____
_____
_____

– For Tax Deduction Purposes –
Hospice of the Owens Valley is a program of Pioneer Home Health Care, Inc. (a non-profit 501c(3) corporation)
Tax ID #: 77-0266099


Hospice of the
Owens Valley
ST. Nick's
Christmas Craft
Market
Saturday Dec. 3rd
8:00 am to 3:00 pm
Tri County Fairgrounds
Heritage Arts Building

Take a Ride on the

POLAR EXPRESS

at the Bishop Twin Theatre!

December 18, 2022
at 1:00pm
$10.00 per person

Wear your jammies and get a free bell!

Snack bar open!

Proceeds to benefit Hospice of the Owens Valley

Pre-sale tickets available at Pioneer Home Health Care
363 Academy Avenue, Bishop 760/872-4663

Hospice of the Owens Valley

Christmas Gift Tree Raffle

The winning ticket will be pulled
December 19th at noon
and one lucky winner
will win a beautifully decorated tree,
AND all the
gift certificates donated
by Eastern Sierra businesses!

Last Year's Tree
was worth over
$800.00

Suggested donations are
$5 for 1 ticket, or $20 for 5 tickets!
Buy tickets at Hospice of the Owens Valley office
363 Academy Avenue, Bishop, CA
Mon – Fri 8:00am – 5:00pm

Support Hospice!

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Maintenance		
Date Last Modified: 09/26/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE:
At least monthly, the hospital tests all automatic and manual transfer switches. The test results and completion date of the tests is documented in a Generator Binder in the Maintenance Department.

POLICY
Northern Inyo Healthcare District (NIHD) performs all appropriate tests on each automatic and manual transfer switch connected to the emergency generators.

PROCEDURE

1. Each automatic transfer switch (ATS) and manual transfer switch are tested at least monthly.

2. If load banks are routinely used as part of the load during testing to raise the load above 30% of capacity, there must be a method to automatically transfer to actual load in the case of a failure of the primary sources of power.

3. All automatic transfer switches shall be electrically operated from the standard to the alternate position, and a return to the standard position.

4. The time of the delay for transfer shall not exceed 10 seconds.

5. If appropriate, a different ATS should be used to initiate the emergency generator monthly test.

6. The completion date and the results of the tests are documented, and will be maintained by the Maintenance Department.

REFERENCES:
1. The Joint Commission CAMCAH Manual (July.-2022) EC.02.05.07 EP 7

RECORD RETENTION AND DESTRUCTION:
Logs in generator log book are maintained for 39 months.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7
2. Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7
3. Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7

Supersedes: v.1 Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Development, Review and Revision of Policies and Procedures		
Owner: Compliance Officer	Department: Compliance	
Scope: PPM Document Owners, Writers and Proxy Writers		
Date Last Modified: 10/10/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/16/2021	

PURPOSE:

1. Policies and Procedures are developed to create a framework that describe and guide workforce in meeting the standards and expected action which have been adopted and approved by the Board of Directors of Northern Inyo Healthcare District (NIHD) or their designee.
2. To provide direction on the required elements of policies and procedures and the required approval process.
3. To assist with determination on when to create a policy and when not to; to determine when a policy is essential and when it is not.
4. Policy helps NIHD to accomplish its mission; maintain accountability; provide workforce and students with clear, concise tools; and clarify how the District does business.

POLICY:

NIHD workforce will have access to well-articulated and understandable policies and related procedures. These policies and procedures will be:

1. Presented in common format,
2. Formally approved,
3. Centrally maintained,
4. Kept current within the framework of an organized system of change control, and
5. Distributed to all relevant workforce in a timely manner.

DEFINITIONS

1. *Annual Plans* – consist of complex District programs or plans which require final approval by the NIHD Board of Directors on an annual basis.
2. *Board of Directors Policy* – Policy designed for organizational governance that sets direction for the District, defines and guides appropriate relationships between the board and the chief executive, and sets the duties and responsibilities of the board. These documents do not go to the NCOC or CCOC committees and are managed by the Board Administrative Assistant.
3. *Clinical Consistency Oversight Committee (CCOC)* – Multidisciplinary team, represented by clinical staff that reviews all clinical policies and procedures, once approved by CCOC, sends to appropriate medical staff committees and board of directors or their designee (generally the Medical Executive Committee) for final approval.
4. *Forms* – approve documents that are utilized for operations at the District. Stored on the NIHD Intranet and as attachments to procedures when appropriate. These documents are approved via the Forms Committee.

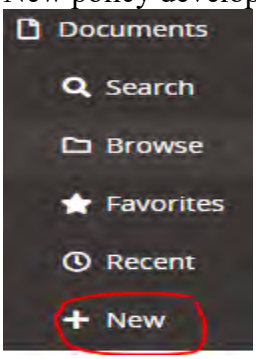
5. *Guideline* – Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and assessment of the benefits and harms of alternative care options. These documents receive final approval at the Medical Executive Committee.
6. *Policy* – The clear, concise statements of the parameters by which an organization conducts its business. Policies are the rules that workforce abide by as they carry out their various responsibilities.
    A. Must be approved by governing body (Board of Directors) every 2 years at minimum.
7. *Non-Clinical Consistency Oversight Committee (NCOC)* – Multidisciplinary team, represented by non-clinical staff, operations team and clinical workforce, who review non-clinical policies and procedures. NCOC reviews and once approved sends policy on to other committees as appropriate prior to final approval at the board of directors or their designee (generally the Executive Committee).
8. *Policy and Procedure Management Software (PPM)* – Repository for NIHD policies and procedures, excluding the procedures in Lippincott Procedures. PPM allows for tracking of current and past policies and procedures, while maintaining access for workforce review.
9. *Procedures* – The instructions or steps that describe how to complete a task or do a job.
    A. Clinical procedures require approval via the medical staff committee process; ultimately approved by the Medical Executive Committee.
    B. Lippincott Procedure Manual is utilized by NIHD for Clinical Procedures.
10. *Protocols* – An algorithm or recipe for managing a disease or condition. This sets a specific standard for process. (Example – wrist x-ray = 3 views)
    A. Require approval via medical staff committee(s) of departments where the protocol is utilized; ultimately approved by the Medical Executive Committee.
    B. Standardized Procedures followed by RN staff that cross from nursing into medical process require a standardized procedure per the California Board of Registered Nursing. These must be approved by the Interdisciplinary Practice Committee, Medical Staff Committee with department oversight and ultimately by the Medical Executive Committee.
    C. Standardized Protocols followed by Physician Assistants follow the process delineated by the California Medical Board.
11. *Workforce* - Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Providers (APPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

PROCEDURE:

1. Establishing need for a new policy or procedure:
   A. Determine a policy or procedure is necessary;
      I. When the cost of a mistake is high. (High Risk, High Volume or Problem Prone)
      II. When process is outside of common sense and must be prescribed.
      III. When consistent poor results across a number of departments or employees is demonstrated.
      IV. When required by regulatory agencies, including but not limited to: California Department of Public Health (CDPH), The Joint Commission (TJC), Title 22, or Centers for Medicare/Medicaid Service (CMS) Condition of Participation.
   B. Determine a policy or procedure is not necessary.
      I. Simple tasks that are able to done a variety of ways to achieve the same outcome.
      II. Processes that are able to be resourced via other manuals, such as One Source, Lippincott Procedure, etc.
      III. Guidelines are recommendations and although they may be adopted by clinical teams, they do not need to be approved at the Board of Directors level. They are generally created after

studies lead to conclusion of best practice. They are not mandated as a policy. Clinical Guidelines must be adopted by the Medical Staff Committee with oversight of the area where the Guideline is being utilized; ultimately approved by the Medical Executive Committee.
IV. Clinical procedures that are separated from policy may be contained within the District's Procedure Resource (Lippincott Procedures), which is based on best practice and updated routinely. This precludes the necessity of duplicate procedures in most instances. Critical notes are added within the Lippincott procedure to customize for NIHD practices. These must be approved via Medical Staff Committee, but do NOT require Board of Directors review or approval. Included in this document type are Standard Operating Procedures.

2. Policy/Procedure Development or Review/Revision
   A. Policy owner or their designee (writer or proxy writer within PPM) may develop or review and update existing policy.
   B. New policy development is created in *document section* within PPM by policy owner using the +New



I. Policy Wizard is utilized to input policy title, owner, and department by policy owner and Approver. NCOC or CCOC will review the Policy Wizard at the time of approval to support the Policy Owner in making correct build, including assignee (reader group) and frequency of policy review by workforce and owners.
   a. Within the #1 Settings the template is chosen based upon type of document required.
   b. Search features are tied to Owner, Department, Writer, Template, Approver and Category.
   c. Writers, Reviewers, approvers and assignees are designated by the Owner, with support and review by the NCOC or CCOC.

II. Research is conducted. Collaboration with subject matter experts and team members impacted by the policy or procedure is best practice during development. Collaborators may include but is not limited to:
   a. Compliance Officer
   b. Legal Counsel (with approval of Executive)
   c. Director of Human Resources
   d. Director or Chief within chain of command

III. References from valid sources and/or regulatory agencies is generally required. Occasionally "not applicable" (N/A) will be appropriate.

IV. Cross Reference P&P – requires review of policies or procedures that may impact the new policy being developed. These are listed as a reference for the end user and to assure the documents are aligned. Other cross reference documents can be located by use of keywords via the search feature within PPM.

C. Revision or Review of existing policy or procedure in PPM:
   I. Published document within PPM is opened.

Document is reviewed by owner and determination that no changes are required. If document is due for Biennial Review by the Board of Directors, Executive Committee or Medical Executive Committee the administrative assistant for the specific committee is notified to put the item onto the next agenda for "Biennial Review without changes". This meets the Centers for Medicare and Medicaid Services (CMS) appendix W provison of care Biennial Review requirement.

III. Create New Version (blue box/top of screen) may be checked to create draft of current policy for revision. This does the following:
   a. Automatically archives the current published version upon final approval of the revised version
   b. Maintains current Property Wizard settings, unless revision of these settings is required (unless a new template is required).
   c. Allows for revisions within the draft version

3. Template development
   I. Compliance Office workforce will develop new templates. Owners and writers may present ideas for new templates to the Policy Steering Committee, but may not create templates.
   II. Templates will have standardized information contained within the header.
   III. If conflict related to new templates occurs, the Policy Steering Committee will meet to resolve issue.

B. Templates will be developed for various document types including, but not limited to:
   I. Policy/Procedure
   II. Standards of Care
   III. Guidelines
   IV. Protocols
   V. Standardized Procedures
   VI. Standard Operating Procedures
   VII. Committee Charters
   VIII. Clinical Guidelines
   IX. Scope of Service

C. Policy and or procedure templates will contain some or all of the following elements:
   I. Purpose
   II. Policy Statement (All documents that contain policy MUST be initially approved and reviewed every two years by the Board of Directors.)
   III. Definitions
   IV. Procedural steps
   V. Record retention and destruction
      a. California Hospital Association reference may be found on the NIHD Intranet>Information>Compliance>Record Retention.
      b. If record retention is not applicable (N/A) must be inserted within this section.
      c. Destruction of record – Confidential records and those with PHI will be shredded or destroyed in compliance with Information Technology Services standards.
   VI. References are required using the American Psychological Association (APA) format.
   VII. Cross-referenced policies
      a. Use "search" function within PPM to find key words.
      b. Review policies identified by search for potential cross-reference.
      c. Assure policies align with new policy/procedure; if not determine if further revision is required of either or both policy/procedure.

VIII. Header will Contain:
   a. Northern Inyo Healthcare District
   b. Document Type
   c. Title of Document
   d. Source (What part of the Workforce will utilize the document- all departments where the document applies)
   e. Owner of the document (title of the role)
   f. Department (of the document Owner)
   g. Effective date and version number for the document

IX. Page numbers for each page in every document.

4. Committee Approval Process

A. Clinical Policies/Procedures:

I. Clinical Consistency Oversight Committee (CCOC) is the first committee to review and determine if a clinical Policy/Procedure document is ready for approval. They make the following determinations:

   a. Frequency of required review/revision (if necessary)
   b. Assignee by role (who needs to read the document and how often.)
   c. Effective date time line is established to allow workforce education on policy/procedure new documents and for revisions of significance.
   d. Medical Staff Committee(s) referral for approval (Medical Staff Office builds committees into Property Wizard, sequenced by upcoming meeting dates). Final Medical Staff Meeting is Medical Executive Committee (MEC).
   e. Board of Directors review approval is required on all policy and procedure documents prior to implementation.
   f. Final approver, generally at Chief Executive level (may be a designee of the Chief).
   g. Clinical documents recommended for archival by owner must be approved by CCOC prior to archival.
   h. After final required approval by Board of Directors or MEC, theAdministrative Assistant to the Board or the Medical Staff Director (or designee) is responsible to assure the document is published.

B. Non-Clinical Policies/Procedures

I. Non-Clinical Consistency Oversight Committee (NCOC) is the first committee to review and determine if a Non-Clinical Policy/Procedure document is ready for approval. They make the following determinations:

   a. Frequency of required review/revision (if necessary)
   b. Assignee by role (who needs to read the document, how often and in what timeframe)
   c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.
   d. What other committee(s) need to review and approve the document prior to sending to the Board of Directors.
   e. Board of Directors review approval is required on all policy documents prior to implementation and every two years.
   f. Executive Committee review/approval is required on all procedure documents prior to implementation and every two years.
   g. Non-Clinical documents recommended for archival by owner must be approved by NCOC prior to archival.

h. After final required approval via Board of directors or the Executive Committee, the Administrative Assistant to the Board or the Administrative Assistant to the Chief Executive Officer is responsible to assure the document is published.

C. Clinical Guidelines tools developed as best practice (generally utilized for specific diagnosis or situations).

I. Medical Staff Committee will approve Clinical Guideline for use within their department and assure education of peers.

II. Medical Executive Committee approval is required prior to implementation.

III. Board of Director approval is not required.

IV. Frequency of review of Clinical Guideline will be determined at Medical Department level.

D. Board of Director policy and procedure will be developed and approved at the Board level.

I. Board may request Board Legal Counsel or Compliance review

II. Board Policy/Procedure will be maintained within PPM and the following will be established:

a. Frequency of required review/revision (if necessary)

b. Assignee by role (who needs to read the document, how often and in what timeframe)

c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.

5. Periodic Review of documents:
   A. This is the responsibility of the document owner, who may delegate by assigning writer(s) or proxy writer.
   B. The PPM will be set up to notify the owner of items due for review or revision via email and task list within PPM.

6. Implementation and effective dates:
   A. Workforce education to the new processes and polices must be considered when determining the effective date for each document.
   B. During CCOC or NCOC approval process the following decision will be documented:
      I. Effective date in relationship to final approval date. (Last Committee or Board of Directors required to approve document)
      II. Is workforce required to read the new document? If so, what roles are required to read the document and how often.
      III. Will a different education process be utilized to train workforce to the new document?

7. Discarding of documents versus Archival of document
   A. Published documents are moved to archives when revised or if they become obsolete. This does require NCOC or CCOC approval for obsolete documents.
   B. Draft documents that are found to be unnecessary may be discarded; becoming irretrievable. This may only be done by the policy owner or their designee and does not require committee approval.

8. General Information for document development for PPM.
   A. Acronyms must be spelled out prior to being utilized in all documents.
   B. May/must are preferred to use of should/shall.

REFERENCES:

1. Center for Medicare/Medicaid Services- **§485.627 Condition of Participation: Organizational Structure C-0241; Interpretive Guidelines §485.635(a)(2) & (4); -§485.627(a) Standard:**

Governing Body or Responsible Individual; (Rev. 200, 02-21-20**).** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

2. American Psychological Association (APA) Format web site: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/general_format.html
3. California Hospital Record and Data Retention Schedule, 2018.

CROSS REFERENCE P&P:

1. Pathways for development, Review and Revision of Nursing Standards

RECORD RETENTION:

All policy, procedure, scope of practice, standards of care, care guidelines and bylaw documents will be maintained for the life of the document, plus 6 years, within the PPM system at NIHD.

Supersedes: v.1 Development, Review and Revision of Policies and Procedures