Northern Inyo Healthcare District

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NORTHERN INYO HEALTHCARE DISTRICT
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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

January 18, 2023 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. Swearing in of Newly Appointed Board member
4. New Business:
   A. Recognition of John Halfen's Contributions to NIHD (*Board will receive and consider approval of recommendations to honor John Halfen)*
   B. Chief Executive Officer Report *(Board will receive a report from the CEO)*
   C. Chief Financial Officer Report
      a. Financial & Statistical Reports (*Board will consider approval of these reports*)

b. Joseph House Financial Analysis (*Board will receive a report on the Joseph House Financial Analysis*)

c. Financial Turn Around Status Report *(Board will receive this report)*

d. Northern Inyo Healthcare District SOW Revenue Cycle Transformation *(Board will consider approval of this contract)*

D. Chief Medical Officer Report

a. Annual Physician Compensation Report (*Board will consider approval of the Annual Physician Compensation Report*)

b. CMO Bi-Monthly Report (*Board will receive and consider approval of the CMO report*)

c. 2023 NIHD QAPI Plan (*Board will receive and consider approval of the annual QAPI Plan)*

E. Attendance of Legal Counsel at Board Meetings (*Board will discuss and consider the need for legal counsel at Board Meetings)*

5. Chief of Staff Report, Sierra Bourne MD:

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

1. Lisa K. Manzanares, MD (*family medicine*)

B. Policies (*Board will consider approval of these policies*)

1. *Advance Directives*
2. *Airborne Infection Isolation Rooms (AIIR)*
3. *Code of Ethics for Nurses*
4. *Healthcare Worker Health Screening and Maintenance Requirements*
5. *Opioid Administration*
6. *Opioid Sedation Scale*
7. *Organ/Tissue/Eye Donation*
8. *Pain Management and Documentation*
9. *Patient Valuables*
10. *Standardized Procedure – Adult Health Maintenance Policy for the NP or CNM*

C. Medical Executive Committee 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 23-01, 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 December 21, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
8. Approval of the Minutes of the January 11, 2023 Special Board Meeting *(Board will consider the approval of these minutes)*
9. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*
    A. *ALARA Plan*
    B. *Dosimetry Program – Occupational Radiation Exposure Monitoring Plan*
    C. Radiology Services Pregnant Personnel
    D. Diagnostic Imaging – Ordering Radioactive Materials
    E. Diagnostic Imaging – Radioactive Material Hot Lab Security
    F. Diagnostic Imaging – Imaging Equipment Quality Control
    G. Sanctions for Breach of Patient Privacy Policies
    H. Electrical Distribution
    I. Fiscal One-Up Approvals
    J. Emergency Purchases
    K. Sale of Supplies
    L. Reimbursement for Local Travel for District Business
    M. Hospital Grade Receptacles
    N. Receiving Processes
    O. Charity Care Program
    P. Billing and Collections
    Q. Prompt Pay Discounts
    R. Bad Debt

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10. Reports from Board Members (*Board will provide this information*)
11. Public comments on closed session items.
12. Adjournment to Closed Session to/for:

a. Conference with Labor Negotiators, District Designated Representatives: Interim CEO and HR Director; 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)

13. Return to open session and report on any actions taken in closed session.
14. 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

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: January 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Lionel "Chad" Chadwick, Interim CEO

RE: Bi-Monthly CEO Report

REPORT DETAIL

AFSCME Negotiations Update:

The District continues negotiations with both AFSCME bargaining units with the expectation of ongoing good faith discussions aimed at contract completion at the earliest opportunity. From a financial perspective we hope that an agreement can result on enhanced recruitment of permanent employees and the accompanying reduction in short-term "travelers" in the District - as well as the enhanced sense of "the NIH team" that a long term agreement can provide. Regular updates on progress will be provided to the Board.

Turnaround Action Group:

A broad-based Turnaround Action Group (TAG) comprised of leaders throughout the District has been formed in response to the Board's clear sense of urgency pertaining to our current financial challenges and to ensure the timely return of the District to fiscal balance. The TAG's objectives are to uncover and act on opportunities for enhanced revenue and reduced costs for improved financial performance. Underlying the TAG's work are always retention of our high standards of quality of care and maximum retention of our existing services. Some actions may be taken directly by management, and other steps may require policy direction of the Board. It is anticipated that the TAG will be an ongoing work group in the District, since many identified opportunities for improvement may take many months to be completed. Regular updates on progress will be provided to the Board.

Permanent CEO Search Update:

In conjunction with the Board's CEO Search Ad Hoc Committee, the District is proceeding with the identification of strong CEO candidates, coupled with a robust selection / interview process that will ensure the selected candidate will be an outstanding fit for the District's leadership needs. The target period for completion of this selection process is late February, with the onsite arrival slated for early April.

CEO Community Presentations:

In an effort to inform our community about activities and directions at the District, I will be continuing the previous pattern of regular community presentations to local governments, business groups, and other community organizations. In that regard, I anticipate presentations to the Bishop City Council and the Inyo County Board of Supervisors in January. The importance of these presentations cannot be overstated, especially in times of financial duress such as we face at this time I feel it is critical that we engage with our communities and that they continue to trust our clinical, financial, and management acumen.

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150 Pioneer Lane
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DATE: January 2023

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

Our team continues collaborating on projects, timing, and financials with the Executive Team. We look forward to participating in a formal project cost tracking and return on investment processes. Our project team for the Clinic Standard Messages has completed the setup and has been live for a little over a month. The next steps will be to update the rest of the patient-facing areas at the District as part two of the project.

Congratulations to Brandon Cox, Project Management Specialist, for completing his Disciplined Agile Scrum Master (DASM) Certification from PMI.

PROJECTS *(this is a high-level summary, not a complete list)*

Discovery – 7 (Patient Appointment Reminders, Onboarding Workflow Efficiency, Phone Standard Message Part 2, Telestroke ED & IP Consulting Sevaro, Specialty Clinic Ergo, Toiyabe Health Information Exchange, RHC Provider Workstation Monitor Installation)

Actively Working – 12 (TelePharmacy Services, ConferMed eConsults, Billing Scrubber Update, Toiyabe Health Information Exchange, Signs & Map Updates, Nuance PowerShare Hub Update, OneContent Upgrade, ORA/Argos Ophthalmic Update, ABI Machine for Wound Care, Hauge MedPlan, Hauge Interface Cerner project, MRI area Update)

Closing – 5 (Clinic Phone System Standard Setup, ABG Instrument, State Mandate Tracking, Employee Health Management System Agility, EMS Radio and Recording System Replacement)

Moves Completed - 6 (Redesign Quality/ Informatics, RHC Recovery Support, RHC Patient Access Ergo, Additional Workstations in Credit & Billing, Virtual Clinic Telehealth Ergo, Perinatal Assistant Manager Ergo)

On Hold Projects - 13 (QliqSoft Secure Text Messaging, OR workflow optimization, Omnicell Cabinets, Infant Security System, eCase Reporting with Cerner, Qstress Test System, SmartSheet upgrade for PHI Compliance, OneContent athena Upload, Copay Workflow Improvement, City of Hope Telehealth, SAP Concur, Cerner Portal Relaunch, Internal Med Office Update)

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

DATE: December 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Neil Lynch, Purchasing

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Purchasing department continues to work hard on back orders. We have seen an increase in supply chain disruptions in all categories with the exception of PPE. PPE supply has been widely available.

Reviewing policy and procedure to ensure that they are up to date and accurately reflect current industry standards and that they still work departmentally and for the district. Some more work will be done on this throughout the beginning of the new year.

OLD BUSINESS

Currently working with HR to fill vacancies in the Purchasing Department.

Business as usual. Purchasing staff have been rotating vacation schedules causing resources to be tight.

(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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150 Pioneer Lane
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DATE: January 2023

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

November's board meeting was canceled due to not having a quorum present. Most of that agenda was pushed over to December's meeting. The Board approved $210 to cover recent CAREshuttle maintenance. In November the Foundation also sent out an appeal letter to all current donors to help support the purchase of the new CAREshuttle and its wheelchair conversion. To date that campaign has brought in close to $10,000.

GRANT WRITING

The District pursued grant funding from the City of Bishop's Community Grant Program and unfortunately we were not funded. The District asked for $10,000 of the $24,000 total coast of the CAREshuttle wheelchair conversion. The District was awarded 6 months continued funding through the Sierra Health Foundation, in the amount of $58,000. This will cover Medication for Addiction Treatment (MAT) services in the RHC for a .2 FTE physician, .3 FTE registered nurse, and 1 FTE medical assistant. This funding covers October 2022 through March 2023. Administration and maintenance for all other current grants is ongoing.

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150 Pioneer Lane
Bishop, California 93514
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DATE: January 2023

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 Cardiopulmonary department has put a second blood gas analyzer into service; this gives us a backup analyzer to serve our patients if an unplanned downtime of the primary instrument occurs. The two blood gas analyzers are on carts and wireless, this will allow the team to take the analyzer to the Nursery or ICU if needed for improved patient care.
- The CP department plan to replace the Stress test system with a new wireless stress test system is on hold. We will reassess for FY 2024.
- Annual fit testing for the N95 respirator started January 1. Each department is assigned a month to get their fit test done to stay compliant with Cal/OSHA. Our primary method to do fit testing is with the Porta Count Respirator Fit Tester, or quantitative testing.
- CP has a new per diem Respiratory Therapist, Travis Bos, RRT, started in October of 2022. Travis comes to NIHD with 14 years of experience as a pediatric transport therapist.
- The Cardiopulmonary department still has one vacant graveyard position. We are actively recruiting for a permanent position.

Diagnostic Imaging (DI):

- DI leadership met with the executive team to provide further detail on the current state of NIHD's Ultrasound department. Presented was information on the current lack of capacity that exists within the department, which has led and continues to lead, to underserving our community when Ultrasound Exams are needed for diagnostic and therapeutic purposes. As a result of the meeting, the executive team agreed to move forward with the delivery of our previously approved Ultrasound equipment. This move will increase capacity in the department and will allow for more timely service to our patients and our referring providers.

- The Diagnostic Imaging Department is now struggling with staffing in several of our key modalities. We have experienced unexpected turnover in our Ultrasound department and unexpected absences within MRI. This is leading in both areas to some slight delays in patient care and the inability to provide 24-7 Emergent Services to our Hospital. Our staff is covering as much as possible and we are avoiding the lack of coverage as much as possible.
- We have started cross-training two of our newer Radiology Technologists in Computed Tomography (CT). This cross training expands the pool of employees that can assist with call and provide CT services when necessary. We expect this cross training to be complete by the summer of 2023.
- The DI department had its annual State and Federal Mammography inspection in December. For the fourth consecutive year, NIHD had no deficiencies in our breast-imaging program and the inspector stated that NIHD "has a five star and three thumbs up breast imaging program. Kudos to Krissy Alcala and Ashley Weatherford for their dedicated efforts to run a first-class program for our district.

Laboratory Services (the Lab):

- Hannah is now a District employee! She started as a traveling CLS with us in February 2021 and is now our full-time Lab Manager.
- Outpatient phlebotomy services continue to be audited and new workflows are being tested to improve customer service and increase efficiency.
- The lab is fully staffed and all leadership roles are filled. 2 of the Lead positions are filled by interim travelers whom we hope to recruit at the end of their three-year contract.
- The lab is preparing for our biennial Joint Commission Survey (window is June – September 2023). A solid foundation has already been set and we are confident they will have a positive outcome.

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: January 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Bryan Harper, Director of ITS/CISO

RE: Department Update

REPORT DETAIL

NEW BUSINESS

ITS- Windows 11 migration for all desktops and laptops (project)
ITS- Disconnecting Verizon cell phone service to ATT for better coverage ($1500/month in savings)
ITS- Reassessing district printer usage for cost savings (project)
ITS- Direct messaging w/ Toiyabe and Valley Health for labs and radiology
ITS- Switch all Phone lines from old PRI to new tech of SIP (cost savings $11,316.00/year)
ITS- Working with Mammoth on Direct Messaging and patient data exchange.
ITS- Working on identifying Cerner outstanding issues with EHR team to provide data to CEO.

CE- Launching the new ORA Argos system for the OR. This accurate lens placement.
CE- Continuing to provide preventative maintenance, repair, and records on medical equipment.
CE- Working with vendors to scope new potential infant security system replacement.
CE- Scoping US replacement and upgrade for the Anesthesia team as well as the Urology team.

Information Security: Continued in person security training, preparation for next year's penetration testing has started and working on budget savings plan for future. We continue to see an increase in the number of attacks to the district.

OLD BUSINESS

ITS- Deploying two new VMware servers and migrating all existing servers to re-deployed and upgraded supported servers.
ITS- Blackberry has been upgraded with new feature and support as well as upgrading from server 2008 to server 2019.
ITS- Working with RHC team on new procedure for car pull-up camera that will be used once the negative pressure rooms are installed.
ITS- Leadership is working with compliance and legal on Athena data migration issues.

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ITS- Working with Clinic staff on overhauling the phone system to become more unified as well as fixing outgoing phone numbers that come up on caller ID.
ITS- Cerner is changing the way NIHD user login (network path) and we have implemented and tested this without issues.
ITS- New camera / audio are now setup in small boardroom.

CE- New Philips X3 Patient monitor for Neonates has been installed and tested in the nursery.

- This will allow staff to have a monitor attached to the infant warmer reducing the number of devices that have to roll separately.

CE- Has also been upgrading its database for equipment to have the most accurate and up-to-date preventative maintenance, repair, and inventory records.

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Bishop, California 93514

(760) 873-5811

DATE: January 2023

TO: Board of Directors
Northern Inyo Healthcare District

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

RE: Department Update

REPORT DETAIL

ENVIRONMENTAL SERVICES

The Environmental Services team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph House to our OR's and PACU. We currently have 23 fulltime employees in ES with one vacant spot to fill, and 2 LOA.

LAUNDRY

The Laundry team operates Monday –Friday from 500am to 1500pm. We currently have 4 employees with 1 part-time spot to fill. Our chemical line is still good, and all equipment is working. Our staff is doing great.

OTHER INFORMATION

Talent Pool- currently has 2 employees and another joining us 1/23/23. The last application was 12/30/2022.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: January 2023

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Barbara Laughon, Manager, *Marketing, Communications, & Strategy*

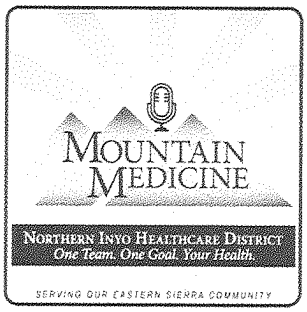
RE: Department Update

REPORT DETAIL

COMMUNITY OUTREACH:

Interim CEO Public Presentations: Strategic Communications worked with Mr. Chadwick to arrange for public presentations regarding NIHD's status to the Inyo County Board of Supervisors, Bishop City Council, and other community organizations.

Holiday Efforts: NIHD once again invited host a **Holiday Wish Tree for Inyo's CASA program** (Court-Appointed Special Advocates). TeamNIHD responded graciously filling all wishes shared with us. Many thanks to our Admissions Team for their support and assistance.



Podcast: Efforts to launch ***NIHD's Mountain Medicine*** podcast resumed in December. A specific launch date remains to be determined. Most recently, Drs. Anne Wakamiya and Bo Nasmyth Loy have recorded sessions for the effort. Completed sessions include Drs. Joy Engblade, Stacey Brown, Jeanine Arndal and Anne Goshgarian. Dr. Richard Meredick will be recording in the coming months. We are hoping Dr. Adam Hawkins among others will participate as well.

Healthy Lifestyle Talks: These free, monthly sessions highlight our services while addressing commonly asked healthcare topics. NIHD has presented these talks for the past eight years. Currently we continue to offer these via Zoom and our YouTube channel. My thanks go to those NIHD Team members who willingly share their knowledge with our community and to Dr. Engblade for her ongoing support. In the final months of 2022, NIHD presented the following:

September: Labor & Delivery: *Meet our Team*
Presenters: Dr. Jeanine Arndal, Certified Nurse Midwife Jennifer Norris, Physician Assistant Jenni Figueroa, and Director of Perinatal Nursing Julie Tillemans
Views: *Live 28, replay to date 84*

October: Going Beyond Pink: *Talking about breast cancer, early detection, support & hope*
Presenters: Dr. Eva Wasef, Dr. Cheryl Olson, Dr. Farres Ahmed, Rosie Graves MPA, and Dana Georgeson PT
Views: *Live 25, replay to date 114*

November/December: Dark to Light: *Coping with Stress, Anxiety & Depression*
Presenters: Dr. Murat Akalin, Heather Edwall MSW LCSW, Linda Christensen MSW LCSW, and Monica Jones MS OTR/L PMH-C
Views: *Live 26, replay to date 79*

January: Focus will be on Infusion Services. Specifics to be determined as of the writing.

Assisted RHC's MAT Team with production of **educational material about the dangers of fentanyl**. Materials were distributed in local schools and other areas where local young people gather.

Worked with Occupational Therapist Monica Jones and videographer Jesse Steele on **educational video regarding Perinatal Mood and Anxiety Disorder**. Video will be available in January.

MARKETING:

Many thanks to the 13-team members who agreed to participate in our **Holiday Gratitude Wishes videos** for our communities. These three videos appeared on the NIHD Facebook and Instagram pages. This allows the community to hear for themselves the dedication and commitment our staff has to providing quality care and service. In all, these video posts reached 2,595 people and received 508 engagements from those people. Thank you to those who spoke from their hearts: *Chris Cauldwell, Dee Dee Costello, Rylie Cottriel, Shawn Delehanty, Lauren DeVore, Michelle Garcia, Elizabeth Haun, Tyler Honeyman, Cheryl Jackson, Jessica Nott, Venessa Perez, Lynda Vance* and *Thomas Warner*. Special thanks to videographer Jesse Steele and Social Media consultant Amanda Long for their guidance.

Strategic Communications also promoted the **NIH Auxiliary's annual Holiday Boutique and Gift Shop sales** on our social media channels. These photo and story posts reached 2,841 people and received 314 engagements from those people.

Published **annual "With Gratitude" ad** on behalf of District in *The Inyo Register.* We did not publish in other usual outlets for cost savings. Please see last page of this report to view ad.

Promoted **MAT Program's *Facing Fentanyl* Community Awareness Event**, held November 1 at the Calvary Baptist Church. Placements included ads in *The Inyo Register, The Sheet, The Mammoth Times, The Sierra Reader, El Sol de la Sierra,* and on radio stations KIBS-FM, KSRW-FM and KRHV-FM (Mammoth). Also coordinated recording of event with Laughing Parrot Productions, video will be available online as a resource once MAT leaders approve.

Once again worked with Breast Health Team to present and promote our seventh annual **Moonlight Mammograms program**, which served 56 patients. This year's public event ran for four nights with sessions also scheduled for NIHD employees as well as patients of Southern Inyo Healthcare District and Toiyabe Indian Health project. My thanks to all our Mammographers for their continued support of this important program. A special thanks to Ashley Weatherford for her enthusiasm and positivity. This year's goodie bags featured small gifts from nine of our trusted partners and local businesses.

Strategic Communications also worked with Eastern Sierra Cancer Alliance and NIH Foundation to present **Community Pink Day** along the U.S. 395 communities. The most visible feature of this event is the pink ribbons hanging along the main streets of each community from Lone Pine to Bridgeport,

to serve as a reminder to schedule not only mammograms, but also important health screenings. It is our hope to enhance this effort in 2023.

Strategic Communications also aided Dr. Cheryl Olson and Oncology Patient Navigator Rosie Graves with two **educational outreaches** at Vons Grocery Store. It is always an honor and joy to watch our team engage one-on-one with community members during outreach events.

Other efforts:

- Holiday Closure notices for Thanksgiving, Christmas and New Year's
- Renewed emphasis on importance of flu shots
- Collaborate with County of Inyo on winter virus news materials *(see below in External Communications)*
- Assisted Rehab Director Joanne Henze with creating a hiring flyer distributed at the Craggin' Classic Event; also made contact with organizers for additional opportunities with this growing event
- New radio spots (Early Detection Screenings/Care You Can Trust) deployed to KIBS-FM and KRSW-FM

COMMUNICATIONS:

Internal:

- Strategic Communications continues to complete a weekly Incident Command report for all staff and providers regarding COVID-19 and related issues
- Random updates about Holiday efforts issued throughout season
- Coordinated 12/6 Town Hall introducing Interim CEO
- Worked with Registered Dietitians Kalina Gardiner and Denice Hynd and Physical Therapist Dana Georgeson to promote internal six-week wellness program, *Fall into Healthy Habits.* Coordinated and hosted Zoom workshops for Denice. All events well attended.

External:

- News release: *NIHD once again earns Gold Seal from Joint Commission (1/9/2023)*
- News release: *NIHD seeks applicants for Board of Directors seat (12/19/2022)*
- News release, collaboration with County of Inyo: *Public Health Monitoring Increased Winter Virus Activity (12/8/2022 – featured NIHD Pediatrician, Dr. Kristen Meredick)*
- News release: *NIHD merges programs for broader patient benefit (12/1/2022)*
- News release: *NIHD Healthy Lifestyle Talk tackles stress, anxiety and depression (11/28/2022)*
- News release: *NIH Auxiliary boutique benefits community healthcare, one purchase at a time (11/1/2022)*
- District Statement in response to union news release *(10/28/2022)*
- News release: *NIHD Healthy Lifestyle Talk Goes Beyond Pink (10/25/2022)*
- News release: *NIHD employees give Diaper Depot a boost (10/20/2022)*
- News release: *NIHD names Stephen DelRossi new CFO (09/21/2022)*

ONGOING

Staffing: Recruitment for on-site Digital Marketing Specialist remains paused.

Project Involvement: Clinic Phone Project, Campus Signage Project

APOLOGIES

Please forgive us for no digital statistics this report. These stats are unavailable to me due to staff illness.

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

DATE: January 2023

TO: Board of Directors
Northern Inyo Healthcare District

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

RE: Department Update

REPORT DETAIL

HR Manager: Daily support for onboarding, staff development, recruitment, and benefits. This past year, Human Resources oversaw the implementation of, and collaborated with Payroll to complete the ADP Comprehensive Payroll go-live. In addition to the implementation of ADP Comprehensive Payroll, Human Resources began a review of the ADP Workforce Now system and implemented the performance management module, reworking the performance management process from paper to electronic and utilizing the performance dashboard for goal management. We collaborated with administration and the board clerk on the completion of the board onboarding presentation for new board members to become familiar with the healthcare district workforce, policy, and procedures. This was put into practice with the onboarding of our new board member the beginning of 2023. We have taken over completing an Active Directory(AD) audit within outlook to bring the AD system up to date, this supports the implementation of other systems that are linked to the AD. The end of the year we launched the Human Resources JD update project. We will have strong focus on updating all JD's within the District into a new format, streamlining naming conventions and assuring duties align with each role. Working with IT and Compliance on onboarding workflow.

HR Assistant: Daily support for new hire onboarding and orientation during first week at the District. Creating workflows in partnership with Recruitment, HR Manager and Staff Development Specialist to improve the onboarding experience of new workforce members. Ownership and continued improvement of the monthly birthday and employee of the month celebrations. Championed I9 audit for compliance with regulatory requirements, contacting employees for updated documentation as needed. Improved process for annual pay increases and notification of employees, streamlining communications and timeliness. Ongoing oversite of ADP personnel file clean up, developed naming conventions and file paths for ease of file navigation.

Recruitment: Developed community outreach for housing options for new hires and travelers within our area, including quick reference binder for team members to utilize in their search. Regular meetings and communication with department leaders to improve recruitment and allowed for the streamlining of process with very clear guidelines. Implementation of an internal applicant-rating tool and competency-based interview questions for applicants that are current employees who would like to churn over. Took over onboarding background checks, communications and workflows in partnership with HR Assistant and Staff Development Specialist. Completed audit for ADP recruitment and updated within system. Completed recruitment file audit, worked to upload and file recruitments from 2022 and 2021. Ended the year with the launch of CEO recruitment, and looking forward to a successful 2023.

Onboarding: Duties have been transitioned to Recruitment, HR Assistant, Staff Development and HR Manager.

Payroll: Transitioned back to Accounting per auditor recommendation.

Benefits/LOA: Saw an increase in LOA requests, processing weekly requests for personal medical and family medical needs. Completed full LOA file audit, as part of process improvement related to regulatory and legal requirements. Completed annual open enrollment with our TPA Keenan, we noticed an increase in employees registering for elective benefits. Completion of new retirement plan selection and rollout with transition to H&H and Empower. Bi-weekly review of the new process with retirement funding every pay cycle, collaborating with payroll to ensure accuracy. Monthly invoicing and billing for benefits, reviewing for accuracy, and following up as needed with concerns, and questions. Tracking of COVID leaves and applicable paid sick leave hours per state requirement's. Completed BETA site review with our partners from BETA in regards to our Onsite Hazzard and Risk Assessment. On-going employee support for leave and benefits questions, including processing new hire benefit enrollments each orientation.

HR/Staff Development: Coordinated the return of in-person training during orientation, including Workplace Violence, Safe Patient Handling and Cyber Security. Facilitated annual CNA training by coordinating and hosting an out-of-the-area instructor to help fulfill the annual 12-hour in-person CEU requirement. Took over as AHA Training Center Coordinator and completed renewal of AHA Instructor Status for the AHA Training Center in preparation for relaunching AHA Community skills sessions in 2023. Took over certification tracking and compliance, have completed audit for license and certifications as required by position. Lead the relocation of the Simulation Lab, RQI Lab, and Education Computer Lab, with positive outcomes and increased use by departments. Scheduled WPV instructor training to develop additional trainers for regulatory required training at time of hire as well as annually. Relias reporting to department leaders prepared 2023 training for launch in the New Year.

HR Director/Labor Relations: Ongoing union negotiations.

Northern Inyo Healthcare District
Fiscal Year 2023

	7/31/2022	8/31/2022	9/30/2022	10/31/2022	11/30/2022	2023 YTD
Gross Patient Service Revenue						
Inpatient Patient Revenue	3,986,305	3,395,933	1,938,350	2,813,064	3,474,955	15,608,606
Outpatient Revenue	11,474,649	12,619,549	11,643,340	12,337,627	12,582,796	60,657,961
Clinic Revenue	1,112,050	1,281,637	1,298,041	1,312,937	1,616,268	6,620,933
Gross Patient Service Revenue	16,573,004	17,297,119	14,879,730	16,463,628	17,674,019	82,887,499
Deductions from Revenue						
Contractual Adjustments	(9,974,707)	(7,321,894)	(6,081,406)	(9,139,351)	(8,553,896)	(41,071,255)
Bad Debt	(1,834,762)	(2,292,073)	110,396	(789,398)	(134,138)	(4,939,975)
A/R Writeoffs	(378,045)	(717,468)	(739,907)	(325,216)	(338,106)	(2,498,741)
Other Deductions from Revenue	492,000	(492,000)	72,943	950	17,166	91,059
Deductions from Revenue	(11,695,514)	(10,823,435)	(6,637,974)	(10,253,015)	(9,008,974)	(48,418,912)
Other Patient Revenue						
Incentive Income	0	0	0	0	0	0
Other Oper Rev - Rehab Thera Serv	5,303	4,367	4,346	10,361	7,875	32,251
Medical Office Net Revenue	0	0	0	0	0	0
Other Revenue	5,303	4,367	4,346	10,361	7,875	32,251
Net Patient Service Revenue	4,882,793	6,478,050	8,246,101	6,220,974	8,672,921	34,500,839
Cost of Services - Direct						
Salaries and Wages	2,175,027	2,269,022	2,195,439	2,179,142	2,262,511	11,081,140
Benefits	2,008,070	1,759,698	1,801,034	1,669,695	1,754,398	8,992,896
Professional Fees	2,373,943	2,061,702	3,102,063	2,821,921	3,457,119	13,816,748
Pharmacy	211,326	671,932	54,166	136,557	596,330	1,670,310
Medical Supplies	315,752	290,221	578,033	366,356	474,848	2,025,210
Hospice Operations	0	0	0	0	0	0
EHR System Expense	107,979	220,753	220,408	183,047	146,908	879,094
Other Direct Expenses	546,374	667,228	808,934	572,765	793,341	3,388,643
Total Cost of Services - Direct	7,738,472	7,940,556	8,760,076	7,929,482	9,485,455	41,854,041
General and Administrative Overhead						
Salaries and Wages	360,265	365,276	370,478	381,872	373,439	1,851,330
Benefits	356,264	312,157	316,570	1,160,994	302,169	2,448,154
Professional Fees	565,435	242,300	410,987	322,217	430,772	1,971,711
Depreciation and Amortization	318,087	332,153	334,828	362,317	346,018	1,693,404
Other Administative Expenses	79,314	164,310	199,143	119,767	314,165	876,699
Total General and Administrative Overhead	1,679,363	1,416,196	1,632,007	2,347,167	1,766,564	8,841,297
Total Expenses	9,417,836	9,356,752	10,392,082	10,276,649	11,252,019	50,695,338
Financing Expense	183,196	182,350	180,796	182,190	178,894	907,426
Financing Income	64,203	431,229	247,716	247,716	247,716	1,238,579
Investment Income	74,115	23,389	(18,154)	99,582	16,704	195,637
Miscellaneous Income	59,508	60,051	73,544	10,519	68,632	272,253
Net Income	(4,520,413)	(2,546,383)	(2,023,671)	(3,880,048)	(2,424,941)	(15,395,456)

Balance Sheet FY 2023

	Prior Year Balances	July 2022	August 2022	Sept 2022	Oct 2022	Nov 2022
Assets						
Current Assets						
Cash and Liquid Capital	9,223,997	8,260,905	9,033,146	7,095,805	8,362,653	7,944,312
Short Term Investments	26,808,421	24,254,218	24,248,339	21,741,818	21,873,055	19,367,377
PMA Partnership	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	24,367,758	21,409,786	19,693,748	20,999,337	17,315,384	18,278,787
Other Receivables	1,504,271	2,029,713	2,200,753	3,264,049	3,433,651	3,673,398
Inventory	3,145,539	3,116,641	3,111,028	3,075,988	3,071,145	3,077,236
Prepaid Expenses	1,318,137	1,842,961	1,808,098	1,708,822	1,404,076	1,765,502
Total Current Assets	66,368,122	60,914,224	60,095,113	57,885,819	55,459,964	54,106,613
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	1,327,387	182,493
Limited Use Assets						
LAIF - DC Pension Board Restricted	639,041	747,613	753,493	760,014	714,585	720,262
DB Pension	14,044,924	14,044,924	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	14,759,509	14,765,186
Revenue Bonds Held by a Trustee	1,111,723	1,105,984	1,100,247	1,090,633	1,085,089	1,079,366
Total Assets Limited as to Use	17,749,184	17,942,733	17,942,963	17,939,954	17,171,984	16,027,045
Long Term Assets						
Long Term Investment	2,274,315	2,274,959	2,777,201	2,741,517	2,731,432	2,729,926
Fixed Assets, Net of Depreciation	77,253,188	76,967,404	76,801,899	77,108,738	76,801,887	76,795,344
Total Long Term Assets	79,527,504	79,242,363	79,579,100	79,850,255	79,533,319	79,525,271
Total Assets	163,644,810	158,099,320	157,617,176	155,676,027	152,165,267	149,658,928
Liabilities						
Current Liabilities						
Current Maturities of Long-Term Debt	2,606,169	2,575,534	2,549,958	2,524,301	2,053,565	1,405,934
Accounts Payable	4,848,604	3,993,933	5,404,967	5,504,922	5,447,118	6,960,778
Accrued Payroll and Related	4,977,342	5,908,449	6,822,949	6,615,701	6,726,652	6,895,391
Accrued Interest and Sales Tax	99,832	145,639	252,061	321,777	126,986	17,172
Notes Payable	2,133,708	2,133,708	2,133,708	2,133,708	2,133,708	2,133,708
Unearned Revenue	2,534,074	1,299,762	607,290	607,290	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	2,146,080	2,146,080
Total Current Liabilities	19,345,808	18,203,104	19,917,013	19,853,780	19,241,398	20,166,352
Long Term Liabilities						
Long Term Debt	33,455,947	33,455,947	33,455,947	33,455,947	33,455,947	32,310,948
Bond Premium	240,908	237,771	234,634	231,497	228,359	225,222
Accreted Interest	16,725,130	16,820,264	16,915,399	17,010,533	17,105,668	17,200,803
Other Non-Current Liability - Pension	47,950,740	47,950,740	47,950,740	47,950,740	48,813,068	48,813,068
Total Long Term Liabilities	98,372,724	98,464,722	98,556,720	98,648,717	99,603,043	98,550,041
Suspense Liabilities	-	-	-	-	-	-
Uncategorized Liabilities	425,933	451,476	709,722	763,396	790,738	837,281
Total Liabilities	118,144,465	117,119,302	119,183,454	119,265,892	119,635,178	119,553,674
Fund Balance						
Fund Balance	44,833,877	42,910,729	42,910,729	42,910,729	42,910,729	42,910,729
Temporarily Restricted	2,589,615	2,589,701	2,589,789	2,589,873	2,589,875	2,589,981
Net Income	(1,923,148)	(4,520,413)	(7,066,796)	(9,090,467)	(12,970,515)	(15,395,456)
Total Fund Balance	45,500,345	40,980,018	38,433,722	36,410,135	32,530,088	30,105,254
Liabilities + Fund Balance	163,644,810	158,099,320	157,617,176	155,676,027	152,165,267	149,658,928
	-	-	-	-	-	-

Ratios

	Jul'22	Aug'22	Sep'23	Oct'23	Nov	YTD
EBITDA	(4,019,130)	(2,031,880)	(1,508,047)	(3,335,541)	(1,900,029)	(9,291,477)
EBITDA Margin	-24.3%	-11.7%	-10.1%	-20.3%	-10.8%	-17%
Contactual Allowance %	60.2%	42.3%	40.9%	55.5%	48.4%	49.7%
Bad Debt %	13.4%	17.4%	4.2%	6.8%	2.7%	10.4%
Write-off %	13.4%	17.4%	4.2%	6.8%	2.7%	10.4%
Salaries and Wages % Net Rev	44.5%	35.0%	26.6%	35.0%	26.1%	35.3%
Benefits % Net Rev	41.1%	27.2%	21.8%	26.8%	20.2%	29.2%
Professional Fees % Net Rev	48.6%	31.8%	37.6%	45.4%	39.9%	40.9%
Pharmacy % Net Rev	4.3%	10.4%	0.7%	2.2%	6.9%	4.4%
Medical Supplies % Net Rev	6.5%	4.5%	7.0%	5.9%	5.5%	6.0%
Hospice Neterations % Net Rev	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
EHR System Expense % Net Rev	2.2%	3.4%	2.7%	2.9%	1.7%	2.8%
Other Direct Expenses % Net Rev	11.2%	10.3%	9.8%	9.2%	9.1%	10.1%
Total Cost of Services - Direct % Net Rev	158.5%	122.6%	106.2%	127.5%	109.4%	128.7%
Cash on Hand	8,260,905	9,033,146	7,095,805	8,362,653	7,944,312	8,362,653
Cash to Debt	0.6	0.5	0.4	0.5	0.5	0.5
Average Age of Plant	16.31	15.71	15.66	14.56	15.33	15.56
Current Ratio	3.35	3.02	2.92	2.88	2.68	304.0%
Quick Ratio	3.18	2.86	2.76	2.72	2.53	288.0%
Gross Margin	-58.5%	-22.6%	-6.2%	-27.5%	-9.4%	-28.7%
Inventory Turnover	3.71	2.48	2.55	3.53	1.99	3.07
Inventory Turn-Days	98.41	147.06	143.06	103.27	183.72	122.95
Accounts Receivable Turnover	4.69	3.17	2.47	3.08	2.05	3.35
Accounts Receivable Turn-Days	77.86	115.05	147.93	118.53	177.87	114.84
Accounts Payable Turnover	5.24	3.75	4.50	6.30	4.01	4.94
Average Payment Period	69.69	97.44	81.13	57.96	91.02	76.56

Joseph House

Room nights used in 2022		1361
Motel Cost @ $175 per night	$	238,175.00
Building Depreciation per year	$	42,245.00
Furniture Depreciation per year	$	30,000.00
**fully depreciated ending 12/31/24*		
Other expenses (staffing, maintenance, etc.)	$	98,308.00
Total Expenses	$	170,553.00
Net Benefit to District	**$**	**67,622.00**
Future Expense estimated at $100,000 per year	$	10,000.00
**Roof Replacement 2023-2024*		
2025 Expenses		
Building Depreciation per year	$	42,245.00
Roof Depreciation per year	$	10,000.00
Other expenses (staffing, maintenance, etc.)	$	100,000.00
Total Expenses	$	152,245.00
2025 Net Benefit	$	85,930.00

RSM US LLP

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January 6, 2023

Stephen DelRossi
Chief Financial Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

Dear Stephen:

Thank you for considering RSM US LLP to assist with the consulting needs of Northern Inyo Healthcare District. Please find enclosed the Statement of Work for Revenue Cycle Margin Improvement services. If you are in agreement, we ask that you please sign the Statement of Work.

We look forward to working with you on your consulting needs.

Sincerely,

Michael Brown
Director
RSM US LLP
239 513 6589

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STATEMENT OF WORK—REVENUE CYCLE MARGIN IMPROVEMENT

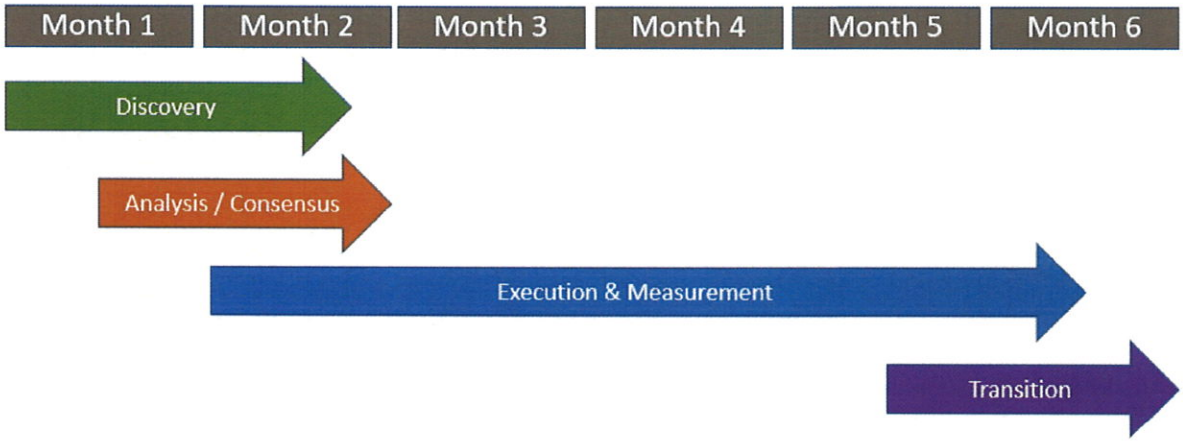
This Statement of Work ("Statement of Work" or "SOW") dated January 6, 2023, is entered into by and between Northern Inyo Healthcare District ("Client," "you" or "your") and RSM US LLP, an Iowa limited liability partnership ("RSM," "we," "us" or "our") pursuant to the Master Services Agreement dated December 23, 2022, (the "Agreement") all of the terms of which are hereby incorporated herein by reference.

A. Services and Scope of Work

Our work will be to assist and advise you with this engagement. As stated below and for clarity, we will not, nor does Client desire us to, perform any management functions, make management decisions, or otherwise perform in a capacity equivalent to that of an employee or officer of Client.

Client implemented Cerner Community Works and has subsequently experienced a consistent drop in key revenue cycle performance metrics. Client is seeking a transformation partner to strategically address the people, process and technology influences on current-state financial performance. RSM will serve to address gaps and deficiencies that will provide the greatest return on investment.

Engagement Activities



Discovery

- Interview key process stakeholders and subject matter specialists to gather pain points and historical information related to the performance of Cerner and impact on processes
- Map out all current revenue cycle processes
- Analyze six (6) months of historical production and financial performance data
- Acquire one (1) year of eight hundred thirty-five (835) files to develop the denial analytics platform
- Evaluate the current inventory of open tickets
- Run available reporting to assess the current state of Cerner design

Analysis and Consensus

- Itemize each of the people, process or technology items impacting the business
- Where possible, RSM will quantify the impact of these items to current performance
- Develop a draft of findings, impact, recommendations and expected return on investment (ROI)
- Set initial priorities based on impact, effort and expected ROI
- Meet with National Institutes of Health (NIH) stakeholders to refine priorities based on organizational objectives
- Meet with NIH and Cerner leadership to review priorities, anticipated work effort, timeline and communication plan

Execution and Measurement

- Develop and deliver technical materials for each change related to a Cerner fix or enhancement
- Develop and deliver training materials related to each change impacting end user experience
- Facilitate Discharged, Not Final Billed (DNFB) task force
- Facilitate Denials task force
- Facilitate High Dollar Review committee
- Provide coaching to employees where guidance is needed to sharpen technical skills
- Pull data weekly to monitor impact of changes to business performance
- Provide weekly report of progress to NIH stakeholders
- Implement corrective action plan to address any lag in performance improvement results

Transition

- Compile a knowledge transfer document related to all changes for internal NIH consumption
- Coach designated small to medium-sized enterprises SMEs in the facilitation of the DNFB task force, Denials task force and High Dollar Review committee
- Provide additional coaching to employees where guidance is needed
- Pull data weekly to monitor impact of changes to business performance
- Provide weekly report of progress to NIH stakeholders
- Implement corrective action plan to address any lag in performance improvement results

Deliverables

- Transformation Roadmap including findings, impact, recommendation and priorities
- Technical documentation for all changes related to Cerner or other bolt-on revenue cycle applications
- Documentation from all task force and committee meetings
- Weekly status report including activities, outcomes, performance tracking and corrective action plans
- Training materials and signed confirmation of training completion

The procedures to be performed will not constitute an audit, review or compilation of Client's financial statements or any part thereof, nor the external examination of management's assertions concerning the effectiveness of Client's internal control systems or an examination of compliance with laws, regulations or other matters. Accordingly, our performance of the procedures will not result in the expression of an opinion or any other form of assurance on Client's financial statements or any part thereof, nor an external opinion or any other form of assurance of Client's internal control systems or its compliance with laws, regulations or other matters.

Unless otherwise expressly set forth herein, changes to the scope, timing and/or cost of the Services set forth in this Statement of Work will be subject to a mutually agreed upon Change Order executed by both parties or, if more appropriate in the reasonable judgment of RSM, a separate Statement of Work executed by both parties.

Timing

Project duration is expected to be six (6) months.

B. Engagement Team

Michael Brown will be responsible for overseeing the engagement and the delivery of all Services to you and will coordinate all fieldwork and engagement communications. Other personnel at the necessary skill and experience levels may be called upon to assist in this engagement as appropriate. While we will attempt to comply with your requests for certain individuals, we retain the right to assign and reassign our personnel, as appropriate, to perform the Services.

If any portion of our Services is performed on Client premises, our personnel shall observe your reasonable policies regarding working conditions, building security and business hours, to the extent our personnel are made aware of such policies.

You acknowledge and agree that we may use one of our subsidiaries located within or outside the United States to assist us with the provision of the Services, which may result in such subsidiary having access to and/or receiving certain protected and/or confidential information of yours.

C. Third-Party Products

This Statement of Work includes the following with respect to Third-Party Hardware Products or Third-Party Licensed Products (each a Third-Party Product):

- RSM services in connection with Client's use of a Third-Party Product
- RSM's recommendation that Client purchase, license and/or subscribe to a Third-Party Product

Third-Party Products purchased by RSM on behalf of Client will be supplied and invoiced by an RSM Product Sales Affiliate.

You acknowledge and agree that the development, implementation and integration of business software systems is inherently not error-free and that corrections, "bugs" and defects arising prior to or subsequent to deployment are common. Client further acknowledges that its usage of a Third-Party Licensed Product may involve the movement and storage of Client's data solely within the infrastructure provided by the Third-Party Licensed Product and not RSM's, and that Client's EULA or other agreements with the Licensor of such Third-Party Licensed Product will govern all obligations relating to data privacy, storage, recovery, security, and processing, as well as the service levels associated, with such Third-Party Licensed Product.

D. Conflicts and Waiver

Client acknowledges and understands that RSM may (i) have a past or ongoing business relationship with a Licensor of a Third-Party Product; (ii) recommend a Third-Party Product from such Licensor to Client; and/or (iii) receive compensation, commissions or other benefits, whether economic or not, from a Licensor of a Third-Party Product in connection with RSM's relationship with such Licensor or RSM's referral or sale of such Licensor's Third-Party Product to Client. In the event that any or all of the foregoing may or does constitute a conflict of interest (whether real or perceived), Client hereby agrees to waive such conflict of interest and agrees to release and hold RSM (and its partners, principals, employees, contractors, subcontractors, affiliates and agents) harmless from and against any claims arising from, out of, or relating to such conflict of interest.

E. Client Acceptance of Work

Our work will be subject to Acceptance Testing as provided in the Agreement.

F. Engagement Assumptions, Client Acknowledgements, Responsibilities and Representations

Our Services, Fees and work schedule are based upon the following assumptions, acknowledgements, representations and understandings with you:

- Client will determine the extent of services it wishes RSM to provide and will undertake the responsibilities set forth in this Statement of Work.
- Client will designate an employee or employees within its senior management who will make or obtain all management decisions with respect to this Statement of Work on a timely basis.
- Client will ensure that we have access to key people, facilities and data, and that all levels of your employees and contractors will cooperate fully and timely with us. We will also let you know where we feel we are not getting the appropriate cooperation or direction and advise you of any other issues related to this engagement. The success of this engagement is dependent upon full openness, communications, cooperation and timely direction.
- Client agrees that all assumptions set forth in this Statement of Work are accurate and agrees to provide us with such further information we may need and which we can rely on to be accurate and complete. We will be entitled to rely on all of your decisions and approvals made independently, and we will not be obligated to evaluate, advise on, confirm or reject such decisions and approvals.
- Client will evaluate the adequacy and results of services and will let us know immediately of any problems or issues you perceive in our personnel, services or deliverables.

- To the extent our services or deliverables include the design or implementation of hardware or software systems, Client agrees to be responsible for making all management decisions. These decisions include but are not limited to the systems to be evaluated and selected, the design of those systems, the controls to be tested, the security and system procedures to be implemented, the scope and timetable of the implementation, testing, training and conversion plan.
- **Systems selection acknowledgement**: Client acknowledges and agrees that both the decision as to what, if any, system to select and the selection of such system is the sole responsibility of Client.

The fulfillment and confirmation of these responsibilities, acknowledgements and representations are critical to the success of this engagement. The successful delivery of our Services, and the Fees charged, are also dependent on your timely and effective completion of your responsibilities, the accuracy and completeness of the assumptions, and timely decisions and approvals by your management. You will be responsible for any delays, additional costs or other liabilities caused by or associated with any deficiencies in the assumptions or in carrying out your responsibilities.

G. Parties' Understandings Concerning Situation Around COVID-19

To the extent any of the services described herein require a party to visit ("Visiting Party") the other party's facilities ("Host Party") in person, the Visiting Party agrees to comply with the Host Party's rules and regulations regarding COVID-19 safety protocols while on the Host Party's premises, provided the Visiting Party is made aware of such rules and regulations. Further, in the event any of the services described herein need to be suspended and/or rescheduled by a party due to the ongoing situation surrounding COVID-19, the party requesting the suspension or rescheduling of the services will provide the other party with prompt written notice of the foregoing. To the extent such suspension and/or rescheduling of the services impacts either the cost of the services or the ability of the Client or RSM to meet any deadlines or timeframes set forth herein, or both, the parties will document this in a written agreement mutually agreed upon and executed by both parties. Each party agrees that: **(I) NEITHER PARTY, NOR THEIR PERSONNEL, WILL BE HELD RESPONSIBLE OR LIABLE TO THE OTHER PARTY FOR ANY LOSSES OR DAMAGES, INCLUDING, BUT NOT LIMITED TO, INTERRUPTION OR LOSS OF BUSINESS, OR ANY LOST PROFITS, REVENUE OR DATA, ARISING FROM OR RELATING TO DELAYS IN THE PERFORMANCE, OR THE NONPERFORMANCE, OF THE SERVICES DESCRIBED HEREIN DUE TO THE SITUATION SURROUNDING COVID-19; AND (II) NEITHER PARTY, NOR ANY OF THEIR RESPECTIVE PERSONNEL, SHALL BE RESPONSIBLE OR LIABLE FOR ANY PERSONAL OR BODILY INJURY ARISING FROM OR RELATED TO EXPOSURE TO COVID-19 THROUGH THE OTHER PARTY'S PERSONNEL IN CONNECTION WITH THE SERVICES, INCLUDING, BUT NOT LIMITED TO, DEATH, OR ANY RESULTING LOSS OR DAMAGE RELATED TO ANY SUCH INJURY, INCLUDING, BUT NOT LIMITED TO, LOST PROFITS, REVENUE, AND DATA.**

H. Additional Understandings Arising from the Performance of Attest Services by RSM to Client or an Affiliate of Client Under a Separate Engagement Agreement

In connection with the performance of these Services, Client agrees to make all management decisions and perform all management functions; designate an individual who possesses suitable skills, knowledge, and/or experience, preferably within senior management, to oversee such Services; evaluate the adequacy and results of the Services performed; accept responsibility for the results of the Services; and establish and maintain internal controls, including monitoring ongoing activities. We will not perform any management functions, make management decisions, or otherwise perform in a capacity equivalent to that of an employee or officer of Client.

I. Fees and Expenses

Our Fees for the Services described in this Statement of Work will be based upon actual time at our blended hourly rates. In addition to our Fees, you will be invoiced for (i) direct expenses, including, as applicable, amounts attributable to travel, meals, fees and expenses for services from other professionals, and for services provided by RSM's Subcontractors, and (ii) a charge of five percent (5%) of the Fees for indirect administrative expenses, such as technology, research and library databases, communications, photocopying, postage and clerical assistance, security, privacy, automation, risk mitigation, regulatory compliance requirements, peer quality reviews and engagement management oversight, RSM's development library, and research and development team engagement involvement.

The blended hourly rate charged for the work identified in this Statement of Work will be $300.

Based on our initial understanding of the engagement scope, we are estimating one thousand five hundred (1,500) hours of engagement work. The total estimated billings for the Services described in this Statement of Work is $450,000, plus Expenses.

Travel time will be billed at fifty percent (50%) of our standard hourly rates and is in addition to the estimated Fees.

The Fees quoted in this Statement of Work will remain valid for sixty (60) days from the date of issuance.

You acknowledge that this is our good faith estimate based upon our understanding of the engagement assumptions and the facts and circumstances we are aware of at this time. If the basis of our estimates is inaccurate, the Fees and Expenses may be different from those we each anticipate. If circumstances are encountered that affect our ability to proceed according to the plan outlined above, such as major scope changes, loss of key Client personnel, unavailable information, or undetermined or requested scope changes during our scoping efforts, we will inform you promptly and seek your approval for any changes in scope, timing or Fees that may result from such circumstances.

J. Invoice Address

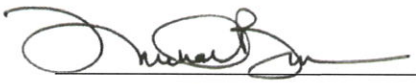
Invoices for our Services rendered pursuant to this Statement of Work will be sent to:

Stephen DelRossi
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

K. Acknowledgement and Acceptance

By the signatures of their duly authorized representatives below, RSM and Client, intending to be legally bound, acknowledge that they have read and agree to all of the provisions of this Statement of Work (including any Exhibits and Attachments hereto) as of the date set forth above. RSM and Client, and each signatory below, hereby represents that said signatory is a duly authorized representative of such party and has the requisite power and authority to bind such party to the terms set forth in this Statement of Work.

AGREED TO AND ACKNOWLEDGED BY:

RSM US LLP		**Northern Inyo Healthcare District**	
By:		By:	
Name:	Michael Brown	Name:	
Title:	Director	Title:	
Date:	January 6, 2023	Date:	
		FEIN/Tax ID Number:	

1/6/2023 3:40 PM

Options to return signed contract:
1. DocuSign
2. Email: CMTAcceptance@rsmus.com
3. Fax: 877 281 9587
4. Mail: RSM US LLP, Attn: Client Resource Center, 201 First Street SE, Suite 800, Cedar Rapids, IA 52401

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

Northern Inyo Healthcare District

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

Date: 12/29/2022
To: Board of Directors
From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Dianne Picken is back from leave and we are glad to have her back!

Physician Recruitment update

- General Surgery: We are excited to announce that Dr. Connor Wiles will be joining the NIHD team in August 2023 as a full time general surgeon. He is completing his residency at Cottage Hospital in Santa Barbara.
- Psychiatric Nurse Practitioner: In partnership with Dr. Murat Akalin, a psychiatrist in San Luis Obispo, we will be welcoming Sue Park, Psych NP. She will be working with Dr. Akalin and consulting with NIHD to see patients and provide psychiatric care in Bishop.
- ED: We continue to be well staffed in the Emergency Department, welcoming Drs. Mary Cheffers, Ryan Raam, and Todd Schneberk in the past 2 months.

Pharmacy Department update

The Pharmacy remodel continues at a steady pace. No new updates.

We will be implementing a telepharmacy service sometime in January. With Jeff Kneip moving to the Pharmacy Director role, we decided not to backfill his full time Staff Pharmacist position. This left 2 Staff Pharmacists carrying the burden of 365 day call coverage. The most common and important duty for the on-call Pharmacist is verifying correct medications and doses. Because this is fairly straightforward work, we have decided to outsource the afterhours medication verification work to a company called CPS. This will offload our pharmacists and allow them more rest at night. During this time, we will be closely monitoring medication accuracy.

Quality Department update

Our Quality department has 3 main focus areas; Regulatory reporting, Survey readiness, and Quality Projects. Our team has a great system for regulatory reporting and stay up to date with multiple regulatory bodies. Our survey readiness was tested with our Joint Commission Survey, which went really well. In terms of Quality Projects, we will be embarking on several projects in 2023 in partnership with nearly every department in the hospital.

Also included in your Board Packet is the QAPI annual plan. We reviewed this plan in December 2022 and made minimal changes. Every year (much like a New Years Resolution), we review the list of projects we completed in the current year and make a list of projects we would like to achieve in the year ahead.

Dietary Department

Our Registered Dietitians (RD) continue to work diligently for our patients. On the inpatient side, we have critically explored different supplements that may be beneficial to our patients. The RD's also keep a bulletin board near the cafeteria (for those waiting in line) to read interesting facts about nutrition and health. We have plans in the coming year to continue to educate our community and staff about nutrition and we look forward to offering the next Employee Engagement Event.

Rehab Department

Our Rehab Department has been going to NIHD provider meetings and introducing services that are offered at NIHD including pelvic therapy for men and women offered by 2 of our Physical Therapists as well as Cognitive Behavioral Therapy (CBT) offered by Monica Jones, our Occupational Therapist. We continue to offer later appointments, to accommodate busy work schedules. We continue to recruit for a full time Speech and Language Pathologist (SLP) and currently have a traveler. We have one other Physical Therapy traveler, otherwise we are fully staffed!

Infection Prevention

Covid 19

We continue to run the RHC "Car Clinic" for acute illness needs, testing for Covid, RSV and influenza. We had planned to move the "Car Clinic" inside the RHC but with the increase in RSV and influenza cases, we are staying outside for now. We have acquired negative pressure units to be installed at the RHC and Internal Medicine, as we prepare to manage these viral illnesses long term.

Due to the complexity of the Covid vaccines in terms of various dilutions and dosages for the primary series and boosters for each age group, we have decided to only carry Moderna products moving forward. Local pharmacies and Inyo County HHS are offering the Covid bivalent vaccine booster from both 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

No cases reported in the US.

Infection Prevention

CDPH Hospital Acquired Infection (HAI) team will be on-site on January 4th to validate NIHD HAI data. The CDPH regional HAI program provides non-regulatory consultation and assistance to support HAI prevention. The Infection Prevention team is excited about the learning opportunity, recommendations on prevention strategies, and suggestions for HAI data analysis and reporting to CMS and CDPH.

Physician Compensation

You will receive the first Annual Physician Compensation Report this month. We will continue to provide updates through the year as appropriate.

Community Health Needs Assessment (CHNA)

In January, we will be rolling out an EConsult service to our primary care clinics. This will allow for our providers to message a variety of specialists to ask specific questions about the care of their patients (see attached). There will be no cost to patients for this service and some insurance companies cover. If your provider seeks the recommendations from a specialist, this service will be discussed with you and utilized if appropriate. This is in response to our CHNA regarding the need for specialty services in our area. We hope that this will decrease the need for patient travel for specialty care.

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

Date: 12/28/22

Title: **Annual Physician Compensation Report**

Synopsis: As requested by the Board, attached is the first Annual Physician Compensation Report. This report provides background information regarding Physician Compensation and summarizes the work accomplished at NIHD over the past 2-3 years.

Prepared by: _____
Name Joy Enopiade, MD
Title CMO

Approved by: _____
Name
Title

Annual Physician Compensation Report to Board of Directors

January 2023

Submitted by Joy Engblade, MD, MMM

Introduction:

With a change in leadership in 2019, the Board of Directors of Northern Inyo Healthcare District identified potential inconsistencies regarding physician compensation and fair market value. The Board asked the leadership at Northern Inyo Healthcare District (NIHD) to evaluate the physician compensation structure. Work has been completed over the past 3 years and the Board has been given intermittent updates along the way. In late 2022, the Board requested an annual report regarding physician compensation as a mechanism to provide high-level oversight to this process. This is the first Annual Physician Compensation Report to the Board of Directors.

Background:

50 years ago, nearly all physician practices were private. Starting in the early 1990's, HMO's were developed and hospital systems saw their physician productivity plummet because physicians became employed, on a fixed salary. By the early 2000's many physicians were back in private practice or on some sort of non-employed model.

During the early 2010's, the pendulum swung back to physician employment, but this time a vast majority of these agreements included a productivity component in hopes of mitigating the poor productivity noted in the early 1990's (1). With these mitigation models in place, hospital systems did not see the huge plummet in productivity they found in the 1990's but physician satisfaction has been decreasing for years, thought to be related to feeling overworked and under supported. Studies cite the main reasons being decreased autonomy with increased accountability, constant change, and a mismatch between what doctors were trained to do versus what they are expected to do. (1)

At the same time, there have been changes in reimbursement focused more on value and less on production. Value Based Purchasing programs became more common. These programs reimbursed based on value where value is defined as 'health outcomes in relation to the cost of the care provided' (2). Value programs include things like coordination of care, population health, and team based care. Many of these reimbursement changes have not directly affected Critical Access Hospitals except for some bundling of services (i.e., surgery bundling reimbursement) but moving forward, we expect more reimbursement changes to affect us.

Historically, all salaries at NIHD have been fixed or paid by shift. We have never incorporated a District wide productivity or quality metric into compensation. Because of the changing health care environment, these compensation metrics have been discussed as a way to increase value, increase patient access to care, and increase reimbursement.

Independent Contractor (IC) vs Employee

Per the IRS, a person is considered an independent contractor if the company: "… has the right to control and direct only the result of the work and not what will be done and how it will be done." (3) If a worker performs services that can be controlled by an employer, then that worker is considered an employee.

Figuring out who is an independent contractor and who is an employee has also been difficult. Usually the deciding factor is based on which party has final say or control over how the work is completed. The court case that illustrates the difference is the Borello Case. This case involved sharecroppers who were hired seasonally as independent contractors. A court eventually ruled that the sharecroppers did not have control around how to do their work or when to do it; that the employer retained "all necessary control over a job that could only be done one way", so by definition, they were employees. (4)

AB 5 addressed the issue deciphering between an independent contractor verses an employee in California. It put into effect a more restrictive "ABC" test for worker classification. The "ABC" test has three components. If these three components are met, then the person is considered an independent contractor. The "ABC" test includes: 1) the worker is free from control and direction of the hiring entity in connection with the performance of the work, 2) the worker performs work that is outside the usual course of the hiring entity's business, and 3) the worker is customarily engaged in an independently established trade, occupation or business of the same nature that is involved in the work performed. (5) Of note, AB 5 law exempted physicians. Even though it exempted physicians, it added confusion to an already confusing distinction.

California Corporate Practice of Medicine

So why does the distinction between an independent contractor and an employee matter? Because in the state of California, physicians cannot be directly employed by a hospital. Physicians in California are either independent contractors or employees of a Medical Group that contract with a hospital. In either case, the hospital has to abide by rules that limit the control a hospital has over the practice of medicine. The intent of these rules are to make sure that the physician has the patient's best interests in mind and not the hospital's best interests. It prevents unlicensed persons from interfering with or influencing a physician's professional judgement (6). There is some debate whether adding a productivity or quality component or incentive to a physician's salary may interfere with that professional judgement.

Outline:

After discussion about salary, employment limitations and the California Corporate Practice of Medicine, the District decided to take a close look at Physician Compensation at NIHD, focusing first on the physicians employed by our local medical group, RCT INC. The big picture plan to reconstruct physician compensation was broken up into several steps. First, we needed to gather the stakeholders to establish a Physician Compensation Philosophy. We felt this was important to establish guiding principles. We created an Ad Hoc committee consisting of two Board members, the NIHD Executives,

the Chief of Staff, Director of HR and the Medical Staff Director. After establishing the Compensation Philosophy, we started to work on the Compensation Structure. To assist with this, we gathered a working group of volunteer physicians who included Drs. Stacey Brown, Stefan Schunk, Lindsey Ricci and myself. There were many discussions regarding productivity and quality bonuses, as well as unintended consequences with these incentives. We discussed how to mitigate the unintended consequences. During this process, we also worked closely with VMG Consulting, a healthcare consulting firm to assist with structure development and fair market value analysis.

Physician Compensation Philosophy at NIHD

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

Goal: We will recruit and retain physicians who are dedicated to the community and are motivated to provide high quality, efficient and effective care.

Philosophy:

We will promote alignment between physicians, the District, and the community by offering compensation that is:

Fair and equitable

Transparent

Consistent

Competitive

Fiscally-responsible

Compliant with federal, state and local laws

Compensation Structure

Nationally, most physician compensation packages include some sort of incentive to be productive and to achieve quality metrics. The Physician Subgroup discussed whether to include or not include these incentives into the NIHD Physician Compensation structure. We also discussed how to mitigate these unintended consequences via a "Social Compact" that was ultimately renamed to "Engagement."

Productivity

Adding a productivity component to a physician's salary could incentivize the physician to be more productive and see more patients. This could help drive change in our clinics (i.e., more engagement in efficiency) and could increase patient access. The implementation of a productivity component could be problematic since this may also be seen as controlling what work will be done, which could classify the physician as an employee and as noted above, direct employment of physicians is not allowed in the state of California. However, there are certainly many organizations that have added a productivity

component to physician's salaries in the state of California so this arrangement is possible without being considered employment.

There are potential issues with adding productivity to a physician's salary at NIHD. Unlike a private practice, the individual physician does not have control over ancillary staff. This lack of control could hinder physician productivity with inefficient scheduling, office throughput, and lack of coordination for patient care. As a District, we obviously want to promote efficiency in our patient care areas and we would like the physicians to be engaged in this process, but it does seem unfair to base a physician's salary on factors out of their control.

From a patient care aspect, there is also concern about a lack of collaborative care, meaning physicians not taking the time to collaborate with colleagues to coordinate care since the time taken in care coordination is not directly reimbursable. It is not clear that this would happen, but this has been discussed as a concern. Our surgeons are also concerned about the patient perception of being paid on productivity. Obviously, the more surgeries a physician performs, the more that physician will be paid. When a surgeon recommends surgery for a patient, the surgeon wants the patient to be confident that surgery is the right clinical decision for the patient, not question the surgeon's motivation for recommending surgery based on productivity incentives.

Some NIHD physicians do not think that adding a productivity bonus would change their behavior on a day to day basis. They feel they are busy during their workdays and could not add anything else, even if more money were offered. They also do not think they would feel motivated to work extra days with a productivity bonus. With that being said, physicians are not always good at assessing their behavioral changes. Pharmaceutical marketing is a good example. In most studies, physicians do not think that pharmaceutical marketing changes their behavior but indeed, it does. (7) Logic says that if you paid physicians to do more, they will likely do more.

Collecting the data to appropriately calculate productivity can also be fraught with issues. Setting up the appropriate data collection systems can be done, but will take front end time and ongoing maintenance. This will increase time for payroll and may mandate a dedicated FTE to ensure this is done timely and correctly.

There is also a concern about a lack of engagement. If a physician is getting rewarded for seeing more patients, that physician will try to see more patients at the expense of doing other needed work around the District. The District needs medical expertise from physicians for policy development, clinical guidelines development and leadership. All of these things take time away from seeing patients. With a push for productivity, we may lose engagement on a Medical Staff level and potentially lose the voice and the buy-in of the practicing physician on a District level.

Despite all of the potential downsides, we decided to incorporate a component of productivity into Physician Compensation to align physician goals with District goals. We have benchmarked baseline productivity data for all physicians and have set goals for the next year. If the physician achieves the goal, the physician will earn a productivity bonus. We anticipate that each year, the productivity goal will need to be re-evaluated and likely reset. At NIHD, we have operational limitations (i.e., staffing and space) that will limit the amount of productivity that is possible. The team also felt strongly about instituting other engagement rewards to mitigate unintended consequences.

Quality metrics

Medicine is moving away from rewarding *quantity* and is moving towards rewarding *quality*. So what is quality? Webster defines it as "a degree of excellence." (8) So what is excellence in medicine? That is a hard question and depends on who you ask. In medicine, both the physician and the hospital are responsible for "a degree of excellence."

From the physician standpoint, if there is a quality concern that involves a Medical Staff member, the case is peer reviewed and protected from being public knowledge. The Peer Review Protection Act of 1974 was created to ensure that frank discussions could be held with physician peers to dissect the concern and improve quality. This protection was to encourage "comprehensive, honest and potentially critical evaluations of medical professionals by their peers." (9) In general, these cases cannot be measured or quantified but they often result in recommendations on how to improve a process or provide physician education amongst colleagues.

When a hospital decides to add quality metrics to a compensation model, the reason is to improve the health of the community. Hospitals sometimes set quality metrics independently when a specific issue is noted, but more often there is an underlying incentive to satisfy quality measures set by regulatory bodies or to gain funding through grants. In any case, these quality measures provide an incentive to perform a certain task. Examples of measurable quality metrics would be standards like colon cancer screening, checking HA1C for diabetic patients, and cervical cancer screening. The issue is that many of these quality metrics are out of the control of the physician. The physician heavily relies on the office staff to collect the information. The physician will depend on her staff to ask these screening questions and she will depend on her patients complete the tasks. You can imagine that if the physician has a patient population with barriers to healthcare, these tasks will not be completed and the physician will not receive a quality bonus at no fault of the physician.

Intuitively, achieving quality metrics would improve the health of the community, but a recent study questions this. (10) In any case, we will continue to be held to a standard of quality based on established quality metrics by regulatory agencies. These metrics are increasingly being made public by the regulatory agencies.

If we were to institute a quality component to compensation, we would need to carefully create a system to decide on what data to collect, then collect the data, verify and validate the data and calculate how that translates into dollars for the physician. Some argue that this time and effort could be better spent doing other activities that would directly benefit patients.

We decided not to include any quality metrics in Physician Compensation for 2023, due to the need to carefully choose metrics and specifically outline success. We anticipate that the metrics will be different for each specialty. In partnership with the Quality department, these metrics will be developed and discussed through 2023 and we anticipate the metrics to be established by the end of 2023 for goals to be achieve in 2024.

Engagement incentives

The initial Social Compact discussions resulted in the "Social Compact" below. The intention of the items below are to offset unintended consequences of compensating for productivity and quality metrics.

Social Compact – things for all physicians to commit to at NIHD

- Take great care of patients
    - Follow quality measures and try to improve
    - Follow Patient satisfaction scores and try to improve
    - Collaborate with District and non-District providers to coordinate care for patients
- Optimize access for patients
    - Make yourself available to serve our community
- Help recruit, develop, and retain talented individuals
    - Teach each other, support each other, treat each other with respect
- Be a good citizen
    - Be a part of a committee or project
    - Be helpful to your colleagues, be a team member
    - Be a positive influence in our community
        - Embrace community teaching opportunities
        - Represent NIHD in a positive light

In order to quantify these items more discretely, the Engagement points system was developed:

Metric	Points	Max points
Attendance and participation at all Med Staff General meetings (excluding excused absence*)	0.25	0.25
Attendance and participation at all Med Staff Department meetings (excluding excused absence*)	0.25	0.25
Chair or Chief of Department	0.25	0.25
Attendance and participation at other department level meetings (i.e. department provider meetings, office meetings; 75% attendance minimum)	0.25	0.25
Participation in committee other than department meeting	0.25	0.5
Chair a committee other than department meeting	0.2	0.4
Participate in project within department or District wide	0.25	0.5

Citizenship, i.e. Helping colleagues with emergency coverage/overflow/staffing/OR assist or other gesture of being a good team member like educational talks to team member – to be approved by team*	0.2	0.4
Community engagement/outreach, i.e. give an educational talk to community like Healthy Lifestyles Talk or misc NIHD outreach – to be approved by team*	0.1	0.4
Teach a student (minimum 2 weeks)	0.1	0.3
TOTALS		3.5

Summary:

After the arrival of a full time Chief Financial Officer (CFO), the bulk of the Physician Compensation work will now be transitioned to the CFO, Stephen Delrossi. Starting in 2023, the CFO and the Finance department will "own" Physician Compensation. The Chief Medical Officer (CMO) will continue to do Physician Recruiting as well as assisting with establishing the operational capacity and clinical needs of the District. This will be in partnership with the CFO as Physician Contracts and Compensation are established.

Physician Compensation at NIHD will be fair and equitable, transparent, consistent, competitive, fiscally-responsible, and compliant with federal, state and local laws. Working with multiple stakeholders throughout the District as well as our healthcare consulting firm, we have established a Compensation structure on which to build compensation packages. This will attract and retain physicians to NIHD. We anticipate that we will need to adjust metrics based on changes in operational and clinical capacity. In partnership with the CMO, CFO, and Medical Staff leadership, we will make these changes collaboratively.

The Board of Directors will receive a Physician Compensation Report annually. Reports moving forward will have less background information and more information regarding metric adjustments, productivity, recruitment and retention, and finances.

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

Date: 12/28/22

Title: **Annual QAPI Plan**

Synopsis: It is recommended that the Board of Directors review the Annual QAPI Plan and accept the plan as written.

Prepared by: _____
Name Joy Engbolade, MD
Title CMO

Approved by: _____
Name
Title

Northern Inyo Healthcare District QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) PLAN

CY 2023

SECTION 1: INTRODUCTION

PURPOSE

The Quality Assurance and Performance Improvement (QAPI) Plan establishes a district-wide program for an interdisciplinary and ongoing approach to monitor, assess, and improve patient care and services at Northern Inyo Healthcare District (NIHD). The QAPI Plan is designed to support the Mission, Vision, and Values of the District and collectively drive the safety and quality of patient care services provided.

MISSION, VISION AND VALUES

The Northern Inyo Healthcare District mission statement is as follows:

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

The Northern Inyo Healthcare District Vision statement is as follows:

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

CORE VALUES: COMPASSION AND INTEGRITY

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

ASPIRATIONAL VALUES: QUALITY/EXCELLENCE AND INNOVATION

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

PERMISSIVE VALUES: TEAM-BASED AND SAFETY

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

SCOPE OF SERVICE AND AUTHORITY

The scope of this plan will include all patient care and support services throughout the District. The plan will measure, analyze, and track performance improvement indicators and other aspects of the quality of care. The plan reviews the District's operating systems and processes of care to identify and implement opportunities to provide high quality and safe care, focusing on improving health outcomes as well as preventing and reducing medical errors.

NIHD's Board of Directors is responsible for this plan, which supports the mission, vision, and values of the District and is ultimately responsible for ensuring that the QAPI Plan activities are met. The Board of Directors delegates the development, implementation, and sustainability of the plan to the Quality Council, Quality Department, and Executive Team.

NIHD's Executive Team delegates the implementation of the QAPI Plan to the Quality Council and Quality Department. The Executive Team ensures resources are available for the implementation of quality and performance improvement activities.

NIHD's medical staff is responsible for participating in the QAPI Plan to achieve quality and safe patient care. Medical staff members contribute to the QAPI Plan through involvement in performance improvement activities, serving on committees, working on project teams, and through taking on leadership roles.

DEFINITIONS AND PRINCIPLES

QUALITY SERVICES

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

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

ADVERSE EVENT

Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.

ERROR

Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.

MEDICAL ERROR

Medical error means an error that occurs in the delivery of healthcare services.

PERFORMANCE IMPROVEMENT PRINCIPLES

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

- Patient Focused. Every level of service shall be viewed from the perspective of the patient. With this frame of mind the District will focus on the patient experience and how best to adopt changes that enhance the experience.

- Workforce Engagement. All NIHD workforce members shall participate in ongoing quality improvement. Workforce members shall understand that along with ownership of how they engage those who contact or present to the District they are also empowered to identify issues, bring those issues to the attention of others, and participate in processes intended to prevent or improve the issue.
- Leadership Involvement. District leadership along with medical staff will serve as 'champions' of initiatives. As champions, they will support, promote, and provide necessary intervention when needed to achieve goals. Additionally, District leadership will ensure that the employees engaged in any given quality initiative have the tools, support, and resources needed to achieve the defined goals.
- Data Informed Practice. The District utilizes data to identify opportunities, determine priorities, and evaluate the effectiveness of quality projects.
- Statistical Tools. The District will apply standard statistical tools to the data collected in order to generate information that is both informative and actionable.
- Prevention over Correction. Although this QAPI Plan will provide for the identification of existing issues/concerns and correcting them, the goal of this QAPI Plan is to emphasize the identification of potential areas of concern to prevent quality of care issues from arising.
- Continuous Improvement. The District will commonly use Plan-Do-Study-Act method of continuous improvement. Furthermore, each endeavor undertaken will warrant an assessment of the best method available to achieve the desired goal.

SECTION 2: PROGRAM STRUCTURE

LEADERSHIP

The key to the success of performance improvement is leadership. Leadership fosters teamwork and provides support to the quality improvement goals, objectives, and activities.

Leadership utilizes performance improvement methodology to identify opportunities for improvement and to monitor the effectiveness, safety, and quality of services provided. They accomplish this by:

- Implementing quality and performance activities that align and support the QAPI Plan.
- Reporting and monitoring indicators on departmental pillars/scorecards.
- Communicating and sharing results of measurement activities and overall performance.

The Quality Department and Quality Council provide ongoing operational oversight of the quality and performance improvement activities at the District.

The Quality Department drives the development of quality and performance improvement activities at the District and participates in committees and project teams related to improving quality of care. The department assists the District in fulfilling its responsibilities to assure patients receive quality care which also complies with regulatory and accreditation organizations. It does this by:

- Developing the annual QAPI Work Plan and collaborating with the Quality Council on the annual review of the QAPI Plan.
- Establishing measurable objectives based upon priorities identified through use of established criteria for improving quality and safety of services.
- Continuously monitoring regulatory standards and District performance.
- Identifying opportunities for improvement and presenting recommendations to the Quality Council for project approval.
- Supporting quality improvement activities.
- Monitoring progress until goals have been met and maintained.
- Standardizing processes to achieve quality improvement in patient care services.

The Quality Council guides and monitors the quality management efforts throughout the District and coordinates quality improvement efforts with the medical staff.
The Quality Council fulfills such responsibility by:

- Evaluating and making recommendations for improvement to the QAPI Plan.
- Reviewing and assessing feasibility of requests for quality related projects.
- Appointing subcommittees or teams to work on specific quality projects as necessary.
- High level trending of data to identify opportunities for improvement.
- Prioritizing QAPI projects and making recommendations to the Executive Team.
- Overseeing the progress of quality projects to assure timely implementation.
- Utilizing regulatory requirements to identify opportunities for improvement.

WORKFORCE MEMBERS

The Northern Inyo Healthcare District Workforce, including the medical staff, play a vital role in the QAPI Plan. The workforce participates and contributes to the Plan through their delivery of quality of care. Workforce members may be asked to participate in committees, project teams and other initiatives.

Workforce members, including individual members of the medical staff, are invited to bring forth ideas and suggestions for performance improvement activities to their department leaders, chairs or directly to the Quality Council.

GOALS & OBJECTIVES

The goals of the QAPI Plan are to assess the services provided by the District, including contracted services, identify quality and performance opportunities, implement improvement activities and ensure monitoring and sustainability of activities. The QAPI Plan takes a pro-active approach at identifying priorities and aligns with the District Strategic Plan on quality improvement and safety.

The following objectives have been established as long-term goals of the QAPI Plan.

- To evaluate and improve performance measurement systems to assess key processes or outcomes.

- To bring leaders, clinicians, and staff together to review data and clinical adverse occurrences to identify problems.
- To carefully prioritize identified problems or desired projects and set goals for their resolution.
- To achieve measurable improvement in highest priority areas for the selected goals.
- To meet internal and external reporting requirements.

Annually, a Work Plan (Appendix A), is established to address the goals and objectives that have been identified as high priority, high volume, or high risk areas. NIHD also prioritizes activities related to improved health outcomes and the prevention and reduction of medical errors, adverse events, acquired conditions and infections, and transition of care.

SECTION 3: PERFORMANCE IMPROVEMENT METHODOLOGY

PERFORMANCE MEASUREMENT

Performance measurement is the process of regularly assessing the results produced by the District. It involves identifying and selecting indicators of processes, system, and outcomes that are integral to the performance of the service delivery system, and analyzing information related to these indicators on a regular basis. Performance improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance improvement they identify.

The purpose of the measurement and assessment is to:

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

Measurement and assessment involves:

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

PERFORMANCE INDICATORS

A performance indicator, otherwise known as a metric or measure, is a quantitative tool that provides information about the performance of a department's process, services, functions, or outcomes.

Selection of a Performance Indicator is based on the following considerations:

- Alignment with and support of NIHD's mission, vision, and/or values
- Regulatory/accreditation requirement
- Clinical Importance that involves areas or processes that are problem prone, high risk, and/or high volume
- Scientific foundation: Relationship between the indicator and the process, system or clinical outcome.
- Validity: Whether the indicator assesses what it purports to assess
- Meaningfulness: Whether the results of the indicator can be understood, the indicator measures a variable over which NIHD has control, and the variable is possible to change by reasonable performance improvement efforts.
- Availability of industry benchmarks

For the purpose of this plan, performance indicators are tracked and monitored by the Quality department. Measurement of the metrics may be District-wide in scope, targeted to specific areas, departments, services, or selected populations.

The measurements may be ongoing, time limited, intensive, or recurring. The duration and frequency of monitoring are based on the need of the organization, external requirements, and based on the results of the data analysis.

DATA ANALYSIS & ASSESSMENT

Data analysis is completed through the collection and compilation of information. Internal and external collection is used for monitoring performance and ultimately guide the QAPI Plan in data informed decision making.

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

- Trends over time.
- Pre-established standards, goals, benchmarks, or expected levels of performance.
- Evidence-based practices.
- Other hospitals, clinics, or similar service providers.

Data will be assessed for patterns, trends, and/or variations that may identify opportunities for improvement. Data analysis may also be necessary when performance levels or variation indicate a serious event, such as the following:

1. A sentinel event has occurred, triggering a root cause analysis.

2. Performance varies significantly from that of other organizations or recognized standards.

SECTION 4: PERFORMANCE IMPROVEMENT INITIATIVES

The purpose of an initiative is to improve the performance of existing services, quality of care, or to design a new service.

Opportunities for improvement (OFI) may be identified and prioritized by the Quality Council through several means, including:

- Results, actions, or recommendation from internal reporting of events (i.e. Unusual Occurrence Reports).
- Results, responses, and status of regulatory and accreditation surveys or District tracer activities.
- Results of operational or process audits.
- Actions and improvements of Root Cause Analyses and/or Failure Modes Effects (and Criticality) Analyses (FMEAs/FMECAs).

SECTION 5: QAPI PLAN EVALUATION

An evaluation of the QAPI plan will occur an annual basis. Any recommendations for change will be discussed at the Quality Council for approval.
A summary of quality projects and initiatives will be compiled at the end of the year and provided to the Executive Team.

Committee Approval	**Date**
Quality Council	12/06/2022
Medical Executive Committee	01/03/2023
Board of Directors	01/18/2023
Last Board of Director Review	08/19/2021

Developed: 10/19ta
Reviewed:
Revised: 5/2020ta 1/2022af, 12/2022af

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: January 3, 2023
RE: Medical Executive Committee Report

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

A. Medical Staff Appointments (*action item*)
    1. Lisa K. Manzanares, MD (*family medicine*)

B. Policies (*action item*)
    1. *Advance Directives*
    2. *Airborne Infection Isolation Rooms (AIIR)*
    3. *Code of Ethics for Nurses*
    4. *Healthcare Worker Health Screening and Maintenance Requirements*
    5. *Opioid Administration*
    6. *Opioid Sedation Scale*
    7. *Organ/Tissue/Eye Donation*
    8. *Pain Management and Documentation*
    9. *Patient Valuables*
    10. *Standardized Procedure – Adult Health Maintenance Policy for the NP or CNM*

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

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Advance Directives		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Clinical Staff District Wide, Admission Services, Medical Records Department		
Date Last Modified: 11/16/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/04/2011	

PURPOSE:

Northern Inyo Healthcare District (NIHD) is committed to honoring the directives as expressed and written by our patients or their designee, known as the durable power of attorney for health care (DPOA), related to medical treatment. In order to meet this goal patient must be offered education about and the option of completing advanced directive paperwork.

DEFINITIONS:

Advanced Directive (AD): Is a written instruction, recognized under state law, such as a living will or durable power of attorney for health care. It is not a signed physician order and cannot take the place of such. The AD helps to define the wishes relative to end of life care for the patient and identifies the DPOA who can speak for the patient in the event that they are incapacitated.

Physician Order for Life Sustaining Treatment (POLST): This is a physician signed order, that is co-signed by the patient or their DPOA, which is utilized in non-hospital settings. This provides orders for care related to resuscitation, which are honored by pre-hospital care providers in California. This form is not considered an advanced directive, as it does not contain a DPOA.

POLICY:

All inpatients and applicable outpatients, or their representatives will be advised of the patient's right to formulate an advanced directive. They will also be advised of their right to update or change the advanced directive at any time. For those inpatients with an advanced directive will have a copy placed in the medical record.

PROCEDURE:

I. **Admission Services Responsibilities-**

1. At the time of registration for Emergency Department or Inpatient or Observation Services, NIHD Patient Access Representatives will have the patient or family/caregiver complete the top portion of the Adult Advanced Directive Acknowledgement form. Form may be found on intranet>Approved Forms> Adult Advanced Directive Acknowledgement. This form is available in English and Spanish versions.file://root.nih.org/home/Shared/Forms%20Committee/Approved/
2. The registration clerk will complete the bottom portion of the Adult Advanced Directive Acknowledgement form. They will provide the patient with handouts as described in the form.
3. If any type of advanced directive is obtained from the patient, the Patient Access Representative will scan it into the patient's electronic medical record to assure it is available to staff providing care to the patient.

a. Prior to scanning the patient's name, date of birth and medical records number will be written onto the top right hand corner by the admission clerk.
b. When possible the clerk will request that a case manager review the advanced directive for completeness prior to having it scanned.

II. Nursing Services Responsibilities -

1. The RN will assess for and document the existence of the patient's advanced directive as a part of the admission assessment process for all adult patients in an inpatient or observation status.
2. RN will be responsible to clarify with the patient if the document represents their current wishes. Patients have the right to review or revise their advanced directives should they wish to do so.
3. If the patient has advanced directives, which are not within the NIHD medical records repository, the family should be encouraged by the RN to bring them to the hospital as soon as feasible. This shall be documented within the patient's electronic medical record.
4. The RN should communicate pertinent information related to the advanced directive to the patient's physician or advanced practice provider (APP).

III. Case Management (CM) and/or Social Service (LCSW) Responsibilities -

1. A member of the case management team will review each adult patient who is in an admitted or observation status on a daily basis to determine need for education or support related to advanced directives.
2. When requested by a patient or family/caregiver, Case Management will provide copies and explain the advance directives process. Support will be provided to assist with completion of forms in a timely manner and support physician/APP discussions.
3. The CM team member who provided the service will complete documentation of process within the patient electronic medical record. Case Management will be available to train staff on the advance directive process as needed.

IV. Physician/APP Responsibilities -

1. The attending physician/APP shall review an Advance Directive contained in the patient's chart and discuss its content with the patient and/or patient's healthcare representative.
2. The physician shall document a summary of all discussions with the patient or significant others concerning the patient's Advance Directive within the electronic medical record.
3. If an Advance Directive exists, but a copy is not available for the record, important care decisions shall be made by the attending physician in consultation with the decision maker using substituted judgment or best interest criteria as appropriate.
4. The physician will incorporate the executed Advance Directive in the patient's treatment plan.
5. Computerized Physician Order Entry (CPOE) shall be completed by the physician/APP to give directions on code status during the hospitalization as appropriate.

V. Completion of Advanced Directive Forms-

1. In order for the advanced directive to be legally binding, it must be notarized **or** signed by two witnesses meeting the following criteria.
   a. The witness must know the patient who is signing the advanced directive or the patient must provide convincing evidence of their identity to the witness; and
   b. The witness must not be appointed as an agent in the advanced directive; and
   c. The witness must not be the patient's health care provider or an employee of the patient's health care provider or an operator or employee of a community care facility or residential care facility where the patient is receiving care; and
   d. At least one of the witnesses must not be a family member or a person that would benefit from the advanced directive or benefit from the patient's estate after their death.
2. In order to complete and sign the advanced directive the following rules apply:
   a. The patient must not be under any duress to sign the document and the patient must be of sound mind; and
   b. The patient must sign the document in front of the notary or in front of the witness; and

c. If the patient is a resident of a skilled nursing facility, a patient advocate or an ombudsman of the facility must also sign the document.

3. Once the advanced directive is completed, a copy of the advanced directive will be placed into the patient's electronic medical record.
4. The advanced directive may be changed at any time by the patient. A newer advanced directive supersedes any previous advanced directive.

REFERENCES:

1. California State Operations Manual 12/2016, 42 CFR 489.100 & 489.102
2. CMS 485.608(a)
3. California Probate Code, Division 4.7, 4701
4. CAMCAH January 2016 RI.01.02.01

RECORD RETENTION AND DESTRUCTION:

Advanced Directives become a part of the patient's medical record, which is managed by the NIHD Medical Records Department.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Admission Procedure of Hospice Inpatient
2. Admission, Documentation, Assessment, Discharge and Transfer of Swing-Bed Patients
3. Code Blue Procedure – Code Blue Team
4. Color-Coded wristband use
5. Consent for Medical Treatment
6. Discharge Planning for the Hospitalized Patient
7. Documentation of Case Management Services
8. End of Life Option Act
9. Forms Development and Control Policy
10. Legal Health Record
11. Long Term Acute Care Hospital
12. Organization-Wide Assessment & Reassessment of Patients
13. Organ, Tissue, Eye Donation
14. Patient's Rights
15. Pediatric Standards of Care and Routines
16. Requests Regarding Resuscitative Measures and Physician Orders for Life Sustaining Treatment (POLST)
17. Rights of Swing Bed Patients
18. Standards of Care: End of Life
19. Standards of Care – Swing Bed Resident
20. Standards of Care – Acute-Subacute services – adult patient

Supersedes: v.4 Advanced Directives

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Airborne Infection Isolation Rooms (AIIR)		
Owner: DON INFX PREVENTION CLINICAL INFORMATICS	Department: Infection Prevention	
Scope: Hospital Inpatient		
Date Last Modified: 07-04-2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2017	

PURPOSE:

To provide a negative pressure required for airborne precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei.

POLICY:

1. Airborne Isolation Infection Rooms (AIIR's) are available:
   a. Acute-Subacute unit room 5, (this room has an ante chamber, new construction)
   b. Intensive care unit room 1, (this room has an ante chamber, new construction)
2. All patients with known or suspected serious illnesses transmitted by airborne droplet nuclei will be placed in (AIIR) Rooms if available. If AIIR not available place patient in room with door closed.
3. Staff to use the below references to determine if infection is airborne, or notify Infection Prevention.
   a. CDC Appendix A located on Nursing and Physician desktop for duration of needed precautions.
   b. Lippincott Procedures Airborne Precautions
4. Each AIIR will have a room pressure controller. This controller is designed to maintain a constant pressure differential. The controller has audible and visual alarms. The negative pressure is always on. The door to the room must closed as much as possible.
5. Sputum Inductions will be performed in the Airborne Infection Isolation Room (AIIR) located in ICU room 1 or Acute-Subacute room 5; attempt to use ICU room1 first.

DEFINTION:

Airborne Infection Isolation Room (AIIR) - Formerly, negative pressure isolation room

- An AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids.

- AIIRs should provide negative pressure in the room (so that air flows under the door gap into the room); and an air flow rate of 6-12 ACH (6 ACH for existing structures, 12 ACH for new construction or renovation); and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter before returning to circulation.

Wall panel: A panel located outside the ante chamber room that includes an audible and visual alarm to warn staff when pressurization is lost or drifts past the preset pressure value.

PROCEDURE:

- Ensure negative pressure setting light is green and there are no alarms in Acute-Subacute room 5 and ICU room 1.
- Don appropriate PPE for type of precautions while in the ante chamber prior to entering the room with the patient. All staff must wear properly fitted N95 mask or Purified Air Powered Respirator (PAPR) before entering room
- Patient must have a surgical mask on when they are admitted to the room, or if they leave the room for a procedure
- Keep door closed between room and ante chamber as well as between ante chamber and the hallway.
- Post airborne precautions signs on the anti-chamber door as well as the door to the room itself.
- All Donning and Doffing of PPE should be done in the ante chamber.
- When the patient is discharged the room should be cleaned per type of organism.
- If the Airborne Isolation Rooms loses pressurization and does not correct itself by closing the doors, the Maintenance Department must be contacted immediately.

Monitoring AIIRs

- The AIIR is monitored and documented Bi-monthly by the Maintenance Department for the Acute-Subacute room 5 and ICU room 1
- Nursing staff will complete daily verification when a patient in Airborne Isolation is placed in Acute-Subacute room 5 and ICU 1. This is confirmed by ensuring that the green light located on the wall panel is on
- The flow-meter on the AIIR (Acute-Subacute & ICU) is checked yearly and if found to be in the yellow or red zone the filter will be changed by Biomed.

Documentation:

- Document on the medical record when the patient was placed in precautions and that the negative pressure is on and working.
- Document each shift on the medical record that the patient remains in precautions with the negative pressure on and working.
- Document each shift that correct isolation precaution signage is in place
- Document on the medical record when the patient is removed from precautions.

REFERENCES:

1. Lippincott Procedures: Airborne Precautions. (Reviewed August 2021). https://procedures.lww.com/lnp/view.do?pId=3261141&hits=airborne&a=false&ad=false&q=airborne
2. Centers for Disease Control and Prevention. (2019). 2007 Guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings. Retrieved from http://www.cdc.gov/hicpac/2007IP/2007ip_appendA.html
3. Centers for Disease Control and Prevention. (2016). Transmission based precautions. Retrieved from https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

4. Centers for Disease Control and Precautions (2019). Precautions to Prevent Transmission of Infectious Disease. https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html
5. Centers for Disease Control and Prevention. (2019). Appendix B. Air. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html
6. Centers for Disease Control and Prevention. (2019). Type and Duration of Infections Recommended for Selected Infections and Conditions. https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html

CROSS REFERENCES:

1. Airborne Precautions in Lippincott Procedure
2. Aerosolized Transmissible Disease Plan

RECORD RETENTION AND DISTRUCTION:
Medical records are retained and destroyed per the NIHD Medical Records Department policy and procedure.

Supersedes: v.2 Airborne Infection Isolation Rooms (AIIR)*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Code of Ethics for Nurses		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Registered Nurses District Wide		
Date Last Modified: 10/05/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/17/2016	

PURPOSE: To establish the ANA Code of Ethics for Nurses with Interpretive Statements as the guide for Northern Inyo Hospital nurses to use in ethical decision analysis and decision making.

The code of ethics for the nursing profession makes explicit the primary obligations, values, and ideals of the nursing profession. It is an understanding of nursing's own understanding of its commitment to society.

POLICY:

1. Each Nursing Department will have a copy of the ANA Code of Ethics with Interpretive Statements for reference by the nursing staff.
2. The Nursing Staff will refer ethical issues to the Ethics Committee per Medical Staff Rules & Regulations.

PROCEDURE:

1. The Code of Ethics for Nurses with Interpretive Statements will be reviewed with the nurse during orientation.
2. The NIHD nurse will follow the Provisions of the Code of Ethics for Nurses according to the following provisions:
    a. The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
    b. The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.
    c. The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.
    d. The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.
    e. The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
    f. The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.
    g. The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.
    h. The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

i. The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy

REFERENCES:

1. ANA, (2015) Code of Ethics for Nurses with Interpretive Statements. Nursesbook.org

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Plan for the Provision of Nursing Care
2. Medical Ethics Referrals and Consultations

Supersedes: v.2 Code of Ethics for Nurses*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Health Care Worker Health Screening and Maintenance Requirements		
Owner: DON INFX PREVENTION CLINICAL INFORMATICS	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 12/22/2022	Last Review Date: No Review Date 09/18/2019	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 09/18/2019	

PURPOSE:

Health screening for the Northern Inyo Healthcare District (NIHD) workforce occurs to ensure the worker is able to perform in the position offered and a plan has been developed for necessary documentation of immunity against specific diseases throughout the working relationship. The workforce reduces the personal risk of infection and the spread of vaccine-preventable infections by receiving recommended vaccines, lab titers and Tuberculosis (TB) screening.

POLICY:

1. The NIHD workforce Health Screening is arranged by the Employee Health (EH) Department in collaboration with Human Resources (HR), Medical Staff Administration, the Rural Health Clinic (RHC), and Department Leadership.~~Mangers.~~
2. The Health Screening begins after a contract or job offer has been made, and before actual employment/relationship begins.
3. Immunization monitoring and TB screening is an ongoing process that continues throughout the working relationship.
4. The scope of this policy, unless otherwise noted, applies to all health care workers (HCW's) at Northern Inyo Healthcare District (NIHD). Recommendations within this policy are in accordance with the United States Center for Disease Control and Prevention (CDC) guidelines for Immunization of Health-Care Personnel, Division of Occupational Safety and Health of California (CAL/OSHA), and California Department of Public Health (CDPH). All vaccination and tuberculosis monitoring policies will be consistent with state and federal standards.

DEFINITIONS

1. **Employee:** NIHD payroll employee
2. **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 Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.
3. **Volunteer and Auxiliary:** Active members that are in contact with patients and their families on campus.
4. **Shadower:** Observing a health care role, but not physically involved in any care.

PROCEDURE:

1. Employee Health will inform the workforce member that ~~health screening~~health-screening requirements need to be completed prior to start date.
2. Human Resources and Medical Staff Administration will provide Employee Health with names, date of birth, and contact information of all new workers who have signed an NIHD contract, or other agreement. Their support is critical to success in acquiring the new worker's childhood and career vaccines from prior employers, clinics, and hospitals, as well as completing a physical exam. It is preferred this process begins at a minimum of two weeks prior to start date.
3. A ~~shadower~~ Shadower is not cleared by Employee Health as they are observing and not in direct contact with patients.
4. To clear a new hire through the Employee Health the nursing team must be able to do the following:
   a. Review prior TB Screening, immunization records, and titers
   b. Develop a plan with the new employee to meet onboarding requirements
   c. The Health History and Physical Exam is completed as defined in this policy.
   d. Once completed, an employee health team member will send an email to HR or Medical Staff Administration, stating the worker is cleared by Employee Health.
5. New Hire Health History and Physical Exam
   a. The New Hire Health History and Physical Exam is only required ~~for all~~for all prospective NIHD payroll employees ~~and all~~and all contracted workers.~~.~~
   ~~b.~~ Contracted 100% remote workers, never on site, are only required to complete the physical exam with whisper test, visual acuity, and color screening. If the contract agreement changes that the worker is requested to come onto campus, the worker and their Manager/Director are responsible to ensure the worker has completed and been cleared by employee health for all employee health workforce requirements of vaccinations, titers, and TB testing before arriving on campus. The process may take up to 2 weeks to complete.
   ~~c.~~b.
   ~~d.~~c. The physical exam will be completed prior to the first day of employment. For employees on payroll, Employee Health will coordinate the physical exam with RHC, and schedule immunizations, lab testing, and onboarding paper work with Laboratory Services, Patient Access Services, and HR. Contracted workers are responsible for completing their own health requirements prior to start date.
   ~~e.~~d. If an NIHD worker returns within six months of separation, the prior Health History and Physical is acceptable. Employee Health staff will review prior immunization records, TB screening, and fit testing to ensure the worker meets currents requirements for their new position.
   ~~f.~~e. Documentation of the following must be included:
      i. Health History
      ii. Physical Exam
      iii. Allergies including latex
      iv. Whisper test or Audiometry
         a. Audiometry is required if failed whisper test
         b. Failed Audiometry requires a referral to Audiologist
      v. Vision Test: Visual Acuity with correction if applicable
      vi. Color vision: Ishihara 14 plates with color failure identification
      vii. Infectious Disease Exposure Screening
   ~~g.~~f. If the worker does not pass any section of the physical, Employee Health will inform HR. Human Resources will arrange an accommodation meeting with the manager and other key stakeholders. Human Resources will contact the worker with the outcome plan.
6. **TUBERCULOSIS (TB) SCREENING**

a. TB Screening is required of all workers who will be on the NIHD campus at any time.
   i. TB Screening is arranged by the Employee Health staff for employees on payroll, Providers, and Volunteers. A QuantiFERON-TB Gold Assay (QFT), a T-Spot, or a Tuberculin Skin Test (TST) in the last 12 months is acceptable.
   ii. NIHD will provide an initial baseline QFT to new workers on payroll, providers, and volunteers as the most efficient and accurate initial documentation regardless of BCG vaccine or past TST positives. A TST 2- step is an alternative if able to be completed prior to start date.
   iii~~3~~. Please reference Employee Tuberculosis Survey Program Policy for testing intervals and processes for positive results.

7. **IMMUNIZATIONS:**
   a. Employee Health vaccine screening, monitoring and administering is limited to the following: Influenza, MMR, Varicella, initial Tdap, Hepatitis B, Meningococcal ACWY, ~~Meningoccal~~Meningococcal B, and TB Skin Tests. If the worker requests other vaccinations, they will be directed to contact their primary care practitioner.
   b. Initial immunization screening is required of all workers prior to their start date.
   c. Annual Influenza vaccinations will be overseen by the Employee Health Department in collaboration with pharmacy and all department leaders.~~managers~~.
   d. Employee Health Standing Orders for Vaccine administration to workers are based on the CDC/ACIP Recommendations. They will be approved by the Employee Health Medical Director annually using the CDC/ACIP order templates. Standing Orders will be stored in the Employee Health Office and on the Employee Health shared drive or NIHD intranet.
   e. A signed consent with CDC screening questionnaire or vaccine declination will be completed for all immunizations.
   f. Immunizations:
      i. **Influenza**
         1. Applies to all workers on campus during the influenza season.
         2. Annually, during each flu season, one dose of influenza vaccine is required if there is no documentation for that season or a signed declination.
      ii. **Measles (Rubeola), Mumps, Rubella (MMR)**
         1. Applies to all workers on campus: except volunteers and auxiliary.
         2. Documentation of 2 MMR vaccines or positive IgG titer results for each, anytime in the past. If immunity or vaccination history is undocumented, an IgG titer will be drawn for Rubella, Rubeola, and Mumps.
         3. CDC recommendations/Standing Orders will be followed for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.
      iii. **Varicella (chickenpox)**
         1. Applies to all workers on campus: except volunteers and auxiliary.
         ~~iv.~~ ~~Documentation~~2. Documentation of 2 Varicella vaccines, or positive IgG titer results anytime in the past. Documented history of disease does not guarantee immunity and requires an IgG titer with vaccination if non immune CDC recommendations/Standing Orders will be followed for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.

      ~~v.~~iv. **Tetanus, diphtheria, pertussis (TdaP)**
         1. Applies to all workers on campus, no exceptions.
         2. Documentation of one dose of Tdap at or after the age of 11.
         3. Booster doses would be provided by the person's primary care practitioner.
      ~~vi.~~v. **Meningococcal**

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1. Both MenACWY and MenB are recommended only for microbiologists and lab personnel potentially plating Neisseria Meningitides.
2. Every 5 years boost with MenACWY if risk continues.

i. **Hepatitis B**

1. Required by OSHA.
2. Applies to NIHD HCW's who will be working in these departments/roles: Activities Director, Patient Access Department , Biomedical, Case Management, Central Sterile Processing, Diagnostic Imaging Techs and Radiologists, Dietary, Environmental Services, Cardiopulmonary Department , Compliance, Laboratory, Language Services, Laundry, Surgical Tech's, Maintenance/Plant Operations, Nursing Staff (RN, LVN, MA, CNA) Pharmacy, Physical Therapy, Occupational Therapy, Security, Social Services, Providers, and any additional roles that will require a worker to enter patient rooms..
3. Documentation of a complete series of Hepatitis B vaccines followed by a Hepatitis B Surface Antibody (HepBs Ab) IgG Titer is the greatest assurance of immunity to Hepatitis B. NIHD will assist the employee to attempt to obtain prior Hepatitis B vaccine documentation. If immunization documentation is lacking, CDC recommends to complete a series of Hepatitis B vaccines if records cannot be located. A titer alone is not recommended unless there is documentation of a full series of Hepatitis B vaccines. This is because, anti-HBs has only been deemed a correlate of protection when following a complete series. If there is a complete series of documented Hepatitis B vaccines, ensure follow up testing for a positive Hep BsAb IgG titer is documented post vaccination. If the titer is negative, the series would be repeated.
4. OSHA requires healthcare facilities to offer Hepatitis B vaccine within 10 days of hire. ~~Lack of documentation and/or a negative Hep Bs Ab IgG titer,~~ OSHA requires a signed declination should the worker decide against Hepatitis B vaccination. The declination/acknowledgement contains the following, staff to check all that apply:
    - Due to my occupational exposure to blood or other potentially infectious materials (OPIM), I may be at risk of acquiring Hepatitis B virus (HBV) infection. NIHD employees on payroll and Providers may seek vaccination through NIHD Employee health at no charge.
    - I understand that documentation of a complete series of Hepatitis B Vaccine followed by a Hepatitis B Surface Antibody IgG Titer is the greatest assurance of immunity.
    - I believe I have received the complete Hepatitis B vaccine series but cannot show proof.
    - I decline Hepatitis B Vaccine at this time

    ~~4.~~

~~i.~~**vi. Covid-19**

1. All NIHD Workforce will complete COVID-19 Vaccination requirement prior to start date according to the COVID-19 Vaccination for NIHD Workforce Policy or CDPH mandates, whichever is most current.

8. **VACCINE DECLINATIONS**
    a. NIHD strives to ensure the safety of our patients and workers through vaccinations. Should a worker decline any of the required vaccines a declination must be signed for each vaccine, acknowledging awareness of risk.
    ~~b. OSHA requires signed declination specifically for the Hepatitis B vaccine.~~
    ~~c.~~b. California law requires signed declination for refusal of vaccines to prevent aerosol transmissible diseases.

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9. **EXCEPTIONS:**
    a. Volunteers and auxiliary members Health Screening Requirements are limited to the following:
        i. Tdap once at or after age 11
        ii. Influenza immunization annually
        iii. TB screening per policy
    b. Vendors are not screened through Employee Health. Vendormate is used in this instance.
10. **COSTS**
    a. Initial required exams, immunizations, titers, and TB testing is offered at no cost to NIHD employees on payroll, providers, volunteers, and auxiliary members upon hire.
    b. Contracted workers and all students will need to meet their health requirements through a primary health care provider at their cost.
    c. Annual influenza immunization is offered to all NIHD workforce during influenza season at no cost.
    d. Ongoing TB testing is offered at no cost to all employees on payroll, providers, and volunteers.
11. **DOCUMENTATION**
    a. Documentation related to vaccinations, titers, TB screening, medical history and Physical Exam will be kept in the Employee Health files and database.
    b. Historical documentation:
        i. All records require Name and Date of Birth
        ~~ii.~~ TB screening documentation. ~~TST requires placement date with result and result date~~
        ~~iii.~~ii. To ensure accuracy of lab results documentation with reference range and collection date are preferred. Documentation of titer results on formal records from Universities or Healthcare Systems will be accepted.
    c. Vaccine's provided by NIHD require a consent which includes a screening questions, the manufacturer, lot, expiration date, and date of published VIS that was provided. This information will be stored in the HCW's health record.
    d. Contracted workers will ensure their records are current within the portal of their contacted company. If the contracted company does not have a portal, NIHD will keep their store their records for 30 years after separation.

REFERENCES:

1. California Hospital Association. (2018). Record and Data Retention Schedule. Retrieved from file://root.nih.org/home/Public/Intranet%20Redesign/Intranet%20Links/Information/Compliance/recordretention2018_epub_enterprise.pdf
2. CAL/OSHA, Aerosol Transmissible Vaccine Declinations. https://www.dir.ca.gov/title8/5199e.html
3. CAL/OSHA, Title 8, Section 5193. Bloodborne Pathogens. https://www.dir.ca.gov/title8/5193.html
4. Centers for Disease Control and Preventionl. ACIP Vaccine Recommendations and Guidelines https://www.cdc.gov/vaccines/hcp/acip-recs/index.htmlCenters for Disease Control and Prevention. Prevention and Control of Influenza with Vaccines— Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
5. Centers for Disease Control and Prevention. Immunization Schedules: Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2022. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html#table-conditions
6. Use of Standing Orders Programs to Increase Adult Vaccination Rates: Recommendations of the ACIP. MMWR 2000;49 (No. RR-1) at www.cdc.gov/mmwr/preview/mmwrhtml/ rr4901a2.htm.
7. Centers for Disease Control and Prevention. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management. MMWR 2013;62 (no RR 10). https://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf

8. Centers for Disease Control and Prevention. Universal Hepatitis B Vaccination in Adults Aged 19-59: Updated Recommendations of the Advisory Committee on Immunization Practices. MMWR 2022;71 (No RR13). https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7113a1-H.pdf
9. Center for Disease Control and Prevention. Immunize.org Ask the Experts Hepatitis B (2022). https://www.immunize.org/askexperts/experts_hepb.asp
10. OSHA Fact Sheet (2011). Hepatitis B Vaccination Protection. https://www.osha.gov/sites/default/files/publications/bbfact05.pdf
11. OSHA, Standard Number 1910.1030 App A - Hepatitis B Vaccine Declination (Mandatory) https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030AppA

RECORD RETENTION AND DESTRUCTION:
Employee Health Records will be maintained for 30 years after separation.

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Influenza Vaccination Policy
2. Employee Tuberculosis Surveillance Program
3. Prevention and Treatment of Pertussis in Hospital Employees
4. COVID-19 Vaccination for NIHD Workforce Policy

Supersedes: v.2 Health Care Worker Health Screening and Maintenance Requirements

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Opioid Administration		
Owner: MANAGER MED SURG ICU	Department: Acute/Subacute Unit	
Scope: District Wide		
Date Last Modified: 08/23/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To provide safe and appropriate opioid pain relief to patients.

POLICY:

1. A thorough assessment of a patient is to be completed by a licensed RN prior to opioid administration (see procedure below for more detailed information).
2. An opioid can be administered by a Registered Nurse (RN) or provider. A Licensed Vocational Nurse (LVN) may administer opioids excluding IV opioid administration.
3. An order from a privileged provider has to be obtained prior to any opioid administration.

DEFINITION:

Acute pain – is a normal sensation that alerts us to possible injury.
Chronic pain – any pain lasting more than 12 weeks; may arise from an initial injury, or there may be an ongoing cause, such as illness.
Opioid – a medicine possessing some properties characteristic of opiate narcotics but not derived from opium.
Opioid naïve – implies patients are not chronically receiving opioids on a daily basis.
Opioid tolerant – implies patients are chronically receiving opioids on a daily basis.

PROCEDURE:

1. Assessment: Upon admission, a thorough assessment should be performed on a patient by a licensed RN prior to any opioid administration. To ensure patient safety, this should be reviewed and updated as needed with each shift as necessary. This assessment includes, but is not limited to:
   - Assessing cognitive abilities to ensure an appropriate pain scale (e.g. 0-10 numeric scale, FACES, or FLACC) and pain goal is applied. This pain goal should be decided upon admission and charted on EHR.
     a) Is the patient alert and oriented?
     b) Are they able to appropriately describe their pain?
     c) What pain scale should be used and what is the patient's desired pain goal if not all pain can be eliminated?
   - Are they age appropriate to be receiving the ordered dose and route prescribed?
   - Asking about history and current medication use
     a) Does the patient have acute or chronic pain?
     b) Do they take any opioid pain medications and for how long?

c) Does the patient have history of Substance Use Disorder (SUD)?

2. Education: Prior to opioid administration, education for the medical personnel and for the patient is imperative.
   - Education for the personnel pertains to understanding the potential effects of opioid administration and what to monitor, such as:
     a) Sedation level
     b) Pain Assessment
     b) Drug interactions
     c) Drug compatibility
     d) Side effects - constipation, nausea and vomiting, respiratory depression, risk of falls, CNS depression, impact on psychomotor and cognitive function
     e) Potential for addiction, tolerance, physical dependency, and withdrawal
   - Education for the patient should include:
     a) Understanding the use of the medications, the desired effects, the potential adverse effects, how the medication will be administered
     b) Pain scale and pain goal and how it relates to what type of pain relief measures can be provided
     c) Onset of action and duration to expect effect of medication
3. Administration: When considering the use of an opioid, a series of checks should be completed:
   - A multimodal approach should be taken when treating pain and trialed prior to ultimately giving an opioid:
     a) Psychosocial support
     b) Coordination of care
     c) Promotion of healthful behaviors
     d) Non-pharmacological approaches
        i. Distraction
        ii. Relaxation techniques
        iii. Positioning
        iv. Cool or warm packs
     e) Non-opioid medications
        i. Non-steroidal anti-inflammatory agents
        ii. Muscle relaxants
   - If after doing the above and an opioid is needed, an order from a privileged practitioner must be obtained
     a) If written as a PRN order, there should be parameters according to a pain scale (e.g. Morphine 2 mg IV as needed for severe pain 7-10)
   - Timely assessment and appropriate monitoring is essential when opioids are administered to permit intervention to counteract an adverse reaction should it occur – refer to Lippincott's 'Patient-Controlled Analgesia' (PCA), 'Pain Assessment and Documentation' and the 'Opioid Sedation Scale' for monitoring guidelines and interventions.
     a) Patients with the following are at high risk for over-sedation and respiratory depression:
        i. Sleep apnea or sleep disorders
        ii. Morbid obesity
        iii. Snoring
        iv. Older age (over 61 years old)
        v. Opiate Naïve (no recent opioid use)
        vi. Post-surgery (particularly upper abdominal surgery)
        vii. Increased opioid dose requirement
        viii. Receiving other sedating drugs (benzodiazepines, CNS depressants, etc.)
        ix. Preexisting pulmonary or cardiac disease or other major organ dysfunction

x. Smoker

- Continually assess the need for opioid administration and advocate for its discontinuation as promptly as able to, per patient's condition
- Educate other staff members within the multi-disciplinary team to take extra precautions with the patient

4. Wasting of opioids:
   - Follow the Opioid Waste policy

DOCUMENTATION:

- Documentation for opioid administration is performed within the Medication Administration Record in the patient chart.
- Documentation for monitoring and assessment of pain and sedation is performed in the Electronic Health Record.

REFERENCES:

1. Centers for Medicare and Medicaid Services. (2014). *Requirements for hospital medication administration, particularly intravenous (IV) medications and post-operative care of patients receiving IV opioid*.
2. Curtis, Mitchell. (2015). *Hospital accreditation: CMS and IV opioid administration*. Retrieved from http://blog.cihq.org/cms-and-iv-opioid-administration
3. Medline Plus. Retrieved April 30, 2016 from https://www.nlm.nih.gov/medlineplus/mplusdictionary.html
4. The Joint Commission. (2012). *Safe use of opioids in hospital, 49*, pp. 1-5.
5. UpToDate. (2016). Drug search engine found on http://www.uptodate.com/contents/search

CROSS REFERENCE P&P:

1. Barcode Medication Administration
2. Opioid Sedation Scale
3. Pain Assessment and Documentation
4. Patient Controlled Analgesia. (August 2019) *Lippincott Procedures*.
5. Safe medication administration practices, ambulatory care. (April 2016). *Lippincott Procedures*. Retrieved on May 1, 2016 from http://procedures.lww.com
6. Opioid Waste policy

Supersedes: v.3 Opioid Administration*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Opioid Sedation Scale		
Owner: MANAGER MED SURG ICU	Department: Acute/Subacute Unit	
Scope: District Wide		
Date Last Modified: 08/23/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The goal is to objectively assess and monitor a patient's level of sedation during opioid treatment and provide the most appropriate level of analgesia while maintaining a safe level of sedation.

POLICY:

To assess and document a patient's level of sedation using the Pasero Opioid-Induced Sedation Scale (POSS). This policy does not apply to comfort care and end of life patients.

PROCEDURE:

1. Utilize the scale shown below.
2. The Pasero Opioid –Induce Sedation Scale includes the consideration and use of Naloxone. *3 and *4 below is a consideration and not an order.
   At Northern Inyo Healthcare District, an order from a privileged practitioner is required prior to the administration of any reversal agent including Naloxone.

Medscape

Pasero Opioid-induced Sedation Scale (POSS)

S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid dose if needed

1 = Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid dose if needed

3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%[1] or notify prescriber[2] or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated.

4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable; stop opioid; consider administering naloxone[3,4]; notify prescriber[2] or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

*Appropriate action is given in italics at each level of sedation.
[1]Opioid analgesic orders or a hospital protocol should include the expectation that a nurse will decrease the opioid dose if a patient is excessively sedated.
[2]For example, the physician, nurse practitioner, advanced practice nurse, or physician assistant responsible for the pain management prescription.
[3]Mix 0.4 mg of naloxone and 10 mL of normal saline in syringe and administer this dilute solution very slowly (0.5 mL over 2 minutes) while observing the patient's response (titrate to effect) (Source for naloxone administration: Pasero, Portenoy, McCaffery M. Opioid analgesics, in *Pain: Clinical Manual* [ed 2]. St. Louis, MO, Mosby 1999, p. 267; American Pain Society [APS]. *Principles of Analgesic Use in the Treatment of Acute Pain and Chronic Cancer Pain* [ed 5], Glenview, IL, APS, 2003.)
[4]Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression.

Source: Pain Manag Nurs © 2009 W.B. Saunders

ASSESSMENT:

A proper sedation assessment requires the nurse to observe how quickly the patient rouses when stimulated by the presence of the nurse, a touch, or conversation. The patient's ability to stay awake once aroused is a critical indicator of level of sedation. To determine this, the patient should:

- Be asked to wake up and answer a simple question. A patient who is easy to arouse will be able to awaken readily and respond with a complete answer to the question without falling asleep (sedation level 1 or 2 on the POSS).
- Falling asleep mid-sentence indicates a sedation level of 3 on the POSS.
- POSS score of 3 or more requires the nurse to hold the opioid dose, notify the medical provider and increase monitoring frequency, based upon provider order, until the patient has a sedation level of less than 3.
- POSS score of 3-4 requires the nurse to notify the medical provider if respiratory assessment (rate and depth) is inadequate. Rapid Response Team initiation should strongly be considered.
- Sedation level and respiratory status is assessed prior to administration of opioid medications and at the time of pain reassessment.
- Initiation of long acting opioid medication requires POSS every 4 hours during the first 24 hours of opioid treatment.
- For chronic pain patients with a stable dosage of opioid, the patient should be assessed prior to administration of opioid and at time of pain reassessment. (See Pain Assessment and Documentation policy)

A proper respiratory assessment during opioid treatment requires the nurse to:

- Watch the rise and fall of the patient's chest to determine the rate, depth, and regularity of respirations. Current respiratory rate should be compared with previous rates, and trends should be noted. Shallow respirations or periods of apnea, even brief periods, require further evaluation.

RN's will follow the Patient Controlled Analgesia (PCA) policy found in Lippincott procedures when administering opioids via PCA pump.

CAUTION: Other sedating agents in addition to opioid may have an additive effect on sedation.

INTERVENTION:

The POSS links nursing interventions to the various levels of sedation. Actions, per provider orders, may include increasing the opioid dose in a patient who is easy to arouse and reports unacceptable pain relief, or decreasing or holding the opioid dose in a patient who is excessively sedated. Medical Provider shall be notified by nurse of POSS score associated with potential need to reduce opioid prescription.

DOCUMENTATION:

Documentation will be entered into the EHR.

REFERENCES:

1. Nisbet, A. & Mooney-Cotter, F. (2009). Comparison of Selected Sedation Scales for Reporting Opioid-Induced Sedation Assessment. *Pain Management Nursing*, 10(3), pp. 154-164.
2. Pasero, C. (2009). Assessment of Sedation During Opioid Administration for Pain Management. *Journal of PeriAnesthesia Nursing*, 24(3), pp. 186-190.

3. The Joint Commission. (2012). "Sentinel event alert: Safe use of opioids in hospitals" [Online]. Accessed October 2018 via the Web at https://www.jointcommission.org/assets/1/18/SEA_49_opioids_8_2_12_final.pdf (Level VII)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Lippincott Procedures. (2019). Patient-controlled analgesia.
2. Opioid Administration
3. Pain Assessment and Documentation

Supersedes: v.3 Opioid Sedation Scale*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Organ/Tissue/Eye Donation		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Emergency Department, ICU, Acute-Subacute Unit		
Date Last Modified: 09/28/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/19/2010	

PURPOSE: To ensure that recovery and donation procedures are established, current and monitored.

POLICY:

1. Northern Inyo Healthcare District (NIHD) maintains an agreement with the Donor Network West (DNW), our federal designated organ procurement organization (OPO) and with Sierra Donor Services (SDS) for eye/tissue and bone procurement.
2. NIHD will contact DNW in a timely manner (within at least one hour) about individuals who reach cardiac time of death (CTOD). For imminent death individuals, hospital will notify DNW upon confirmation of irreversible or non-recoverable prognosis from attending physician.
3. DNW will direct care to preserve tissue viability and serve as a resource.
4. A person may deed his/her body to be donated for research only if prearrangement has been made prior to death.
5. Eye recovery may be completed in any patient care area by SDS.
6. Imminent death must be reported to DNW.
7. All deaths must be reported to DNW within one (1) hour of pronouncement.
8. NIHD will collaborate with DNW to educate staff on donation issues, reviewing death records to improve identification of potential donors and maintaining potential donors while necessary testing and placement of organs and tissues take place.

DEFINITIONS:

Brain Death: Total and irreversible cessation on all brain stem function including the brain stem and maintained on cardiopulmonary support system. Potential types of donation: heart, lung, liver, pancreas, kidneys, and intestines, along with eyes, skin, bone, veins, connective tissues, heat for valves.

Cardiac Death: Irreversible cessation of cardiac/respiratory function. Potential types of gifts recovered after Cardiac Death includes eyes, skin, bone, vessels, connective tissues, heart for valves.

Imminent Brain Death:

1. A patient with a severe neurological injury and
2. Who requires mechanical ventilation; and
    a. Has suffered a non-recoverable illness/injure or,
    b. For whom physicians are evaluating a diagnosis of brain death; or
    c. For whom a physician has ordered that life-sustaining therapies be withdrawn, pursuant to the family's decision.

Legal Next of Kin: (In descending order):

- Agent
- Spouse

- Adult Child
- Parent
- Adult Sibling
- Adult Grandchild
- Grandparent
- Legal Guardian/Conservators
- Adult exhibiting special care/concern
- Other person with authority to dispose of the decedent's body

PROCEDURE:

A. At the time of cardiac death or imminent death (for patients on ventilators), the RN will check the chart for advance directives which expresses the patient's wishes with respect to organ and/or tissue donation. If the advance directive states that the patient does not wish to make an anatomical gift at the time of death, referral will be made to DNW in order to inform DNW of the patient's wishes.

B. Notification of Imminent & Cardiac deaths to the Donor Network at 1-800-553-6667 (800-55-DONOR). Ventilated patients will be triaged as organ referrals and non-vented as tissue referrals.
   1. For the patient on mechanical ventilation, the House Supervisor (HS) or designee will notify DNW when criteria for imminent death have been met (suffered a non-recoverable illness or injury, plans for formal brain death evaluations) or when there are discussions regarding the discontinuation of mechanical and/or pharmacological support.
   2. For the patient who is pronounced cardiac dead (not on mechanical ventilation), the HS or designee will notify the Donor Network (1-800-55Donor) within one (1) hour.
   3. DNW will determine medical suitability for organs tissue & eye donation.
   4. A DNW Coordinator (via the Donor Network referral line) is available 24 hours a day to:
      a. Approach legal next of kin to offer the option of organ/tissue donation;
      b. Assist in the clinical management of the potential donor;
      c. Notify coroner and secure authorization for donation.

C. Consent for Donation
   1. Consent from Legal Next of Kin:
      a. The request for anatomical donation will be made by the Transplant or Family Resource Coordinator from DNW or by a designated requestor trained by DNW (House Supervisor).
      b. The on-site DNW Coordinator will evaluate all patients on ventilators referrals for appropriateness of organ donation.
      c. Request for donation will occur only after declaration of brain death or, in the case of organ donation after cardiac death, after the decision has been made to withdraw life support.
      d. For the patient who is considered an appropriate candidate for organ donation, the DNW Coordinator will meet with the family to provide support, answer questions, and offer the option of organ and tissue donation.
      e. For the patient who is not on mechanical support: the DNW Coordinator will contact the legal next of kin by phone after expiration to request donation of tissue and/or eyes.
      f. In order to honor the patient's wishes, the HS reviews the chart at the time of death to insure that the patient did not decline anatomical donation in an advance directive. In the absence of an anatomical gift made prior to the donor's death, approval for donation must be obtained from the attorney-in-fact under a valid Durable Power of Attorney for Health Care that expressly authorizes the attorney-in-fact to make an anatomical gift of all or part of the

principal's body. If there is no Durable Power of Attorney for Health Care giving such authorization approval must be obtained from the legal next-of-kin which is defined in the following order: spouse, adult children, parents, adult siblings, grandparents, guardian or conservator.

g. In all instances, discretion and sensitivity to the family circumstances shall be encouraged in all discussions regarding donation of organs and tissues.
h. The deceased individual's religions and cultural beliefs or obvious non-suitability for organ and tissue donation must be considered.
i. The following consents are legal in the State of California:
    i. A donor card, a donor registry form, will, or other authorization form signed by the donor.
    ii. Signed authorization of the attorney-in-fact or the legal next-of-kin for 'Contribution of Anatomical Donation'.
    iii. If recorded telephone consent from the legal next-of-kin is obtained by DNW staff, a transcription of the consent will be sent to the NIHD for inclusion in the permanent record.
j. The signed consent form is maintained within the patient's medical record.

D. Coroner Authorization
    1. If the deceased falls under the jurisdiction of the coroner, the coroner must be advised that a request for anatomical donation has been made. The coroner's authorization must be obtained before proceeding with donation.
    2. The DNW Coordinator will notify the coroner at the completion of the organ recovery if applicable.

E. Hospital authorization following diligent search for next of kin for Brain Dead Donors.
    1. The hospital may authorize anatomical donation only if there is no family available or known. Every effort must be made to locate the next-of-kin by examination of personal effects, questioning of acquaintances and communication with local police regarding missing person records. By statute, the search must be thorough and must be in progress for a minimum of 12 hours (California Health and Safety Code, Section 7151.5) Hospital authorization following diligent search will apply to brain dead donors only.

F. Organ Donation following brain death
    1. Donor Criteria and Donor Maintenance
        a. Organ donation can take place after brain death has been established, and the potential donor is maintained on organ support systems.
        b. A person shall be pronounced brain dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function. There shall be independent confirmation of the brain death by another licensed physician. These physicians may not participate in or have any contingent interest in organ transplantation that may follow. Likewise, any member of the transplant team cannot be involved in the diagnosis of brain death.
        c. A reasonably brief period of time will be afforded the family or next to kin to assemble at the patient's bedside between the time the physicians declare brain death and discontinuation of cardiopulmonary support. During this time only previously ordered cardiopulmonary support will be provided. No other medical intervention is required.
        d. Donor Maintenance

i. The donor will be maintained on organ support systems and cared for by hospital and DNW staff until the transplant teams have arrived and the organ recovery surgery is completed. The Coordinator from DNW may write orders for donor maintenance after brain death has been declared.
ii. Appropriate consultations and clinical tests will be provided to ensure suitability of the organs, e.g. bronchoscopy, echocardiograms, and chest x-rays, biopsies, etc.
iii. Mechanical support will be discontinued in the OR after organ recovery.

1. Organ Recovery
   a. Perioperative Services will provide an OR suite, anesthesia support, one scrub tech/RN and one circulating tech/RN
   b. The DNW Coordinator will work closely with the OR staff to schedule the organ recovery procedure in the OR.
2. Medical Center Reimbursement: All charges that are incurred from the time the patient is declared brain dead and consents obtained, including the operating room fees, shall be billed to Donor Network West.

G. Organ Donation after Cardiac Death (DCD) following the decision to withdraw life support.
   1. Donor Criteria and Donor Maintenance
      a. Organ donation can take place following cessation of cardiopulmonary function when a patient or the legal next of kin has elected to withdraw life supporting therapy. Candidates for organ donation after cardiac death will meet the following criteria:
         i. The patient has a non-recoverable illness or injury that has caused neurologic devastation though the patient does not fulfill the criteria for brain death, and/or patient has other system failure resulting in ventilator dependency and meets the criteria for imminent death.
         ii. The patient of legal next of kin has elected to withdraw life support following discussion with the physician. The referral to DNW will occur as outlined above in section one.
         iii. The patient is expected to expire within one hour of the withdrawal of life support.
         iv. The patient has a known cause of injury or illness and no known medical conditions that would exclude organ donation. The patient has inadequate respiratory effort to maintain life when disconnected from the ventilator. Such determination will be made by the DNW Coordinator. If the case falls under the jurisdiction of the coroner, the DNW Coordinator will contact the coroner to request authorization for organ donation.
   2. Referral to DNW and consent for organ donation after cardiac death.
      a. When there are discussions regarding the withdrawal of life support, signaling imminent death, a timely referral to DNW will take place as outlined above in section one.
      b. The DNW Coordinator will evaluate the patient for suitability for donation after cardiac death. The evaluation will include Glasgow Coma Score, presence or absence of brain stem reflexes, laboratory findings, medical/social history, use and amount of vasopressor medication and assessment of respiratory drive.
      c. If the patient is determined to be a candidate for organ donation after cardiac death, and the legal next of kin has made a decision to withdraw life support, the DNW Coordinator will present the option of organ donation to the family. The decision to withdraw support must be made independently of and prior to any decision to donate

organs. The family will be informed of all aspects of the donation and recovery process and appropriate consents will be obtained.

d. Support and counseling will be provided to the donor family. Case Management may be directly involved with DNW and critical care staff in caring for families. The DNW Family Care Advocate will provide continuing family care after completion of the organ recovery.
e. If the legal next of kin consents to donation after cardiac death, consent will also be obtained for any other procedures or medical interventions performed for the purpose of organ donation prior to the determination of death, e.g. administration of Heparin prior to death.

3. Donor Maintenance
   a. Diagnostic studies will be performed by hospital staff to determine suitable organ function and interventions to optimize organ function may also be done following the family's consent.
   b. The NIHD physician and care team will continue to write and implement orders during the evaluation and prior to withdrawal of care. DNW shall not write any orders.
4. Withdrawal of life support in the OR and pronouncement of the patient
   a. Perioperative Services will provide an OR suite, one scrub tech/RN and one circulating RN. Anesthesia support is not necessary.
   b. The DNW Coordinator will work closely with the OR staff to schedule the recovery procedure in the OR.
   c. When the transplant team is assembled, the patient will be transported to the OR while still on mechanical ventilation. Up to four members of the family will be allowed to accompany the patient to the OR entrance then the family will be escorted by the Family Resource Coordinator from DNW to a consultation room.
   d. The patient will not be discharged from the system until death occurs. The patient's physician, Respiratory Therapist and an ICU nurse will accompany the patient to the OR and stay with the patient until pronounced dead. The RN caring for the patient will administer any medications needed by palliation. DNW staff will assist with transport. The patient will be draped and prepared for recovery.
   e. Once the patient has been prepared and organ recovery equipment and supplies are in place, the transplant recovery teams will leave the room and wait in a designated area until the patient has been pronounced. After pronouncement, the transplant teams may re-enter the OR for organ recovery.
   f. Medication for patient comfort up to and during the withdrawal of support will be administered in accordance with established practice of the physician. Extubation will be performed by the patient's physician.
   g. Pronouncement of death will occur when the following conditions are met: 5 minutes of apnea AND 5 minutes of asystole or a rhythm consistent with irreversible cessation of circulatory function, e.g. pulseless electrical activity or ventricular fibrillation, demonstrated by cardiac monitoring.
   h. The organ recovery will then proceed.
   i. The patient's physician or attending physician will document the date and time of death in the medical record and will complete the death certificate if applicable.
   j. If the patient's death does not occur within the designated timeframe, the recovery effort may, at the discretion of the transplant team, be terminated. The patient will then be transported back to their room where the attending physician will direct patient care. The House Supervisor or designee will notify the Donor Network (1-800-553-6667) within an hour of asystole to close out the referral.

5. Medical Center Reimbursement: All charges related to the evaluation and recovery or organs for transplantation, incurred after the donation after cardiac death disclosure form has been signed by the family including the operating room fees and work up started, shall be billed to the Donor Network West, 12667 Alcosta Blvd. Suite 500, San Ramon, CA 94583.
6. The patient's attending physician shall not be paid or reimbursed by, nor associated with or employed by DNW. The patient's attending physician shall not participate in the procedures for removing or transplanting an organ.

H. Tissue & Eye Donation
    1. Donor Criteria
        a. Tissue donation will be considered on all deaths, including those patients who are declared brain dead. Tissues may include: bone, dura mater, costal cartilage, middle ear tissue,
        i. Fascia lata, skin, veins, tendons, ligaments, heart valves, pericardium, and eyes (corneas and sclera).
        b. Age Eligibility: Newborns (minimum 36 weeks and 5 pounds); upper age limitations are determined by DNW.
        c. Eye donations: if suitable for transplant purposes, the body should be refrigerated within first 12 hours after death and the corneas (or whole globes for research) must be removed within 20 hours after circulation ceases. The procedure is performed by a designee of DNW. Other tissues can be removed up to 24 hours after circulation ceases providing the body is refrigerated within 12 hours of asystole. If the body has not been refrigerated, the recover tissue(s) must be harvested within 15 hours. The preferred location for tissue retrieval is the OR. Tissue retrieval may be performed by the staff of DNW in a non-sterile environment using aseptic techniques (e.g. pathology department, morgue, or coroner's office).

EDUCATION/TRAINING:

A. Resource Manual for Organ and Tissue & Eye Donation is available in the House Supervisor's office including the appropriate phone numbers needed.
B. All House Supervisors and those cross trained to the HS role will be trained periodically.

DOCUMENTATION:

A. All referrals, referral numbers, and communication with DNW for donation, whether accepted or declined by the next-of-kin are to be documented by the HS reporting and handling the process in the medical record. This documentation occurs on the 'Release of Body to Mortuary' form.
B. The charts of all expired patient, aged 80 years or less, are audited on monthly basis by DNW.
C. Checklist, "Process for Organ Donation After Cardiac Death" (not part of the medical record) is a tool utilized to assure necessary steps are taken by the HS.

Supersedes: v.1 Organ/Tissue/Eye Donation*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Pain Management and Documentation		
Owner: MANAGER MED SURG ICU	Department: Acute/Subacute Unit	
Scope: District Wide		
Date Last Modified: 09/23/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

1. To provide for standardization of pain screening/assessment, management and documentation across the treatment continuum, with a particular focus on the hospital in-patient.
2. Assessment of pain for the verbally non-communicative infant, child or adult must rely on behavioral and or physiologic parameters.

POLICY:

Pain assessment will be documented on the Admission Nursing Assessment form initially and on a regular basis on the unit patient care flow sheet or unit nursing record thereafter.

At a minimum, the following standards for pain assessment, treatment, and documentation will be followed. Additionally, individual unit's standards of care that pertain to pain assessment, management, and documentation will be followed.

The same numerical scale for pain assessment will be used for each individual patient If the type of pain scale is changed it will be noted.

The following scales will be used:

A. **Neonatal/Infant Pain Scale (NIPS)**
This scale may be used for *infants less than 1 year* of age.
See addendum I

B. **Facial, legs, activity, cry, consolability scale (FLACC)**
This scale can be used in *children ages 2 months to 7 years.*
FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.
See addendum II

C. **Wong-Baker FACES Pain Rating Scale:** This scale is used for adults and pediatric *patients older than 3 year of age.* The Wong-Baker FACES Pain Rating Scale can also be used with *patients who have mild dementia* or for those who are unable to understand a numeric pain scale.
It is a self-report tool in which the patient points to the face that corresponds to his pain intensity. NIH uses the 0 to 10 scale.

See addendum III

D. **Patient Self Report of Pain:** The Numeric Pain Scale may be used for patients *5 years of age or older*.
The patient must be able to count.
The patient reports pain severity on a 0-10 scale by associating with a numerical value or facial expression.
See addendum IV

E. **Observational Pain Scale for Critically Ill Adults:** May be used for patients who are unable to communicate their pain level. May be used for sedated, somnolent, sleeping, or cognitively impaired patients.
See Addendum V

Severity of pain, based on the 0 to 10 score from scales (above) is as follows:

- Absence of pain = 0
- Mild pain = 1 to 3
- Moderate pain = 4 to 6
- Severe pain = 7 to 10

STANDARDS:

1. Patients or their representatives will be informed that they have a right to be involved in their pain management as stated in the Patient Bill of Rights. This information will be included in the Conditions of Admission that the patient signs on admission to the hospital.

2. Patients or their representatives will be instructed in the use of the pain rating scale to report their pain (age-appropriate, condition appropriate, and language appropriate). The type of pain scale used will be documented on the patient care record.

3. When possible, patients will be asked to participate in setting a comfort goal. Pertinent comfort measures will be taught to the patient and family. This information will be documented on the patient care record.

4. The pain goal is set by the patient, their representative, nurse or other clinical discipline for patients who are unable to set a goal. The goal is monitored for inpatients at a minimum of every 24 hours as part of the Interdisciplinary plan.

Pain Screening and assessment:

A. Screening:
   a. All patients will be screened for the presence of pain:
      i. On admission or initial patient encounter
      ii. Before and after a procedure
      iii. With a change in condition
      iv. With patient's self-report of recurring or new pain
      v. As appropriate for patient's condition
   ~~b. With each routine vital sign assessment. If the patient is being screened by a CNA, Tech or MA, only patient self-report of pain severity may be used. The screener will immediately report to licensed personnel using the following guidelines:~~

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i. ~~Pain that is above the patient's acceptable level of pain~~
ii. ~~Any chest pain~~
iii. ~~Any new onset of pain~~

5. Upon Admission, all patients will be asked about the presence and intensity of pain at the time of initial evaluation and as clinically indicated.
6. Initial pain assessment and or new report of pain:
   A. When the patient denies pain: if the patient denies pain, document zero (0) as well as the patient's acceptable pain severity level in the electronic health record. No further pain documentation is needed at this time.
   B. Once pain has been identified, further pain assessment must be completed by a nurse or physician and includes the following elements:
      a. **Pain Severity** is determined by the patient's self-assessment or by alternative pain scales such as the FLACC or NIPS
      b. The nurse may collaborate with the family and or significant other as well as review suspected causes of pain to evaluate the patients' pain. This is especially helpful with pain assessments of the non-communicative patient.
      c. **Location** The location of pain will be assessed and documented. For patients evaluated using the FLACC or NIPS, pain location may not be assessable. The RN will use knowledge about the patients' condition, behavior and history to assist in pain location assessment.
      d. **Acceptable severity** of pain on a 0-10 scale. The patient may change the acceptable level at any time.
      e. **Additional/optional elements** that should be noted during a pain assessment and may assist with the development of a plan of care include:
         i. Quality and Character of pain
         ii. Radiation location as appropriate
         iii. Duration and frequency of pain
         iv. Effects of pain: impact on daily functioning and associated symptoms
         v. Alleviating factors, response to past interventions, what helps decrease or relieve pain, usual relief measures
         vi. Aggravating factors: what increases or triggers pain
7. Pain must always be assessed and evaluated in light of the patient's entire clinical condition. Examples of scenarios that may not require additional assessment:
   A. Pain level less than or equal to patient reported acceptable severity
   B. Patient declines additional assessment or intervention
8. Any patient declination of assessment or intervention will be documented in the health record**.**

Focused re-assessment

1. Focused pain reassessment must be completed by a nurse or trained team member as part of the shift assessment or treatment plan and in response to the patient's initial assessment. The team member documents in the shift assessment a minimum of every shift. The assessment is documented in the EHR and includes:
   A. Pain severity
   B. Pain location
   C. If possible, an acceptable severity of pain on a 0-10 scale will be used. If a patient denies pain it may be documented as "denies pain", or it may be documented as zero (0).

A post intervention reassessment is conducted within a reasonable time frame after pharmacologic intervention and or other pain management interventions have occurred.

a. After pharmaceutical intervention, the RN/LVN reassesses the patient's response:
    i. Pain shall be reassessed and pain intensity documented within 30 minutes after Intravenous administration of pain medication.
    ii. Pain shall be reassessed and pain intensity documented within 60 minutes ± 15 minutes after Intramuscular injection of pain medication for inpatient and outpatient admissions.
    iii. Pain shall be reassessed and pain intensity documented with 60 minutes ± 15 minutes after oral drug therapy for inpatient and outpatient admissions.

D. Re-assessment must be performed in light of the patient's entire clinical condition. Examples of scenarios that may not require additional assessment:
    a. Pain level less than or equal to patient reported acceptable level
    b. Patient declined additional assessment or intervention

E. Pain intensity will be assessed prior to any repeated PRN pain medication administration.

Pain management and plan of care:

The RN will begin development of the pain management plan of care in collaboration with the patient, family, significant other, medical plan of care and interdisciplinary care team. An evidence-based, individualized plan of care is created upon admission and updated as needed based on the diagnosis or patient's individual needs (Gulanick & Myers, 2011). The individualized plan of care includes nursing interventions for pain management.

1. A pain rating higher than the patient's comfort goal will elicit intervention. Interventions will be initiated as ordered. If pain persists, the physician will be notified.

DOCUMENTATION:

The following will be documented in the patient's medical record:

a. Patient/family (as applicable) teaching
b. Type of scale used
c. The comfort goal, when appropriate
d. Initial and subsequent pain assessments
e. Pain relief intervention
f. Any interdisciplinary review
g. Any modification of the treatment plan

The following records/forms may contain this documentation:

a. Admission Nursing Assessment
b. Nursing Plan of Care
c. Unit Nursing Record or Patient Care Flow Sheet
d. Medication Documentation Sheet (if applicable)
e. Discharge Instructions

REFERENCES:

1. http://wongbakerfaces.org/
2. https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_FLACC/
3. https://www.uwhealth.org/healthfacts/parenting/7711.pdf

4. https://com-jax-emergency-pami.sites.medinfo.ufl.edu/files/2015/02/Neonatal-Infant-Pain-Scale-NIPS-pain-scale.pdf
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5. *From* Merkel, S. I., et al. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23,* 293–297
6. McCaffery M, Pasero C: Pain: Clinical Manual, p. 410 Copyright 1999 Mosby, inc.)
7. Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc. 2003;4(1):9-15.*

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Nursing Assessment/Reassessment
2. Opioid Sedation Scale
3. Opioid Administration

Supersedes: v.3 Pain Management and Documentation*

Addendum I:

NEONATAL INFANT PAIN SCALE (NIPS): *Use for infants less than one year of age* The Neonatal Infant Pain Scale (NIPS) is a behavioral scale and can be utilized with both full-term and Pre-term infants. The tool was adapted from the CHEOPS scale and uses the behaviors that nurses have described as being indicative of infant pain or distress. It is composed of six (6) indicators:

- Facial expression
- Cry
- Breathing patterns
- Arms
- Legs
- State of arousal

Each behavioral indicator is scored with 0 or 1 except "cry" which has three possible descriptors (scored 0,1or 2). See the NIPS Scale for the description of infant behavior in each indicator group.
Infants should be observed for one minute in order to fully assess each indicator.
Total pain scores ran from 0-7. The suggested interventions based upon the infant's level of pain are listed below.

Evaluate newborn for causes of pain versus the need for routine comfort measures. Pain indicated by:

1. Birth injuries/trauma
2. Maternal drug history indicating potential for neonatal withdrawal symptoms
3. Painful procedures (i.e., IV starts, lab draws, tube placement, injections, circumcision, etc.)

Discomfort indicated by/response - treatment:

1. Need for repositioning - Reposition for correct body alignment, flexed midline position.
2. Need for diaper or linen change - Change diapers or clothing
3. Signs of hunger (i.e., hand-mouth activity, sucking, rooting) - Feed per orders or offer non-nutritive sucking for infants unable to feed for medical reasons

NEONATAL INFANT PAIN SCALE (NIPS)

Scores	0	1	2	
Facial Expression	Relaxed Muscles Restful face Neutral expression	Grimace Tight facial muscles, furrowed brow, chin, jaw (negative facial expression – nose, mouth, and brow)		
Cry	No cry Quiet, not crying	Whimper Mild moaning, intermittent	Vigorous cry Loud scream, rising , shrill, continuous (note: silent cry may be scored if baby is intubated, as evidenced by obvious mouth, facial movement)	
Breathing Patterns	Relaxed Usual pattern for this baby	Change in breathing In drawing, irregular, faster than usual, gagging, breath holding		
Arms	Relaxed / Restrained No muscular rigidity, occasional random movements of arms	Flexed / Extended Tense, straight arms, rigid and/or rapid extension, flexion		
Legs	**Relaxed / Restrained** No muscular rigidity, occasional random leg movement	**Flexed / Extended** Tense, straight legs, rigid and/or rapid extension, flexion		
State of Arousal	Sleeping / Awake Quiet, peaceful, sleeping or alert and settled	Fussy Alert, restless, and thrashing		
Total:				

Addendum II:

Facial, legs, activity, cry, consolability scale (FLACC)
For children ages 2 months to 7 years.
The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain. See Addendum IV

FLACC Behavioral Pain Assessment Scale[19]			
The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.			
	Scoring		
Category	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consol ability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Total score:			
From Merkel, S. I., et al. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23,* 293–297.			

Severity of pain, based on the 0 to 10 score from scales (above) is as follows:

- Absence of pain = 0
- Mild pain = 1 to 3
- Moderate pain = 4 to 6
- Severe pain = 7 to 10

Addendum III:

Wong-Baker FACES Pain Rating Scale
For adults and pediatric patients older than 3 year of age or who have mild dementia or who do not understand the numeric pain scale.
It's a self-report tool in which the patient points to the face that corresponds to his pain intensity. NIH uses the 0 to 10 scale. Explain to the patient what each face means before having him rate his pain.
To use the FACES scale, explain to the patient that each face represents a person who feels happy because he has no pain or is sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how he is feeling.

Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consol ability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Total score:			

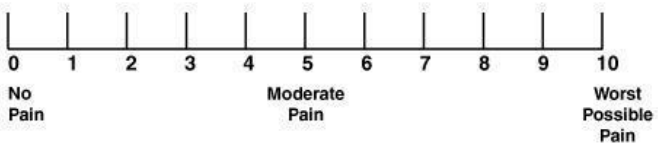
Severity of pain, based on the 0 to 10 score from scales (above) is as follows:

- Absence of pain = 0
- Mild pain = 1 to 3
- Moderate pain = 4 to 6
- Severe pain = 7 to 10

Addendum IV:

Numeric Pain Scale

A numeric pain scale is a self-report tool. To use it, the patient must have a concept of numbers and their relationship to each other. The scale can be used vertically or horizontally. The numbers range from 0 to 10, where 0 is no pain and 10 is the worst possible pain. The nurse should ask the patient to pick which number corresponds to her/his pain level



Severity of pain, based on the 0 to 10 score from scales (above) is as follows:

- Absence of pain = 0
- Mild pain = 1 to 3
- Moderate pain = 4 to 6
- Severe pain = 7 to 10

Addendum V:

Observational Pain Scale:
Used for patients who are unable to communicate their pain level

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during care giving, after the administration of pain medication).

Categories	0	1	2	Score
Face	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead	Frequent grimace, tearing, frowning, wrinkled forehead	
Activity (movement)	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes	
Guarding	Lying quietly, no positioning of hands over areas of body	Splinting areas of the body, tense	Rigid, stiff	
Physiology (vital signs)	Stable vital signs	Change in any of the following: • SBP>20 mm Hg • HR>20/min	Change in any of the following: • SBP>30 mm Hg • HR>25/min	
Respiratory	Baseline RR/SpO_2 Compliant with ventilator	RR>10 above baseline, or 5% ↓SpO_2 mild asynchrony with ventilator	RR>20 above baseline, or 10% ↓SpO_2 mild asynchrony with ventilator	
			TOTAL SCORE	

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Each of the 5 categories is scored from 0-2, which results in a total score between 0 and 10.
Document total score by adding numbers from each of the 5 categories.
Scores:
Severity of pain, based on the 0 to 10 score from scales (above) is as follows:

- Absence of pain = 0
- Mild pain = 1 to 3
- Moderate pain = 4 to 6
- Severe pain = 7 to 10

Addendum VI

Deep Breathing for relaxation with the option of peaceful imagery

1. Breathe in slowly and deeply.
2. As you breathe out slowly, feel yourself beginning to relax; feel the tension leaving your body.
3. Now breathe in and out slowly and regularly, at whatever rate is comfortable for you.
4. To help you focus on your breathing and breathe slowly and rhythmically:
   Breathe in as you say silently to yourself "In two three"
   Breathe out as you say silently to yourself "Out two three"
   Or
   Each time you breathe out, say silently to yourself a word such as peace or relax
5. You may imagine that you are doing this in a place you have found very calming and relaxing for you, such as laying in the sun at the beach.
6. Do steps 1 through 4 only once or repeat steps 3 and 4 for up to 20 minutes.
7. End with a slow, deep breath. As you breathe out you may say to yourself, "I feel alert and relaxed."

Additional points:

- This technique for relaxation has the advantage of being very adaptable. You may use it for only a few seconds or for up to 20 minutes. For example, you may do this regularly for 10 minutes twice a day. You may also use it for one or two complete breaths any time you need it throughout the day or when you awaken in the middle of the night.
- If you use this technique for more than a few seconds, try to get in a comfortable position in a quiet environment.
- A very effective way to relax is to add peaceful images once you have performed steps 1 through 4 above. Following are some ideas about finding your own peaceful memories.

Something may have happened to you a while ago that can be of use to you now. Something may have brought you deep joy or peace. You may be able to draw on the past experience to begin your peace or comfort now. Think about these questions:

- Can you remember any situation even when you were a child, when you felt calm, peaceful, secure, hopeful, or comfortable?
- Have you ever laid back, kicked off your shoes, and daydreamed about something peaceful? What were you thinking of?
- Do you get a dreamy feeling when you listen to music? Do you have any favorite music?
- Do you have any favorite poetry that you find uplifting or reassuring? Are you now or have you ever been religiously active? Do you have favorite readings, hymns, or prayers? Even if you haven't heard or thought of them for many years, childhood religious experiences may still be very soothing.

Very likely some of the things you think of in answer to these questions can be recorded for you, such as your favorite music or a prayer read by your clergyman. Then you can listen to the recording whenever you wish. Or, if your memory is strong, you may simply close your eyes and
recall the events or words.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Patient Valuables		
Owner: MANAGER MED SURG ICU	Department: Acute/Subacute Unit	
Scope: Acute/Subacute ICU		
Date Last Modified: 11/09/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY:

Every patient admitted to the hospital must be asked if they have (in their possession) valuables such as money, watch, jewelry, important papers, credit cards, etc. Family members should be encouraged to take these items home or they should be stored in the designated lock up area accessible by the House Supervisor.

The nurse admitting the patient to the hospital is responsible to see that the patient's valuables are safely secured either with the family or itemized on the valuables envelope and given to the House Supervisor to be securely held under lock in the designated area.

PROCEDURE:

A. Valuables Envelope
   1. Print patient's name under "NORTHERN INYO HOSPITAL". (or add patient sticker to the envelope)
   2. All cash must be counted and total documented in the presence of the patient or a witness.
   3. Items such as wallets, purse, etc. should be described as to size and color, with a general description of the contents. E.g. credit cards, driver's license, etc.
   4. Jewelry should be described by appearance. E.g. One yellow colored ring with a white stone; one ladies white colored watch with plastic band. **Do not attempt to identify a piece of jewelry as to the type of stone other than by color and possible size.**
   5. Do not attempt to estimate the value of any item except the cash.
   6. The patient **must** sign the envelope where it states "Signature of Depositor", when all items have been listed and the envelope is sealed. If the patient is unable to sign, secure a witness to sign for the patient and indicate reason patient is unable to sign.
   7. The person who lists and places the valuables in the envelope must date and sign the envelope where it states "Received by" and "Date".
   8. The "tear off" flap must have the same information as #1, #6, and #7 on the envelope. The "flap" is taped to the inside of the patient's medical record chart.
   9. The envelope is given directly to the House Supervisor who is then responsible for locking it in the designated area.

B. Removing Items from the Envelope before Discharge
   1. If, at a patient's request, cash or other items are removed from the envelope, such information needs to be recorded on the envelope as well as date and time. The valuables envelope may then be re-secured after the nurse and patient verify all contents and sign the acknowledgement. The Envelope is once again given to the House Supervisor.

C. Reclaiming Valuables

1. The tear off flap must be presented to the House Supervisor by the Nurse discharging the patient before valuables can be returned.
2. The contents must be checked in the patient's presence and the patient must sign and date the bottom of the envelope indicating that the patient has received the items listed on the envelope.
3. The empty valuables envelope is placed inside the patient's chart and it becomes part of the record.

D. Documentation in the Patient Record

1. The disposition of valuables must be documented on the admission assessment tab titled "Valuable Information".
2. Upon discharge from the hospital, the return of valuables is noted in the discharge notes. Upon transfer to another facility, it should be noted that the patient's valuables were either returned to the patient or to a designated appointee.

REFERENCES:

1. Patient Valuables

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Patient's Rights – California Department of State Hospital: https://www.dsh.ca.gov/About_Us/Patients_Rights.html

Supersedes: v.4 Patient Valuables*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 09/19/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/01/2018	

PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of adult health maintenance (specific chronic diseases – protocols i.e. hypertension, diabetes).

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Function: management of adult health maintenance.
3. Circumstances:
    a. Patient Population: adult patients
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
4. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:
1. Definition: health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults.
    a. Includes health assessment and disease prevention utilizing:
        i. physical exam
        ii. diagnostic testing
        iii. immunizations
        iv. developmental screening
        v. health education
2. Data base:
    a. Subjective:
        i. Obtain complete histories on all first-time patients; interval histories on subsequent visits.
    b. Objective:
        i. At each visit obtain vital signs, weight, allergy history and pain assessment.
        ii. Risk assessment when establishing care and as indicated.
        iii. Perform complete physical examinations as indicated.
        iv. Perform appropriate psychosocial assessment.
        v. Laboratory/diagnostic testing as needed.
3. Plan:

a. Diagnosis established utilizing current coding standards in CPOE format.
    i. Health maintenance
    ii. Acute illness
    iii. Current assessment of chronic illness
b. Therapeutic regimen
    i. Diet as appropriate for age/nutritional status
    ii. Initiate and modify orders for home health services
    ~~ii.~~iii. Medications
        1. Vitamins/mineral supplements
        2. Immunizations as indicated
        3. Hormonal replacement as indicated
        4. Medications appropriate to address acute and chronic health problems.
    ~~iii.~~iv. Activity/exercise as appropriate for age/health status
    ~~iv.~~v. Health education related to age/health status, preventative health behaviors.
    ~~v.~~vi. Interventions appropriate to address acute and chronic health problems.
    ~~vi.~~vii. Refer to specialist or other community resource indicated
c. Physician consultation is to be obtained under the following circumstances
    i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    ii. Acute decompensation of patient situation.
    iii. Problem which is not resolving as anticipated.
    iv. History, physical, or lab finding inconsistent with the clinical picture.
        1. Upon request of patient, nurse, or supervising physician.
d. Follow-up
    i. According to adult health maintenance schedule, sooner as indicated.
e. Record keeping
    i. Appropriate documentation to be maintained in patient's chart.
    ii. Allergic reaction to vaccine/medication

4. For contraindications and precautions to immunization as stated in the vaccine package insert, consult with a physician before administration of vaccine.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Procedure - Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

_____	_____
Chairman, Interdisciplinary Practice Committee	Date
_____	_____
Administrator	Date
_____	_____
Chief of Staff	Date
_____	_____
President, Board of Directors	Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

1. _____ _____
   NAME DATE

2. _____ _____
   NAME DATE

3. _____ _____
   NAME DATE

4. _____ _____
   NAME DATE

5. _____ _____
   NAME DATE

6. _____ _____
   NAME DATE

7. _____ _____
   NAME DATE

8. _____ _____
   NAME DATE

CALL TO ORDER

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

Chair Veenker read a statement regarding the financial status of NIHD.

PRESENT

Jody Veenker, Chair
Mary Mae Kilpatrick, Vice Chair
Jean Turner, Treasurer
Melissa Best-Baker, Secretary
Lionel Chadwick PhD, Interim Chief Executive Officer
Allison Partridge RN, MSN, Chief Nursing Officer
Stephen Del Rossi, MSA, Chief Financial Officer
Joy Engblade, MD, Chief Medical Officer

ABSENT

None

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. Public comments were heard from the following:

- Dean Lewis
- Christine Hanley

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Vice Chair, Mary Mae Kilpatrick, made a correction to Agenda item A, noting it should be Calendar Year 2023.

Treasurer, Jean Turner, commended an Association of Healthcare District's webinar.

ELECTION OF BOARD OFFICERS FOR CALENDAR YEAR 2023

Chair Veenker called attention to the Election of Board Officers for Calendar Year 2023. Vice Chair Kilpatrick proposed the following slate of officers:

- Chair, Mary Mae Kilpatrick
- Vice Chair, Melissa Best-Baker
- Secretary, Jean Turner
- Treasurer, Vacant
- Member at Large, Jody Veenker

Treasurer Turner motioned to approve the slate of Board Officers, Secretary, Melissa Best-Baker, seconded and the motion passed 4-0.

DISTRICT BOARD RESOLUTION 22-20, SELF-CORRECTION RESOLUTION

Isabel Safie, Legal Counsel, introduced District Board Resolution 22-20, the Self-Correction Resolution. She provided an overview of errors in the 401-contribution plan as well as corrective action documented in the District Board Resolution. Ms. Safie asked if there were any questions and a discussion ensued.

Vice Chair Kilpatrick motioned to adopt District Board Resolution 22-20, Self-Correction Resolution, Treasurer Turner seconded and the motion passed 4-0.

UPDATE ON ZONE 3 BOARD MEMBER VACANCY

Chair Veenker called attention to an update on the Zone 3 Board Member Vacancy. Interim Chief Executive Officer (CEO), Lionel Chadwick, provided an update on the application process and expected timeline to fill the vacancy.

CHIEF EXECUTIVE OFFICER REPORT

CEO Chadwick began his report by commending Northern Inyo Healthcare District's quality of care. Additionally, he provided an update regarding the CEO search process and the addition of a turnaround action group for financial purposes.

CHIEF FINANCIAL OFFICER REPORT

Chair Veenker introduced Chief Financial Officer (CFO), Stephen DelRossi, who provided the Chief Financial Officer Report.

APPOINTMENT OF FINANCE AND AUDIT COMMITTEE

CFO DelRossi introduced the need to appoint a Board Member to the Finance and Audit Committee. A discussion ensued.

Vice Chair Kilpatrick motioned to appoint Melissa Best-Baker to the Finance and Audit Committee, Treasurer Turner seconded and the motion passed 4-0.

FINIANCIAL AND STATISTICAL REPORTS

CFO DelRossi discussed the financial and statistical reports for September and October.

FINANCIAL TURN AROUND STATUS

CFO DelRossi provided an update on Northern Inyo Healthcare District's financial turnaround status. CFO DelRossi noted they are taking action to increase collections and reconcile losses.

Chair Veenker asked for clarification from CFO DelRossi and a discussion ensued. The board expressed appreciation for CFO DelRossi's work.

CHIEF OF STAFF REPORT

Chair Veenker introduced Dr. Sierra Bourne who provided the Chief of Staff report.

MEDICAL STAFF REAPPOINTMENTS

Dr. Bourne introduced the medical staff reappointments and provided clarification regarding credentialing.

Treasurer Turner motioned to approve the medical staff reappointments, Melissa Best-Baker seconded and the motion passed 4-0.

MEDICAL STAFF APPOINTMENTS

Dr. Bourne called attention to the medical staff appointments and asked if the Board had any questions.

Vice Chair Kilpatrick motioned to approve the medical staff appointments, Treasurer Turner seconded and the motion passed 4-0.

MEDICAL STAFF RESIGNATIONS

Dr. Bourne called attention to the medical staff resignations and thanked the providers for their service.

Melissa Best-Baker motioned to approve the medical staff resignations, Treasurer Turner seconded and the motion passed 4-0.

POLICIES

Dr. Bourne introduced the following Medical Staff policies for approval:

1. Management of the Behavioral Health Patient (5150 and non-5150)
2. Mandated Reporting: Child Abuse/Neglect; Dependent Adult/Elder Abuse; Injury by Firearm or Assault/Abuse

The board asked for clarification and a discussion ensued.

Treasurer Turner motioned to approve the policies with the proposed address correction, Vice Chair Kilpatrick seconded and the motion passed 4-0.

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Bourne provided a report of the Medical Executive Committee meeting.

CONSENT AGENDA

Chair Veenker called attention to the Consent Agenda.

Secretary Baker brought attention to a correction of the November 16th, 2022 meeting minutes.

Treasurer Turner motioned to approve the Consent Agenda with the proposed correction, Secretary Baker seconded and the motion passed 4-0.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair Veenker announced that at this time, persons in the audience may speak only on items on the Closed Session portion of this meeting. Public comments were heard from the following:

- Dean Lewis

ADJOURNMENT TO CLOSED SESSION

At 6:25, Chair Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

a. Conference with Labor Negotiators, District Designated Representatives: Interim CEO and HR Director; 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 announced there would be no reportable action.

ADJOURNMENT

Adjournment at 7:05 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

Attest: _____
Jean Turner, Northern Inyo Healthcare District, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 p.m. by Mary Mae Kilpatrick, Northern Inyo Healthcare District (NIHD) Board Chair.
PRESENT	Mary Mae Kilpatrick, Chair Melissa Best-Baker, Vice Chair Jean Turner, Secretary Jody Veenker, Member-at-Large Lionel Chadwick PhD, Interim Chief Executive Officer Allison Partridge RN, MSN, Chief Nursing Officer (present via zoom) Joy Engblade, MD, Chief Medical Officer (present via zoom)
ABSENT	Stephen Del Rossi, MSA, Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Chair Kilpatrick 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 public comments were heard.
APPOINTMENT OF THE ZONE 3 BOARD VACANCY	Chair Kilpatrick called attention to the Appointment of the Zone 3 Board Member Vacancy. Member-at-Large, Jody Veenker, introduced the item and thanked Interim Chief Executive Officer, Lionel Chadwick, for sitting in on the interviews. Member-at-Large Veenker acknowledged that all three (3) candidates were sophisticated and with valuable experience. It was Member-at-Large Veenker's recommendation that Ted Gardner fill the Board vacancy. Chair Kilpatrick looked to the Board for further questions or comments. No discussion was had. It was motioned by Secretary, Jean Turner, seconded by Vice Chair, Melissa Best-Baker, and passed with a 4-0 vote to appoint Ted Gardner to the Zone 3 Board vacancy.
APPROVAL OF FINANCIAL AND STATISTICAL REPORTS	Chair Kilpatrick called attention to approve the financial and statistical reports that were presented as an action item at the Regular Board Meeting, December 21, 2022. It was motioned by Vice Chair Best-Baker, seconded by Member-at-Large, Veenker and passed with a 4-0 vote to approve the financial and statistical reports.

LETTER IN SUPPORT OF NOMINATION OF SECRETARY, JEAN TURNER, TO ACHD BOARD OF DIRECTORS

Chair Kilpatrick called attention to a letter in support of Board Member, Jean Turner, to join the Association of California Healthcare Districts (ACHD) Board of Directors. Chair Kilpatrick read the letter to the Board of Directors. A discussion regarding the benefits of serving ACHD was had.

It was motioned by Member-at-Large Veenker, seconded by Vice Chair Best-Baker and passed 4-0 to approve the letter in support of nominating Jean Turner to the ACHD Board of Directors.

CEO REPORT

Chair Kilpatrick called attention to the CEO Report. Interim CEO Chadwick discussed his participation in various community events and meetings: the Bishop City Council, Inyo County Board of Supervisors and the Bishop Chamber of Commerce. Additionally, Interim CEO Chadwick has been attending various departmental meetings within NIHD in order to build relations and allow for open communication.

Interim CEO Chadwick addressed the impacts of the recent severe weather and the potential need to discuss employee housing during these conditions at a later date. Interim CEO Chadwick also commended the Rural Health Clinic's Car Clinic staff and NIHD's maintenance workers who have continued to provide excellent service despite the weather conditions.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair Kilpatrick announced that at this time, persons in the audience may speak only on items on the Closed Session portion of this meeting. No public comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 5:46, Chair Kilpatrick announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

a. *Conference with Labor Negotiators, District Designated Representatives: Interim CEO and HR Director; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6)*

Chair Kilpatrick announced there would be no reportable action.

ADJOURNMENT

Adjournment at 6:15 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

Attest: _____
Jean Turner, Northern Inyo Healthcare District, Secretary

RESOLUTION NO. 23-01

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 18th day of January, 2023 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Mary Mae Kilpatrick, Chair
Board of Directors

ATTEST:

_____
Name: Autumn Tyerman
Title: Board Clerk

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: ALARA Program		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging, Hospital Clinical Staff		
Date Last Modified: 12/07/2022	Last Review Date: 12/16/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/20/2017	

PURPOSE:

The purpose of establishing an ALARA (as low as reasonably achievable) Program is to incorporate practices, procedures and quality assurance checks to keep occupational and medical exposure to radiation as low as reasonably achievable.

Definitions:

ALARA – "as low as reasonably achievable," acronym for the philosophy of keeping medical and occupational radiation exposure as low as reasonable achievable.

RSO – Radiation Safety Officer

RSC – Radiation Safety Committee

POLICY:

The term ALARA is an acronym for maintaining radiation exposures, and effluent releases of radioactive material in uncontrolled areas "as low as reasonably achievable" taking into account the available technology, economic costs in relation to benefits to the public health and safety, and other societal and socioeconomic considerations in their relationship with the utilization of radioactive materials and radiation – producing equipment in the public interest.

The ALARA philosophy extends to exposure to individuals in the performance of their duties (Occupational exposure) and to patients undergoing medical evaluations and treatments.

To achieve this goal, the management should address dose reduction for both workers and patients.

Although the program presented here is developed specifically for occupational exposure considerations, management should incorporate into their program those procedures, practices, and quality assurance checks that can eliminate unnecessary or extraneous radiation exposures to patients without compromising the quality of medical service. Such practices and checks include, but are not limited to:

a) Use of appropriate and well-calibrated instrumentation and equipment.
b) Use of appropriate digital imaging techniques
c) Staying with the well-established dosage limits unless deviation is absolutely essential in the judgment of the responsible physician.

1. Management Commitment

a) We, the management of Northern Inyo Healthcare District, are committed to an efficient medical use of radioactive materials and radiation producing equipment by limiting their use to clinically indicated procedures, utilizing efficient exposure techniques, and optimally operated radiation equipment; limiting dosages to those recommended by the manufacturer unless otherwise necessary, using calibrated diagnostic and related instrumentation; and using appropriately trained personnel.
b) We commit to the program described below for keeping occupational individual and collective doses ALARA. Toward this commitment, we hereby describe an administrative organization for radiation safety and will develop all necessary written policy, procedures, and instruction to foster the ALARA philosophy within our institution. The organization will include a Radiation Safety Committee (RSC) and a Radiation Safety Officer (RSO).
c) We will perform a formal annual review of the radiation safety program, including ALARA considerations. The review will cover operating procedures and past dose records, inspections, and recommendations of the radiation safety staff or consultants.
d) We will modify operating and maintenance procedures, equipment, and facilities if these modifications will reduce exposures and the cost is justified.

2. Radiation Safety Committee

a) Review of Proposed Users and Uses
    (1) The RSC will thoroughly review the qualifications of each applicant with respect to the types and quantities of radioactive materials and radiation-producing equipment and methods of use for which application has been made, to ensure that the applicant will be able to take appropriate measures to maintain exposure ALARA.
    (2) When considering a new use of radioactive material or radiation producing equipment, the RSC will review the efforts of the applicant to maintain exposure ALARA.
    (3) The RSC will ensure that the users justify their procedures and that individual and collective doses will be ALARA.
b) Delegation of Authority
(The judicious delegation of RSC authority is essential to the enforcement of an ALARA program.)
    (1) The RSC will delegate authority to the RSO for enforcement of the ALARA program.
    (2) The RSC will support the RSO when it is necessary for the RSO to assert authority. If the RSC has overruled the RSO, it will record the basis for its action in the minutes of the quarterly meeting.
c) Review of ALARA Program
    (1) The RSC will encourage all users to review current procedures and develop new procedures as appropriate to implement the ALARA concept.
    (2) The RSC will perform an annual review of occupational radiation exposure. A special meeting may be called for particular attention to instances in which the investigational levels in Table 1 are exceeded. The principal purpose of this review is to assess trends in occupational exposure as an index of the ALARA program quality and to decide if action is warranted when investigational levels are exceeded (see Section 4 below for a discussion of investigational levels). Maximum legal limits of occupational exposure are listed in Table 2, for reference.

(3) The RSC will evaluate the institution's overall efforts for maintaining doses ALARA on an annual basis. This review will include the efforts of the RSO, authorized users, and workers as well as those of management.

Table 1

Investigational Levels*

	Investigational Levels (mRem/calendar quarter)	
	Level I**	Level II**
1. Whole body; head and trunk; active blood-forming organs; or gonads, lens of eye	312	624
2. Lens of Eye	936	1872
3. Extremities	3125	6250
4. Skin of whole body	750	2250
5. Thyroid uptake	0.1 uCi	0.3 uCi

*Note that investigational levels in this program are not new dose limits but serve as checkpoints above which the results are considered sufficiently important to justify investigations. See Section 4 for further discussion.

**Investigational levels are as listed on Radiation Detection Company Dosimetry Report.

Table 2

Maximum Annual Levels*

	Maximum Annual Occupational Dose limits in mRem
1. Whole body	5,000
2. Extremities, Skin	50,000
3. Lens of the eyes	15,000
4. Fetus	500

*Legal limits for occupational radiation exposure, NCRP Report No. 116, Table 19.1

3. Radiation Safety Officer

a) Annual and Quarterly Review

(1) *Annual review of the radiation safety program.* The RSO will perform an annual review of the radiation safety program for adherence to ALARA concepts. Reviews of specific methods of use may be conducted on a more frequent basis.

(2) *Quarterly review of occupational exposures.* The RSO will review at least quarterly the radiation doses of authorized users and workers to determine that their doses are ALARA in accordance with the provisions of Section 5 of this program and will prepare a summary report for the RSC.

(3) *Quarterly review of records of radiation surveys.* The RSO will review radiation surveys in unrestricted and restricted areas to determine that dose rates and amounts of contamination were at ALARA levels during the previous quarter and will prepare a summary report for the RSC.

b) Education Responsibilities for ALARA Program

The RSO (in cooperation with authorized user) will ensure that radiation workers and, as applicable,

(1) Ancillary personnel are trained and educated in good health physics practices and procedures.

(2) The RSO (or designee) will schedule briefings and educational sessions to inform workers of the ALARA program efforts.

(3) The RSO (or designee) will ensure that authorized users, workers, and ancillary personnel who may be exposed to radiation will be instructed in the ALARA philosophy and informed that management, the RSC, and the RSO are committed to implementing the ALARA concept.

c) Cooperative Efforts for Development of ALARA Procedures

(1) Radiation workers will be given opportunities to participate in formulating the procedures that they will be required to follow.

(2) Radiation workers will be instructed in recourses that may be taken if they feel that ALARA is not being promoted in the workplace.

d) Reviewing Instances of Deviation from Good ALARA Practices

(1) The RSO will investigate all know instances of deviation from good ALARA practices and, if possible, will determine the causes. When the cause is known, the RSO will implement changes in the program to maintain doses ALARA.

4. Authorized Users

a) New Methods of Use Involving Potential Radiation Doses

(1) The authorized user will consult with the RSO and/or RSC during the planning stage before using radioactive materials and radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trials runs may be helpful.

(2) The authorized user will review each planned use of radioactive materials or radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trial runs may be helpful.

5. Establishment of Investigational Levels in Order to Monitor Individual Occupational Radiation Doses (External and Internal)

This institution hereby establishes investigational levels for occupational radiation doses which, when exceeded, will initiate review or investigation by the RSC and/or the RSO. The investigational levels that we have adopted are listed in Table 1. These levels apply to the exposure of individual workers.
The following actions will be taken at the investigational levels stated in Table 1.

a) Personnel Dose Less than Investigational Level I
   (1) Except when deemed appropriate by the RSO, no further action will be taken in those cases where an individual's dose is less than Table I values for the investigational Level I.

b) Personnel Dose Equal To or Greater Than Investigational Level I But Less Than Investigational Level II
   (1) The RSO will review the dose of each individual whose quarterly dose exceeds the investigational Level I and will report the results of the reviews at the first RSC meeting following the quarter when the dose was recorded. If the dose does not equal or exceed Investigational Level II, no specific action related to the exposure is required unless deemed appropriate by the Committee. The committee will, however, review each such dose in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the committee minutes.

c) Personnel Dose Equal to and Greater Than Investigational Level II
   (1) The RSO will investigate in a timely manner the causes of all personnel doses equaling or exceeding Investigational Level II and, if warranted, will take action. A notification letter will be sent to all personnel with doses equaling or exceeding Investigational Level II. A report of the investigation and any actions taken will be presented to the RSC at its first meeting following completion of the investigation. The details of these reports will be included in the RSC minutes.

d) Reestablishment of Investigational Levels to Level Above Those Listed in Table 1
   (1) In cases where a worker's or a group of workers' doses need to exceed an investigational level, a new, higher investigational level may be established for that individual or group on the basis that it is consistent with good ALARA practices. Justification for new investigational levels will be documented.
   (2) The RSC will review the justification for and must approve or disapprove all revisions of investigational levels.

REFERENCES:

1. CA Title 17
2. CA-RHB "Guide for the preparation of an application for a radioactive materials license authorizing medical use"
3. 10 CFR 35, 10 CFR 20
4. NCRP Report No. 116, Table 19.1
5. Radiation Detection Company Dosimetry Report

RECORD RETENTION AND DESTRUCTION:

- Dosimetry reports will be kept for duration of employment + 30 years
- Patient dose records will be maintained in interpretive report as part of the medical record

CROSS REFERENCE P&P:

1. Dosimetry Program - Occupational Radiation Exposure Monitoring Program
2. CHA records retention recommendations

Supersedes: v.2 ALARA Program*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Dosimetry Program - Occupational Radiation Exposure Monitoring Program		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging Technologists, Surgery RN and Scrub Tech		
Date Last Modified: 10/28/2021	Last Review Date: 12/16/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/18/2015	

PURPOSE:
To establish guidelines for monitoring occupational radiation exposure and ensure that radiation worker's exposure and monitoring complies with "As Low As Reasonably Achievable" (ALARA) principles.

POLICY:
In order to detect and evaluate occupational exposure to external radiation, individual monitoring devices will be issued to individuals who are likely to receive, in one year from sources external to the body, a dose in excess of 10 percent of the legal limit as defined in the ALARA Program. It is Northern Inyo Healthcare District (NIHD) policy that all Imaging technologists wear their personal radiation dosimetry badge at all times when on duty, as required by 10 CFR 20, 20.1101.

PROCEDURE:
Radiation Monitoring Badges:

1. Supervisors / Managers of employees that work in areas with potential for radiation exposure shall have a radiation ("film") badge ordered for and delivered to all employees that work within those areas.
2. NIH provide "TLD" (thermoluminescent dosimeters) badges and rings to monitor radiation exposure.
3. Employees shall wear their badge at all times while working within the defined areas where there is potential to exceed the 10% dose threshold outlined in the policy statement.
4. The badge shall be worn at collar (thyroid) level outside of lead.
5. If two (2) dosimetry badges are issued (either because of high dosimetry levels or fetal monitoring), the second badge shall be worn at waist level under lead.
6. If a finger badge is issued, this shall be worn on the hand most likely to receive the most exposure.
7. At no time will any employee deliberately tamper with a dosimetry badge, as this is ground for disciplinary action.
8. The Radiation Safety Officer shall review the records quarterly, and all employees shall have access to their records at any time.
9. A record that does not contain sensitive information shall be posted at the employee information board in the Imaging Department.
10. All original records shall be kept for the duration of licensure of the hospital as required by the state and/or the NRC.
11. Review of staff dosimetry monitoring shall be conducted at least every quarter by the Radiation Safety Officer, Diagnostic Medical Physicist or Health Physicist. The review shall assess if the staff

radiation exposure levels are within ALARA levels set by the US Nuclear Regulatory Commission's 10 CFR 20 Standards for Protection Against Radiation regulation.

12. Occupational workers approaching maximum allowable exposure shall be counseled. A physicist shall review exposures for accuracy and explanation.
13. NRC regulations prohibit the occupational worker who reaches maximum allowable radiation exposure from additional exposure to occupational sources of radiation for the duration of the period (quarter/annual). NIHD shall ensure the occupational worker receives no additional occupational radiation from registered or licensed sources.
14. Area exposure badges are used to measure background radiation within the DI department and are placed and removed from the bulletin board in the DI employee hallway coinciding with employee dosimetry badge distribution. Area monitoring reports will be reviewed by RSO in conjunction with employee dosimetry report review.
15. Control badges shall be kept in an area free from radiation exposure. At NIHD, control badges will be stored in the diagnostic Imaging break room. Control badges are used by the radiation badge company to monitor background radiation at the facility. Control badges are used to accurately calculate occupational exposure.

ATTACHMENTS:

1. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999
2. Declaration of Pregnancy Form Letter

REFERENCES:

1. US Nuclear Regulatory Commission (USNRC), NRC Library, Document Collections, NRC Regulations (10 CFR), *Part 20 - Standards for Protection Against Radiation,*, http://www.nrc.gov/reading-rm/doc-collections/cfr/part020/
2. 10 CFR 20→ Subpart C → §20.1201
3. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999

RECORD RETENTION AND DESTRUCTION:

- Duration of Employment +30 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. ALARA Program
2. CT Radiation Safety Policy
3. Radiology Services Pregnant Personnel

Supersedes: v.2 Dosimetry Program - Occupational Radiation Exposure Monitoring Program*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Radiology Services Pregnant Personnel		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Radiology Technologist		
Date Last Modified: 10/28/2021	Last Review Date: 12/16/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Purpose: Teratogenic effects of ionizing radiation in the first trimester of pregnancy have long been known. Although the reported epidemiological association of excess risk in childhood cancer with prenatal radiation exposure of 1 to 10 Rem to the embryo, or fetus, is still uncertain, it is conservative radiation protection philosophy to assume that such a risk may exist. This policy will define Northern Inyo Healthcare District's (NIHD) response to this condition.

Policy:

NIHD will take all necessary steps to reduce the exposure of pregnant personnel to as low as reasonably achievable.

Although not required, as soon as a radiology technologist believes that she is pregnant, it is highly recommended that she notify Diagnostic Imaging leadership.

The following specific technical assignments will be allowed:

1. General radiography and fluoroscopy in the department
2. Computed Tomography, mammography, MRI and ultrasound
3. Surgery and portable radiography.

Under no circumstances will pregnant technologists be allowed to hold patients.

Management will notify all appropriate personnel of the pregnancy so that all staff may make every reasonable attempt to ensure that pregnant technologists and technologists in general perform examinations prior to the administration of radionuclides from nuclear medicine.

A second body dosimetry badge shall be acquired for pregnant personnel. It shall be worn at the midsection. When a lead apron is worn, it shall be a wrap-around, and the badge shall be worn under the apron. The dosimetry company shall be informed of the badge's purpose for proper record keeping.

The Radiation Safety Officer shall be notified so that potential radiation exposure to the pregnant individual can be evaluated.

1. The occupational exposure of the expectant mother shall not exceed 500 mRem during the full gestational period. (Source: National Council on Radiation Protection and Measurements)
2. Pregnant personnel shall read the pregnancy advisory literature (Appendices A and B, 8.13-3 through 8.13-7, see attachments on left sidebar) and document that fact on the Declaration of Pregnancy form.

REFERENCES:

- National Council on Radiation Protection and Measurements
- American College of Radiology

RECORD RETENTION AND DESTRUCTION:

- Duration of Employment plus 30 years

CROSS REFERENCED POLICIES AND PROCEDURES:

- Pregnant Personnel in the Perioperative Unit*
- Dosimetry Program – Occupational Radiation Exposure Monitoring Program”

Supersedes: v.2 Radiology Services Pregnant Personnel

Declaration of Pregnancy

To: _____, Radiology Department Manager

In accordance with the NRC's regulations at 10 CFR 20.1208, "Dose to an Embryo/Fetus," I am declaring that I am pregnant. I believe I became pregnant in _____ (only the month and year need to be provided).

I understand the radiation dose to my embryo/fetus during my entire pregnancy will not be allowed to exceed 500 mrem (millirem) (unless that dose has already been exceeded between the time of conception and submitting this letter). I also understand that meeting the lower dose limit may require a change in job or job responsibilities during my pregnancy.

I have received and read Appendices A and B, "Effects on the Embryo/Fetus of Exposure to Radiation and Other Environmental Hazards" and "Pregnant Worker' Guide.

_____

Your Signature

_____

Your printed name

_____

Date

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Diagnostic Imaging - Ordering Radioactive Materials		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Nuclear Medicine Department		
Date Last Modified: 11/19/2021	Last Review Date: 12/16/2021	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2015	

PURPOSE: ensure that materials and quantities of radioactive materials (RAM) ordered are authorized by the license and that possession limits for RAM are not exceeded.

POLICY: The nuclear medicine technologist maintains written records that identify the authorized user or department, isotope, chemical form, activity, and supplier.

PROCEDURE:

1. For routinely and occasionally used materials, the Radiation Safety Officer or designee (nuclear medicine technologist) shall keep written records that identify the authorized user or department, isotope, chemical form, activity, and supplier.
2. The written records of order will be checked to confirm that the RAM received were ordered through proper channels.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,

RECORD RETENTION AND DESTRUCTION: Records will be kept for 10 years

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI NM General rules of the safe use of radioactive materials
- DI NM Radioactive package receipt

Supersedes: v.1 Diagnostic Imaging - Ordering Radioactive Materials*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Radioactive Material Hot Lab Security		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Nuclear Medicine, Diagnostic Imaging, House Supervisors		
Date Last Modified: 12/06/2022	Last Review Date: 12/16/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 2014	

PURPOSE:
To define authorized entrance to the radioactive materials (RAM) hot lab.

POLICY:
1. The hot lab door shall remain locked at all times, unless authorized personnel are inside or supervising entrance to the hot lab.
2. Only authorized nuclear medicine personnel, Diagnostic Imaging Departmental Leadership, House Supervisors, Radiation Safety Officer and Medical Physicists may enter the hot lab unsupervised.
3. For afterhours deliveries, please refer to the "Diagnostic Imaging - Radioactive Materials Delivery After-hours Procedure"

REFERENCES:
1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
2. 10 CFR 35

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Diagnostic Imaging – Radioactive Materials Delivery After-Hours procedure
2. DI NM General Rules for the safe use of Radioactive Materials

Supersedes: v.2 Diagnostic Imaging - Radioactive Material Hot Lab Security

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Imaging Equipment Quality Control		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope:		
Date Last Modified: 12/06/2022	Last Review Date: 12/16/2021	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

Ensures Imaging Services equipment is operating in a manner that is safe and compliant with state and federal regulations

POLICY:

1. The imaging department technologist shall perform quality control on all imaging equipment following manufacturer recommendations located in equipment manuals.
2. Quality control limits are set by manufacturer, manufacturer's field service engineer (FSE), or the medical physicist.
3. Equipment not performing within the designated specifications shall be removed from service immediately.
4. The Director of Diagnostic Services (DDS) and radiologist shall be notified of deficiency or malfunction.
5. The DDS or designee shall contact the appropriate manufacturer or FSE, or biomedical engineer.
6. Following correction or repair, appropriate quality control shall be repeated.
7. After passing quality control standards, equipment shall be placed back into service.

REFERENCES:

- National Council on radiation protection and measurements (NCRP) Report No. 99
- California Code of Regulations – Title 17

RECORD RETENTION AND DESTRUCTION:

- Until next Inspection + 6years

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI – Monitoring and Documentation of Fluoroscopic Quality Control
- Mammography Quality Control

Supersedes: v.1 Diagnostic Imaging - Imaging Equipment Quality Control*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Sanctions for Breach of Patient Privacy Policies		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 04/19/2022	Last Review Date: No Review Date	Version: 7
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2011	

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

POLICY:
Northern Inyo Healthcare District's (NIHD) sanctions are instituted based upon the determined level of breach of patient's protected information in a consistent process that is specifically determined by the severity of incident, utilizing a scale. All workforce members who commit a privacy breach will be treated per this process, regardless of rank or position. The action level may lead to termination for the most severe offenses.

DEFINITIONS:

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

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 Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

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

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

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

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

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

Malicious - with intent to harm or with intent to gain personally.

PROCEDURE:

I. Breach Incident Determination of Severity

A. Minor Breach – an inadvertent and non-malicious breach
Examples include but are not limited to: distributing, emailing or faxing protected health information (PHI) to the wrong individual unintentionally.

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

C. Major/Severe Breach – is a deliberate violation that purposefully or maliciously violates a patient's privacy or disregards NIHD policy.
Examples include but are not limited to: releasing or using data for personal gain, destroying or altering data, purposefully accessing or attempting to gain access to patient information which the workforce member does not need to access to perform their job, maliciously attacking or hacking District information systems, releasing patient data with the intent to harm an individual or the District, or a pattern of repeated moderate violations.

II. Whistleblower Protection

A. Neither the District nor any workforce member of the District may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who reports any conduct that is unlawful or otherwise violates professional or clinical standards including, but not limited to the reporting of conduct that results in the breach of privacy of any patient of NIHD.

B. Proven violation of this section will result in immediate loss of employment.

III. Disciplinary Action

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

IV. Standard Sanctions – Levels

A. Level 1: Re-training and/or coaching memo.

B. Level 2: Documented verbal counseling or written warning, as determined by leadership in conjunction with Human Resources, placed into workforce member's Human Resources (HR) File.

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C. Level 3: Written warning, probation, or suspension, including notification that further violation of the privacy of PHI will result in termination, as determined by leadership in conjunction with HR. Documentation will be placed into workforce member's HR file.
D. Level 4: Termination.

V. Modification of Sanction Levels

A. Action level may be modified by the consensus of the Privacy Officer, Human Resources Director, and the employee's manager by considering the following:
   1. Previous history or corrective action (level of action may increase based on repeat offenses)
   2. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.

Sanctions for Breach of Patient Privacy – Incident Severity Scale Tool

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

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

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REFERENCES:

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

RECORD RETENTION AND DESTRUCTION:

Records related to documentation placed in the workforce member's HR file are maintained for the length of employment, plus six (6) years.
Unusual Occurrence Reports are maintained for ten (10) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Sanctions for Breach of Patient Privacy Policies
2. Privacy Screen Policy
3. Password Policy
4. Sanctions for Breach of Patient Privacy Policies
5. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information

Supersedes: v6 Sanctions for Breach of Patient Privacy

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Electrical Distribution EC.02.05.01 EP21		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Facilities		
Date Last Modified: 12/08/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
Electrical distribution in the hospital is based on the following categories.

POLICY
The electrical distribution system at Northern Inyo Healthcare District (NIHD) is divided into three categories:

1. Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required.

2. Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients.

3. Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours.

REFERENCES:

1. The Joint Commission CAMCAH Manual (Jan.2021) EC.02.05.01 EP21

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Electrical equipment
2. Utility Systems Electrical and Generator Failure EC.02.05.01 EP10b

Supersedes: Not Set

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Fiscal One-Up Approvals		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: Fiscal and Accounting Department		
Date Last Modified: 12/08/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To clarify who has authority to approve Fiscal Department workforce members expense reimbursement at Northern Inyo Healthcare District (NIHD). Consistently followed approval practice protects the workforce and the District from fiduciary malfeasance.

DEFINITIONS:
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 Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

POLICY:
All accounting and fiscal services require an approval from a staff member that is one level above that of the preparer (accountants require controller or controller in training, controller in training requires controller, controller requires Chief Financial Officer (CFO), CFO requires Chief Executive Officer).

CFO will not prepare or enter journal entries, balance sheet reconciliations, or cash and equivalent balancing.

REFERENCE:
1. Generally Accepted Accounting Standards

RECORD RETENTION AND DESTRUCTION:
Keep all invoices, accounts receivable/payable documents for a minimum of fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Reimbursement for Local Travel for District Business
2. Travel Between Hospital Locations

Supersedes: Not Set

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Emergency Purchases		
Owner: Director of Purchasing	Department: Purchasing	
Scope: District Wide		
Date Last Modified: 12/01/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/17/2015	

PURPOSE:
To clarify process and requirements associated with 'emergency' need to purchase materials outside of normal process in order to meet Northern Inyo Healthcare District's (NIHD) mission.

POLICY:
Emergency purchases will be approved prior to purchase. (See Procedure Section B and C.)
Information about the purchase will be provided to Purchasing no later than the next business day.

PROCEDURE

A. Certain instances may occur when procurement is deemed to be so urgent that adherence to the normal requisition/purchasing system would be detrimental to patient care or safety.

B. During normal business hours:
   1. The individual who identifies the emergent need will contact Purchasing by telephone, explain the situation and jointly determine what action is to be taken. This may entail Purchasing staff taking necessary action or the user getting a purchase order number and taking action himself or herself.
   2. The individual is responsible for getting the properly signed requisition, as well as any information about the purchase (as noted below) to Purchasing as soon as possible. At no time should this exceed one working day.

C. After normal business hours:
   1. The individual who identifies the emergent need will contact the Administrator-on-Call (AOC) to receive authorization for the emergency purchase.
   2. The individual will arrange for the purchase and delivery.
   3. The individual is responsible for getting the properly signed requisition, packing slip/delivery ticket, as well as any information about the purchase (as noted below), to purchasing as soon as possible. At no time should this exceed one working day.
   4. Purchasing will assign a purchase order number and contact the supplier to inform them of the number for invoicing purposes.

D. When the customer arranges for the purchase he or she must get the following information and include it on the confirming requisition.
   1. Date and time placed;

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2. Approved Supplier representative who accepted the order;
    a. Suppliers not on approved NIHD list, must be verified (via the link below) is not on the excluded list. https://exclusions.oig.hhs.gov/
3. Quantity, description and, if possible, catalog number of item(s) ordered;
4. Price for the item(s) and;
5. If after hours, the name of the administrator who approved the purchase.

RECORD RETENTION AND DESTRUCTION:

Invoices documenting purchase or lease of clinical laboratory equipment and test kits, reagents, or media will be maintained for 15 years.

Invoices on fixed assets, equipment will be maintained for the life of asset or equipment, plus 15 years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Purchasing and Signature Authority
2. Asset Control
3. Delivery of Received Goods
4. Receiving Documentation
5. Vendor Credentialing

Supersedes: v.1 Emergency Purchases

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Sale of Supplies		
Owner: Controller	Department: Fiscal Services	
Scope: Materials Management, House Supervisors, Accounting		
Date Last Modified: 12/21/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/07/1995	

PURPOSE:
Periodically Northern Inyo Healthcare District workforce and other individuals will request that the District sell supplies, equipment or miscellaneous services. The purpose of this policy is to give the guidance to District personnel on how to respond to such request.

POLICY: This policy only pertains to medical supplies stocked by the District.

1. NON-MEDICAL SUPPLIES
   Except in emergency, as determined by the Chief Executive Officer (CEO), Northern Inyo Healthcare District (NIHD) does not sell non-medical supplies to persons not currently patients in the hospital. The District is not in the business of reselling office supplies, housekeeping supplies, kitchen supplies, personal use items, or any other non-medical supplies or services not listed in this policy to District workforce, or the public.
2. MEDICAL SUPPLIES SOLD TO OTHER FACILITIES
   Due to our rural location, there are times when other non-profit facilities in our area call upon us to sell them supplies in an emergency. NIHD sells medical supplies to other institutions in these cases. The receiving facility is charged 10% more than the District's acquisition cost for the item.
   Notify accounting of the transaction; accounting bills the designated (receiving) institution.
   If medical equipment/supplies (such as implants) are borrowed from another institution and are utilized on patients at our hospital, the supplies needed to replenish such equipment will be ordered from the manufacturer on a District purchase order for payment of such equipment and sent to the institution from which it was borrowed.
3. MEDICAL SUPPLIES SOLD TO PATIENTS
   NIHD does not purchase medical supplies for resale in general. Periodically the District has a purchase request for supplies or equipment from a patient. Support and direct the patient to obtain the items from other sources when possible.
   In the unusual circumstance where there is eminent need of the supply and it is not available locally, NIHD will sell the item to the patient. The patient is charged 10% more than the District's acquisition cost for the item.
   Obtain the item from Purchasing, rather than the supply storage in clinical department to avoid issues with the Periodic Automated Replenishment (PAR) levels.
   Complete the form for Supplies Sold and send copy to Accounting and Purchasing Department.

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ATTACHMENT: Use attached, *Supplies Sold to Non-Patients Form* to document sale.

REFERENCE:

1. Office of Inspector General:
https://oig.hhs.gov/exclusions/background.asp
2. Exclusions from Office of Inspector General: https://exclusions.oig.hhs.gov/

RECORD RETENTION AND DESTRUCTION:

Maintain record of receipt of sale for six (6) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Used equipment sales
2. Discharge Medications

Supersedes: v.1 Policy on Sale of Supplies and Pharmaceuticals

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Reimbursement for Local Travel for District Business		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: District Wide		
Date Last Modified: 12/21/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/15/2017	

PURPOSE:
To provide reimbursement to employees for usage of their personal vehicle when conducting Northern Inyo Healthcare District (NIHD) business.

POLICY:
The District provides vehicles for some recurring needs and employees should always try to use the vehicles if available. Employees must be listed as potential drivers on the hospital insurance to use those vehicles.

Management may request that employees in some positions may be allowed to drive their personal vehicles in the local area for specified NIHD related business.

PROCEDURE:
In order to reimburse staff members for this usage, there will be a Local Mileage log available for tracking of travel. Employees must log each trip and turn in the log monthly to their manager for approval. The Senior Manager will submit the log to Accounts Payable by the 5th of the following month for processing.

Local Mileage log is available on the NIHD Intranet>Resources>Forms and Templates>Administrative>Mileage Form Log or as an attachment to this policy within Policy and Procedure Manager (PPM).

Mileage will be paid at the most current IRS guidelines for mileage reimbursement.

REFERENCE:
1. IRS Mileage: https://www.irs.gov/tax-professionals/standard-mileage-rates

RECORD RETENTION AND DESTRUCTION:
Payment record based on invoices, including mileage logs, will be maintained for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Compliance Program for Northern Inyo Healthcare District
2. Travel between hospital locations
3. Reimbursement of expenses

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Supersedes: v.1 Reimbursement for Local Travel for Hospital Business

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Hospital-Grade Receptacles EC.02.05.01 EP22		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Maintenance		
Date Last Modified: 12/08/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE Hospital grade receptacles used at Northern Inyo Healthcare District (NIHD) and tested after initial installation, replacement or servicing in patient bed locations and where deep sedation or general anesthesia is administered. This is according to NFPA 99-2012 standard.

In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, playrooms, and activity rooms are labeled tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.

REFERENCES:

1. The Joint Commission CAMCAH Manual (Jan 2021) EC.02.05.01 EP22
2. NFPA 99-2012

RECORD RETENTION AND DESTRUCTION: N/A

CROSS-REFERENCED POLICIES AND PROCEDURE: N/A

Supersedes: Not Set

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Receiving Process		
Owner: Director of Purchasing	Department: Purchasing	
Scope: Purchasing Department		
Date Last Modified: 12/08/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/09/2015	

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PURPOSE:
This policy outlines procedures for receiving most normal deliveries. See individual procedures for damaged goods, capital equipment, refrigerated items, hazardous materials, flowers, and after hour's deliveries.

POLICY:
Receiving will ensure that goods delivered to the institution are as ordered and undamaged. Receiving will document receipt of orders and ensure items are delivered internally.

PROCEDURE:

A. Unless otherwise noted on the purchase order, acceptance by the Receiving department completes the purchasing transaction and commits the hospital to payment. In cases where formal acceptance is delayed (usually for capital purchases), acceptance by the Receiving department still creates a bailment responsibility for items.
B. Except as otherwise noted or as outlined in supplements to this policy, all goods will be delivered to the receiving area and received by members of the Purchasing department. No receipt will be accepted by others or at times other than the established receiving times unless prior arrangements have been made by the Purchasing department.
    1. Pharmaceutical items will be delivered directly to the Pharmacy and be received by Pharmacy personnel.
    2. Food items will be delivered directly to Food Service and be received by Food Service personnel.
    3. Some engineering items will be delivered directly to the Engineering department; these items will be checked by Engineering personnel.
    4. Certain other supplies will be delivered directly to departments through various "stockless" programs. Receipt of these goods will be as established in the individual program.
C. It is the responsibility of the carrier to unload individual items from the truck into the Receiving department. Pallets will be unloaded by Receiving or Purchasing personnel and delivered to the Receiving department. Before signing to accept, the receiver will verify that all goods are the property of the hospital, that all packages and containers are free of signs of damage or contamination, and that the bill of lading agrees with the package count.
    1. After verification, the receiver will sign the bill of lading and accept the goods.
    2. In the event that the receiver is not given ample opportunity to ensure that all the goods are, in fact, property of the hospital and as noted on the bill of lading, the receiver shall make note of such on the shipper's receiving document. This comment might be, "signing for numbers of

packages only," for a UPS shipment or, "signing for numbers of pallets only," for a prime vendor shipment.

3. If there is apparent damage or contamination this fact will be noted on the shipper's receiving document. If the damage appears extensive, the Purchasing department should be notified immediately and a decision made whether to accept or refuse. See policy on receiving damaged goods.

D. Receiving documentation will normally start with the packing list.
   1. The packing list should be located and opened. The purchase order number should appear on this slip. If no purchase order number can be found, the purchase order number may be found by searching the MMIS. Alternately, contact Purchasing. If a purchase order cannot be found, the goods will be put into the holding area awaiting instructions from Purchasing.
   2. Once the purchase order has been identified, the actual goods present will be compared to those listed on the packing list. Any discrepancies including concealed damage will be noted on the packing slip.
   3. After the goods have been verified, the receipt information will be entered from the packing list into the MMIS. Any items received that are not on the purchase order or are in quantities larger than listed on the purchase order will be segregated. These over shipments will not be received but will be noted, along with other discrepancies, as in 2 above, in the comments section of the receiving screen.
   4. All discrepancies and/or over shipments will be reported to Purchasing.
   5. A receiving document will be generated for each department and/or inventory getting goods from the shipment. This document will accompany the goods to the ordering department.

E. The NIH Shipping/receiving system is reserved exclusively for hospital business. Employees and Medical Staff are not to receive/ship packages (i.e. "catalog orders, boxes, mailers etc.") of a personal nature through the Purchasing department. If the Purchasing Department receives a package via a carrier such as UPS, FedEx etc. of a personal nature, it will be handled in the following way:
   1. Addressee will be notified by email that a personal package has been received, and cannot be processed by the hospital.
   2. Package will be placed in a holding area.
   3. Addressee will be contacted, educated on the appropriate procedure for receiving personal property, and directed where to pick up the package. Failure to pick up the package will result in its return to shipper.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:
Maintain packing slips, bill of laden, other shipping documents and invoices for six (6) years.

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Diagnostic Imaging – Radioactive Materials Delivery After-hours Policy/Procedure

Supersedes: v.2 Receiving Process

review

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Charity Care Program		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: District Wide		
Date Last Modified: 01/12/2023	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/15/2017	

PURPOSE:

To define the parameters of eligibility, amount of aid possible, and the process of access to the charity care program mandated by California **Health and Safety Code Section** (CA HSC) **127400-127446.**

DEFINITIONS:

CA HSC 127400: As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient," means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the District's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level (FPL)" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 400 percent of the federal poverty level.

(d) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation. Northern Inyo Healthcare District includes a hospital and clinics, referred to as "the District".

(e) "Department" means the Department of Health Care Access and Information.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the District. Self-pay patients may include charity care patients.

(g) “A patient with high medical costs” means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). For these purposes, “high medical costs” means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the Healthcare District that exceed the lesser of 10 percent of the patient’s current family income or family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months.

(3) A lower level determined by the Healthcare District in accordance with the District’s charity care policy.

(h) “Patient’s family” means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(i) “Reasonable payment plan” means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. “Essential living expenses” means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

POLICY:

Northern Inyo Healthcare District (NIHD) will provide healthcare access to individuals who are uninsured, under insured, or who have high medical costs. This is available for medically necessary service/care. Federal Poverty Level Guidelines (FPL) for income will be the basis of eligibility for NIHD’s Charity Care Program. The Notice of Available Charity and Discount Services included in this policy will be updated annually when FPL is released, using 400 percent of the government poverty income level for free care, discounted care, and financed care. NIHD will offer financing arrangements to ease the burden of healthcare costs. The following criteria will be followed for determining the level and type of assistance:

1. Eligibility criteria will be the applicant’s, applicant’s family, or entire household gross income, including alimony, child support, financial support of absent parent, and all other income from whatever source derived, coupled with household size.
2. Income from whatever source derived will be used to consider the applicant’s level of responsibility. The following indicates the amount and type of assistance available:
    a. When the total income is at or below 100% of the FPL, NIHD will offer free care through the charity care application and approval process;
    b. When the total income is above 100% and equal to or lower than 200%, NIHD will offer a 25% discount and long-term financing through the charity care application and approval process;
    c. When the total income is above 200% and equal to or lower than 250%, NIHD will offer a 20% discount and long-term financing through the charity care application and approval process;
    d. When the total income is above 250% and equal to or lower than 300%, NIHD will offer a 15% discount and long-term financing through the charity care application and approval process;

    e. When the total income is above 300% and equal to or lower than 350%, NIHD will offer a 10% discount and long-term financing through the charity care application and approval process;
    f. When the total income is above 350%, NIHD will offer long-term financing through the charity care application and approval process;
3. Monetary assets will be considered in the determination of eligibility. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.
4. Verification of the patient's household income may consist of, but not limited to, the following applicable documents:
    a. Paycheck stubs for current three months;
    b. Unemployment payment stubs;
    c. Disability payment stubs;
    d. Bank statements for current three months;
    e. Copy of current or previous year income tax return;
    f. Copy of currently approved local social service assistance program (Medi-Cal).
5. Should the applicant have no source of income, inquiry will be made as to how the patients supports him or herself**.**
6. All other resources of coverage will first be sought. This includes, but is not limited to, any available local social service assistance program such as Medi-Cal and CCS (California Children's Services); Medicare; Insurance; employer provided or offered health plan; other available third party sources; participation in the Affordable Care Act.
    a. Individuals without insurance will be assisted in following the Affordable Care Act, participating in "Open" Enrollment.
    b. Written denial is required for applicants not eligible for assistance through their local department of social services.
    c. Should an applicant be eligible for Medi-Cal or other State's Medicaid programs with a Share of Cost, the applicant may still be entitled to the Charity Care Program to assist with meeting Share of Cost responsibilities. Once their Share of Cost is satisfied, the applicant's Medi-Cal will be accepted as payment for covered services.
    d. Failure to comply with timely application for local social service assistance programs, or failure to complete the application for available local social service assistance programs may be a basis for denial of the NIHD Charity Care Program.
7. To sustain eligibility, NIHD Charity Care recipients will be required to submit a new Charity Care application every twelve months, including new application to available local social service assistance programs.
8. If any information given proves to be untrue, NIHD may re-evaluate the application and take whatever action becomes appropriate up to disqualification and revocation of charity.
9. Efforts to identify patient's qualification for NIHD Charity Care Program will be initiated as early as possible but will not be criteria of determination.
10. Conditional qualification may be made in cases where eligibility for other available assistance programs such as Medi-Cal has not yet been determined.
11. Individuals who do not respond to notices of Charity or Discount services, and who do not respond to billing and collection efforts, and are subsequently assigned to an outside collection agency may not be considered for NIHD's Charity Care program.

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12. Charity Care denials for patients based upon their income may become subsequently approved should their income change following their original determination based on additional supplied information. Subsequent determinations will not result in a refund of prior payments.
13. Effect of the determination of eligibility will not be open-ended. Charity status may be reviewed at any time during the covered time period, not to exceed one year.
14. Included in the initial billing (patient statement) of the uninsured individuals, will be the NORTHERN INYO HEALTHCARE DISTRICT REQUEST FOR HEALTH COVERAGE INFORMATION / NORTHERN INYO HEALTHCARE DISTRICT NOTICE OF OTHER COVERAGE PROGRAMS / NORTHERN INYO HEALTHCARE DISTRICT NOTICE OF AVAILABLE CHARITY/DISCOUNT SERVICES (included in this policy).
15. Post notices of NIHD's Charity Care & Discount Payment Program in all patient care areas, waiting rooms and reception areas as well as the Credit (payment) and Billing Information Office. This will include the Rural Health Clinic and all Northern Inyo Associates Offices.
16. Applications for the NIHD Charity Care Services will be available through Northern Inyo Healthcare District Administration, Social Services Department, and the Credit and Billing Information Office.
    a. The application will include the patient's or applicant's complete name; address; telephone number; social security number; employer; family size; income as described above; service rendered/requested; date of service; applicant's signature; and space for eligibility determination.
17. The Credit & Billing Information Staff will process complete applications within ten (10) business days.
18. Send the applicant a final determination by the US mail.
19. https://healthconsumer.org for additional assistance.

REFERENCE:

1. California Health and Safety Code Section 127400-127446.

RECORD RETENTION AND DESTRUCTION:

Maintain all patient accounting files for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Billing and Collections
2. Price Transparency
3. Credit Balance Refund Processing
4. Prompt Pay Discounts
5. InQuiseek - #600 Financial Policies

Supersedes: v.1 Charity Care Program*

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REQUEST FOR HEALTH COVERAGE INFORMATION

NOTICE OF OTHER COVERAGE PROGRAMS

NOTICE OF AVAILABLE CHARITY/DISCOUNT SERVICES

When you presented for your recent services, it appeared that you may not have health insurance or other coverage. If this is incorrect, please contact our Credit and Billing Information office at (760) 873-2190 at your earliest convenience to provide us with your coverage information.

If you do not have health insurance coverage, or other coverage, you may be eligible for Medicare, ~~Healthy Families~~, MediCal, ~~CMSP~~, or CCS.

You may contact our Credit and Billing Information office at (760) 873-2190 or your local Social Services office for an application for MediCal, ~~CMSP, or the Healthy Families Program~~.

You may obtain information from the Social Security Office regarding Medicare benefits or your local county Health Department regarding CCS benefits.

It is the policy of the Northern Inyo Healthcare District to provide a reasonable amount of care without, or below charge to people who are uninsured, under insured, or ~~an individual~~ with high medical costs. Individuals within the annual income requirements established below may be eligible to receive free or discounted medical care based upon income level and family size.

Size of Family Unit	Poverty Income Guidelines
1	~~$ 41,580~~ 13,590
2	~~$ 56,070~~ 18,310
3	~~$ 70,560~~ 23,030
4	~~$ 85,050~~ 27,750
5	~~$ 99,540~~ 32,470
6	~~$114,030~~ 37,190

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7	~~$128,555~~ 41,910
8	~~$143,115~~ 46,630

For family units with more than eight members, add ~~$14,560~~ $4,720 for each additional member.

If you believe you may be eligible, or if you would like more information or an application, contact the Credit and Billing Information Office, Monday – Friday 8:30a.m. - 4:30p.m. Telephone: (760) 873-2190.

approval

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Billing and Collections		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: Patient Access, Billing and Collections		
Date Last Modified: 12/21/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To provide clear and consistent guidelines for conducting cash and cash equivalent collection functions in a manner that promotes compliance with federal, state, and District rules, patient satisfaction, and efficiency.

POLICY:
In non-emergent circumstances, at or before the time of service, NIHD will collect the patient's co-pay, deductible, and patient's share on insurance eligibility. In emergent circumstances, collection will occur after the patient has been stabilized and is no longer in distress from the medical emergency.

PROCEDURE:
General Rules:
With respect to the collection of medical debt, the statute of limitations for breach of written contract is typically four years. The start time is either the most recent payment date, or the date on which the breach occurred – whichever happened later.

Under state law, NIHD must allow a 180-day negotiation period, which is roughly equivalent to five months, for the determination of a payment plan. NIHD will not send medical bills to a debt collection agency until the 180-day period has elapsed.

The Fair Debt Collection Practices Act (FDCPA) and the California Fair Debt Collection Practices Act (CFDCPA) - Rosenthal Fair Debt Collection Practices Act - protects consumers from abusive or deceptive debt collection practices. The FDCPA prohibits numerous consumer debt collection strategies. The following actions will not be taken by NIHD:

- Call repeatedly for the purpose of causing annoyance or distress.
- Make threats of any kind.
- Pretend to be lawyers, credit reporting company representatives, or government representatives.
- Use abusive or obscene language.

Before assigning a bill to collections or selling patient debt, NIHD will, at a minimum, provide the following:

- Date or services of the bill;
- Name of the entity to which the bill is being assigned or sold;
- Declaration as to how to obtain an itemized bill and an application for the hospital's financial assistance program.

Section 127430 - Written notice prior to commencing collection activities against patient
(a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:
(1) A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act.

The summary shall be sufficient if it appears in substantially the following form: "**State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov**."

(2) A statement that nonprofit credit counseling services may be available in the area.
(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.
(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

Insurance Billing:

- For all insured patients, NIHD will bill applicable third-party payers based on information provided by or verified by the patient or their guarantor in a timely manner.
- If a claim is denied (or is not processed) by a payer due to an error by NIHD, NIHD will not bill the patient or their guarantor for any amount in excess of what the patient or their guarantor would have owed had the payer paid the claim.
- If a claim is denied or is not processed by a payer due to factors outside of NIHD's, staff will follow up with the payer and patient or their guarantor as appropriate to facilitate resolution of the claim. If resolution does not occur after follow-up efforts, Northern Inyo Healthcare District will bill the patient or their guarantor.
- After insurance adjudicates the bill, the appropriate entries will be added to the record.
- If a balance remains on the account, the account will move to Early-out, Self-pay status.
- The general flow of a patient's bill is as follows:
    - Verification of benefits
    - Bill insurance company or companies;
    - After insurance resolution, bill appropriate amount as determined through contractual arrangements; simultaneously, the account moves to self-pay, early-out status;
    - Patient will receive 5 monthly statements, telephonic communications, or any other reasonable means of communication;
    - Patient will receive a Good Bye letter on the 6th statement informing them, among others, that their balance is transferring to a debt collection agency;

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- Up until the time the account is sent to the collection agency, the patient has the opportunity to seek assistance, if assistance is still available due to timing issues, through the Charity Care policy.

Patient Billing: Early-out and Self-pay

- Hospital care at NIHD is available to all those who may be in need of necessary services.
- Patient or guarantor may request an itemized statement at any time.
- For uninsured patients, NIHD will bill uninsured patients or guarantors and they will receive a statement as part of the organization's normal billing process.
- NIHD will provide all uninsured patients their Notice of Available Charity Services**.**
- For insured patients, after claims have been processed by third-party payers, NIHD will bill patient or guarantor the liability amount as determined by their insurer.
- If a patient or guarantor disputes account, has questions or concerns, or requests documentation regarding the bill, NIHD will seek resolution. Patient will be notified of findings.
- NIHD may approve payment plan arrangements for patients or their guarantor who indicate they may have difficulty paying their balance in a single installment.
- Generally, based on income, the balance may be financed for a length up to 60 months. The length of the financing will be based upon the corresponding Federal Poverty Level (FPL), and as follows:
    - When the total income is at or below 100% of the FPL, NIHD will offer financing up to 60 months with a minimum payment of $10.00 per month*;
    - When the total income is above 100% and equal to or lower than 200%, NIHD will offer financing up to 60 months with a minimum payment of $20 per month*;
    - When the total income is above 200% and equal to or lower than 250%, NIHD will offer financing up to 60 months with a minimum payment of $25 per month*;
    - When the total income is above 250% and equal to or lower than 300%, NIHD will offer financing up to 60 months with a minimum payment of $30 per month*;
    - When the total income is above 300% and equal to or lower than 350%, NIHD will offer financing up to 60 months with a minimum payment of $35 per month*;
    - When the total income is above 350%, NIHD will offer long-term financing up to 60 months with a minimum payment of $40 per month*;
    - Under unusual circumstances (e.g. outstanding balance greater than $1,500), the length of financing may exceed 60 months;
        - Approval must be obtained from the CFO for variances;
    - Financing must be offered in 6 month increments until an agreement is made;
    - The minimum amounts can be less than stated with the approval of the CFO.
- * The minimum payment may be less than or more than stated above based on the individual's ability to pay.

NIHD is not required to accept patient or their guarantor initiated payment arrangements and may refer accounts to a collection agency as outlined below if the patient or their guarantor is unwilling to make acceptable payment arrangements or has defaulted on an established payment plan.

Collections Practices

In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, Northern Inyo Healthcare District may engage in collection activities—including outsourcing to outside collection agency to collect outstanding patient balances.

1. General collection activities may include patient statements, follow-up calls, letters, email, messages, or any other authorized form.

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2. Northern Inyo Healthcare District will make every effort to identify eligibility for financial assistance programs, or Charity program for uninsured, under insured, or high cost patients.
3. Patient balances may be referred to an outside collection agency for collection for all accounts greater than 180 days if financing arrangements were not reached. The District will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:
   a. There is a reasonable basis to believe the patient or their guarantor owes the debt.
   b. All third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient or their guarantor. NIHD shall not bill a patient or their guarantor for any amount that an insurance company is obligated to pay.
   c. NIHD will not refer accounts for collection while a claim on the account is still pending payer payment. However, the District may classify certain claims as "denied" if such claims are in "pending" mode for an unreasonable length of time despite efforts to facilitate resolution.
   d. NIHD will not refer accounts for collection where the claim was denied due to a District error. However, NIHD may still refer the patient liability portion of such claims for collection if unpaid.
   e. NIHD will not refer accounts for collection where the patient or their guarantor has initially applied for financial assistance or other District-sponsored program and NIHD has not yet notified the patient or their guarantor of its determination (provided the patient or their guarantor has complied with the timeline and information requests delineated during the application process).

Financial Assistance
NIHD provides all patients or their guarantor the opportunity to apply for financial assistance for their accounts, payment plan options, and other applicable programs.

NIHD assist patients or their guarantor with access to financial assistance and their Charity service program during the collections process.

See Northern Inyo Healthcare District Charity Program for procedure.

IRS Rule:
26 U.S. Code § 61 - Gross income defined
(a)General definition
Except as otherwise provided in this subtitle, gross income means all income from whatever source derived, including (but not limited to) the following items:
(11)Income from discharge of indebtedness;
NIHD reserves the right to negotiate financing based on applicable IRS Codes and References.

REFERENCES:
1. 26 U.S. Code § 61 - Gross income defined
2. Fair Debt Collection Practices Act (FDCPA)
3. California Fair Debt Collection Practices Act (CFDCPA) - Rosenthal Fair Debt Collection Practices Act
4. Medicare CMS Manual 15: The Provider Reimbursement Manual.

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RECORD RETENTION AND DESTRUCTION:
Maintenance of records is for a minimum of fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Charity Care Program
2. Bad Debt Policy
3. Pricing Transparency Policy

Supersedes: Not Set

review

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Prompt Pay Discounts		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: Billing & Collections, Patient Access		
Date Last Modified: 12/21/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/12/2015	

PURPOSE:
The purpose of the Policy is to offer a discount to patients for their portion of their bill. Offering a discount for early payment decreases the amount of time to final adjudication of the bill, and it decreases the amount of work by shortening the collection cycle.

POLICY:
It is the policy of NIHD to offer prompt pay, district residents, and non-district resident's payment discounts for paying the accounts either at the time of service or within 30 days of first bill. It is not the policy of the district to reduce co-pay amounts.

PROCEDURE:
30% Prompt Pay Discount:
Private patients who pay their estimated charges at the time of service are eligible for a Discount of 30%. The 30% discount is in lieu of the hospital submitting the bill to any insurance or third party payer. Should patient's total bill differ upon final computation of charges, resulting in additional balance owed, patient will have opportunity to submit additional payment less 30%. Should final computation result in credit due to patient, refund will be sent to patient. Contracted Insurance Companies, Medicare, and Medi-Cal do not accept bills or claims from patients; they only accept bills or claims from providers directly per subscriber and provider contracts and regulations. Should patient submit a bill to a non-contracted payer and such payer inadvertently pays NIHD directly, the discount will be adjusted accordingly, ultimately applying discount to patient's true out of pocket. The discount will not yield the patient a profit.

25% District Resident Discount:
Private patients who reside within Northern Inyo Healthcare District within the following zip codes qualify for the discount: 93513, 93514, who pay their out of pocket portion of their bill within 30 days of the date of the hospital's first statement showing the balance due by the patient are eligible for a Discount of 25%. The discount is only applicable to the patient's portion of the bill not reimbursed by insurance, Medicare, Medi-Cal, or any third party payer. Should the patient's bill be subsequently reprocessed by insurance or third party payer, resulting in different out of pocket amount, discount will be adjusted accordingly, ultimately applying discount to patient's true out of pocket. The discount will not yield the patient a profit.

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20% Discount:
Private patients who pay their out of pocket portion of their bill within 30 days of the date of the hospital's first statement showing the balance due by the patient are eligible for a Discount of 20%. The discount is only applicable to the patient's portion of the bill not reimbursed by insurance, Medicare, Medi-Cal, or any third party payer. Should the patient's bill be subsequently reprocessed by insurance or third party payer, resulting in different out of pocket amount, discount will be adjusted accordingly, ultimately applying discount to patient's true out of pocket. The discount will not yield the patient a profit.

Credit & Billing Information Office (760) 873-2190 / Monday through Friday, 8:30 a.m. - 4:00 p.m.

REFERENCE: N/A

RECORD RETENTION AND DESTRUCTION:
Retain patient account records for no less than fifteen (15) years or until a minor reaches the age of 28.

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Charity Care
2. Bad Debt
3. Billing and Collections
4. Price Transparency Policy

Supersedes: v.1 Prompt Pay Discounts

review

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Bad Debt		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: Revenue Cycle Team		
Date Last Modified: 12/16/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/2002	

PURPOSE:
The purpose of the Policy is to comply with and provide information regarding the billing and collection of patient debt, pursuant to the California Health and Safety Code, the Federal Patient Protection and Affordable Care Act; to define the policy for billing and collection of accounts and to ensure reasonable collection efforts are administered. The following policy and procedures are to be followed for billing and collecting of patient accounts. The purpose of the procedure is to establish a system whereby we will have constant knowledge of each account.

DEFINITIONS:
Bad Debts: Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

Allowable Bad Debts: Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308 of the CMS Provider Reimbursement Manual. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

Contractual Allowances or Discounts: Contractual allowances or discounts are the excess of the hospital's normal charge for healthcare services over the payment received from third party payors under contractual agreements.

Policy Discounts: Differences between revenue recorded at established rates and amounts realizable for services provided to employees (i.e. Prompt Pay Discounts).

Charity Allowances: Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

Deductible and Coinsurance Amounts: Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons.

Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

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Group Policy: The insurance policy purchased on behalf of the Guarantor by a larger (typically employer) group.

Guarantor: The person who is financially responsible for the patient's bill.

Patient/Guarantor Responsibility: Any balance due where the financially responsible party is the patient or patient's guarantor and not a third-party payer; also known as "Self-Pay."

Patient Statement or Statement: A bill for services rendered. This can be a summary of activity or a detailed bill listing each charge and applicable credit on a patient account.

Extraordinary Collection Action (ECA): Under Internal Revenue Code 501(r), an Extraordinary Collection Action is an action that a hospital may take against an individual in order to obtain payment for a bill for healthcare services provided to the individual and that are covered by Northern Inyo Healthcare District's (NIHD) Financial Assistance Charity Care Policy. More specifically, each of the following is an ECA:

- Selling an individual's debt to a third party, as permitted under California State Code;
- Reporting adverse information about the individual to a consumer credit reporting agency or credit bureau;
- Deferring or denying elective medically necessary care (non-emergent) because of an individual's nonpayment of a bill for previously provided care eligible for coverage under NIHD's Financial Assistance Charity Care Policy;
- Requiring a payment before providing elective medically necessary care (non-emergent) because of outstanding bills for previously provided care eligible for coverage under NIHD's Financial Assistance Charity Care Policy;
- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or other personal property;
- Commencing a civil action against an individual or obtaining a writ of attachment; and
- Garnishing an individual's wages.

Financial Assistance: Assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for Medically Necessary Services who meet the eligibility criteria for such assistance. Financial assistance may not be granted for elective services.

Charity Care Policy: A separate policy that describes NIHD's financial assistance program including the criteria patients must meet in order to be eligible for financial assistance as well as the process by which individuals may apply for financial assistance. NIHD's Charity Care Policy can be obtained free of charge in NIHD's admissions areas, by contacting the Business Office, requesting by mail, or on the official website.

Agency Placement: Outside collection agencies are used to collect accounts in Bad Debt Collection Status. When an account is in Bad Debt Collection Status, it has not been deemed totally worthless and uncollectible.

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POLICY:
In the interest of promoting financial stability and conserving resources for indigent care, it is the policy of NIHD to provide clear and consistent guidelines for conducting billing and collection functions in a manner that will ensure that debts owed by guarantors for medical services provided by NIHD are collected in a manner that promotes compliance with the law, patient satisfaction, and efficiency.

PROCEDURE:
Under state law, NIHD must allow a 180-day negotiation period, which is roughly equivalent to five monthly statements and a sixth statement containing a notice of transfer to a collection agency. NIHD will not send medical bills to a debt collection agency until the 180-day period has elapsed.

Payment on accounts will be pursued consistently, regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, disability, education, employment or student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor.

Every patient or guarantor will be given reasonable time and communication to be aware and understand their financial responsibility. The guarantor will be held financially responsible for services provided and adequately documented. Understanding each guarantor's insurance coverage is the responsibility of the guarantor. Any self-pay liability secondary to insurance coverage is defined by the guarantor's group policy. NIHD will rely on the insurance carrier's adjudication for identifying self-pay balances.

A statement of hospital and physician services will be sent to the patient or guarantor in incremental billing cycles. Billing representatives may attempt to contact the patient or guarantor via telephone, mail, collection letter, text messaging, email, or any other appropriate method during the statement billing cycle in order to pursue collections. Collection efforts are documented in the patient's account.

A bad debt account is an uncollectible account resulting from the extension of credit. Payment defaults, or bad debts, may result from the following: non-payment of agreed upon payment arrangements, patients that cannot be contacted for payment, patients file for bankruptcy and lack sufficient assets to make payment, insolvent estates, and guarantors who refuse to pay.

When all feasible collection efforts have been exhausted on an account and it has been determined that the balance is uncollectible, the account shall be identified as bad debt and will go into a "bad debt" status in the hospital billing system. This generally will not occur until the account has aged for a period of 180 days.

General Credit Policy – An attempt to get the responsible party to agree to a specific payment plan. NIHD may extend credit based on information provided in the Billing and Collections.

Any and all accounts that are placed into the bad debt collection status will meet the following criteria:

- NIHD has made reasonable efforts to determine a patient's eligibility for financial assistance under NIHD's Financial Assistance Charity Care Policy
- NIHD will pursue collection actions for amounts outstanding when the patient qualified for Financial Assistance and partial relief was granted.

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    - As stated in NIHD's Financial Assistance Charity Care Policy, a patient may qualify for an extended interest charity payment plan for any patient out-of-pocket fees. The payment plan shall consider the patient's income and the amount owed.
- Account with a "Return Mail" status is eligible for collection assignment after all good-faith efforts to identify a correct address have been documented and exhausted.
- The debt must be related to covered services and derived from self-pay status or from the remaining deductible and co-insurance amounts of insured patients.
- Sound business judgment established that the account was unlikely of recovery.
- The bad debt was held for at least 180 days from the date of the first bill.
    - If a patient currently has accounts with unresolved bad debt balances, NIHD reserves the right to send other open accounts with patient balances to collections earlier.
- If a Guarantor disagrees with the account balance, the Guarantor may request the account balance be researched and verified prior to account assignment to a collection agency.
- Accounts at a collection agency may be recalled and returned to NIHD at the discretion of NIHD and or according to state or federal laws and regulations. NIHD may choose to work the accounts to resolution with the Guarantor or a third party as needed, or place the accounts with another collection agency.
- Extraordinary Collection Action (ECA)-NIHD reserves the right to use ECA.
- After these items have been completed and no action to pay by the guarantor or patient was taken, the account(s) will be processed as follows:
    - All accounts with a balance of $10.00 or greater will qualify for automatic placement with an outside collection agency.
    - All accounts with a balance of $9.99 or less will qualify for automatic small balance write off.
    - After the outside collection agency determines that the debt is uncollectible or after the small balance write-off was completed, a form 1099M will be issued by February 28, if by mail, or March 31, if by electronic file to the IRS.

REFERENCES:

1. IRC 501-R
2. Medicare CMS Manual 15: The Provider Reimbursement Manual.

RECORD RETENTION AND DESTRUCTION:

Maintenance of records is for a minimum of fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Charity Care Program
2. Billing and Collections policy
3. Pricing Transparency Policy
4. Prompt Pay Discounts

Supersedes: v.1 Bad Debt Policy

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