Northern Inyo Healthcare District

Board Meetings

June 21, 2023 Regular Board Meeting

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

June 21, 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. New Business:
   A. Ad Hoc Committee Reports (*Board will provide this information*)
      a. Governance (Jean Turner)
      b. HR (Mary Mae Kilpatrick)
      c. Finance (Melissa Best-Baker)
      d. Compliance (Jody Veenker)

B. Chief Executive Officer Report
    a. Anesthesia/Drager Machine *(Board will receive this report)*
    b. Legislation *(Board will receive this report)*
    c. Labor *(Board will receive this report)*
    d. Accountable Care Organization (ACO) *(Board will receive this report)*

C. Chief Financial Officer Report
    a. Financial & Statistical Reports (*Board will consider the approval of these reports*)
    b. TAG Update *(Board will receive this report)*

D. RSM Update, Stephen DelRossi *(Board will receive this report)*

E. PMA Building Update/Therapy Rehab (*Board will consider the approval of the Medrano Roofing Inc quote and build out of Therapy Space*)

4. Chief of Staff Report, Sierra Bourne MD:
    A. Policies (*Board will consider the approval of these Policies and Procedures*)
        1. *Emergency Management Plan*
        2. *Medical Staff Department Policy – Pediatrics*
        3. *Plan for the Provision of Nursing Care*
        4. *Trophon® Environmental Probe Repressor (EPR)*
    B. 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.

5. Approval of minutes of the May 17, 2023 Regular Board Meeting *(Board will consider the approval of these minutes)*
6. Approval of Policies and Procedures – Biennial Review, no changes required (*Board will consider the approval of these Policies and Procedures)*
    a. Diagnostic Imaging – Radioactive Material Hot Lab Security
    b. Diagnostic Imaging – Imaging Equipment Quality Control
    c. ALARA Program
    d. Diagnostic Imaging – Ordering Radioactive Materials
    e. DI Timeliness for Critical Results
    f. DI – NM P&P – Daily Area Surveys
    g. DI – MRI Safety Plan

h. DI – NM P&P – Area Surveys and Wipe Tests

i. DI – Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine

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7. Reports from Board Members (*Board will provide this information*)
8. Public comments on closed session items.
9. Adjournment to Closed Session to/for:
    a. Conference with Legal Counsel - Existing Litigation. Government Code 54956.9(d)(1). Name of case: Tillemans v. NIHD
    b. Conference with Legal Counsel – Anticipated Litigation. Government Code 54956.9(d)(4).
10. 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
April 2023 – Financial Summary

	MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance
IP Gross Revenue	2,295,049	2,950,716	2,591,855	(655,667)	(296,806)	31,399,308	31,054,702	31,247,143	344,606	152,165
OP Gross Revenue	12,236,228	11,801,078	11,218,600	435,151	1,017,628	119,788,805	105,561,331	113,998,979	14,227,474	5,789,826
Clinic Gross Revenue	1,390,394	1,250,044	1,194,937	140,350	195,457	13,983,428	11,849,655	12,080,009	2,133,773	1,903,419
Net Patient Revenue	6,779,267	9,658,372	7,507,749	(2,879,105)	(728,482)	73,411,382	78,452,471	77,016,827	(5,041,089)	(3,605,445)
Cash Net Revenue % of Gross	43%	60%	50%	-18%	-7%	44%	53%	49%	-8%	-5%
IP Days	158	191		(33)		2,049	2,202		(153)	
IP Days w/o Newborns	130	161		(31)		1,803	1,941		(138)	
OP Visits	3,585	3,554		31		36,027	36,650		(623)	
RHC Visits	2,760	2,708		52		26,514	27,775		(1,261)	
NIA Clinic Visits	1,553	1,655		(102)		16,819	16,332		487	
Surgeries IP	11	17		(6)		183	187		(4)	
Surgeries OP	106	121		(15)		1,017	789		228	
Diagnostic Imaging	2,002	1,951		51		19,998	19,445		553	
Emergency	863	678		185		8,200	7,043		1,157	
Rehab	809	677		132		7,303	8,292		(989)	
Nursing Visits	211	206		5		2,469	2,873		(404)	
Observation Hours	2,104	1,867		237		18,301	17,464		837	
REVENUE										
Payor mix										
Blue Cross	31.60%	22.00%		9.60%		19.50%	21.00%		-1.50%	
Commercial	5.70%	7.90%		-2.20%		6.00%	5.80%		0.20%	
Medicaid	26.60%	27.20%		-0.60%		26.40%	28.80%		-2.40%	
Medicare	34.20%	41.90%		-7.70%		45.10%	42.60%		2.50%	
Self-pay	1.90%	0.00%		1.90%		2.80%	1.50%		1.30%	
Workers' Comp	0.00%	1.00%		-1.00%		0.20%	0.30%		-0.10%	
DEDUCTIONS										
Contract Adjust	8,452,990	7,317,362	6,552,862	1,135,628	1,900,128	78,111,499	65,966,041	70,189,506	12,145,458	7,921,993
Bad Debt	240,320	1,288,758	710,477	(1,048,438)	(470,157)	9,082,593	7,152,198	7,610,117	1,930,395	1,472,476
Write-off	450,123	611,004	234,303	(160,881)	215,820	4,629,078	2,358,668	2,509,682	2,270,410	2,119,396
Other		(2,886,359)	-	2,886,359	-	(449,476)	(4,616,032)	-	4,166,556	(449,476)

Favorable bad debt allowance this month as a result of a decrease in >270 AR balances and March self-pay charges as $4m was sent to collections.

CENSUS										
Patient Days	158	191		(33)		2,049	2,202		(153)	
Adjusted Days	1,079	1,036		43		10,752	10,527		225	
Employed FTE	337	336		1		339	348		(9)	
Contract FTE	29	48		(19)		39	41		(1)	
Total FTE	365	384		(19)		378	388		(10)	
EPOB	2.81	2.39		0		1.64	1.96		(0)	

DENIALS

Managed Medi-Cal (Medicaid HMO/PPO) increased $4.2m due to previously unidentified Medicaid accounts sent to Novus collections.

CHARITY

under review

BAD DEBT

As AR is worked previous calculations and assignments are moving and will continue to move as we better understand the nature of the debt.

CASH

PHASE 1 of self-pay collections

Cash posted was $7.36m for April and $8.48m for May.
On 5/6/23 approximately 2000 accounts - accounts older than 6 months - were sent to Medi-plan, our self-pay collector.
On 5/26 letters were sent to those patients that their accounts were being referred to bad debt collections.
On 6/15 will receive these accounts.

PHASE 2 of self-pay collections

On 5/26/23 all remaining self-pay accounts were sent to Medi-plan, our self-pay collector.
On 6/15/23 letters were sent to the appropriate patients that their accounts were being referred to bad debt collections.
Other accounts will be sent account statements as the accounts age to 150 days.
On day 151 the active accounts will be sent a letter indicating that the accounts will be sent to bad debt in 30 days if payment is not received.
On 6/30 the appropriate accounts will be sent to collections.

PAYOR ISSUES

Blue Cross owes $1.7 million of non-routine collections. We have reported to the insurance commissioner's office. NIHD's lawyers have been engaged.

SALARIES										
Per Adjust Bed Day	$ 3,225	$ 2,368		$ 857		$ 2,509	$ 2,224		$ 286	
Total Salaries	$ 3,479,805	$ 2,453,040	$ 2,769,485	$ 1,026,765	710,320	$ 26,981,851	$ 23,409,487	$ 28,064,113	$ 3,572,364	(1,082,262)

April: staff were allowed to "cash-out" PTO and raises were processed.
May: Severance packages were issued and PTO was "cashed-out."

	MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance
BENEFITS										
Per Adjust Bed Day	$ 2,070	$ 1,927		$ 142		$ 2,115	$ 1,857		$ 258	
Total Benefits	$ 2,233,439	$ 1,996,853	$ 2,212,639	$ 236,586	20,800	$ 22,735,404	$ 19,547,076	$ 22,421,408	$ 3,188,328	313,996
Benefit expense is consistent with YTD average.										
PROFESSIONAL FEES										
Per Adjust Bed Day	$ 2,641	$ 2,633		$ 8		$ 2,623	$ 2,082		$ 541	
Total Physician Fee	$ 1,450,598	$ 1,220,698		$ 229,900		$ 13,180,050	$ 10,592,579		$ 2,587,471	
Total Contract Labor	$ 522,140	$ 852,254		$ (330,114)		$ 8,074,386	$ 6,521,816		$ 1,552,570	
Total Other Pro-Fees	$ 876,729	$ 655,113		$ 221,616		$ 6,949,845	$ 4,805,200		$ 2,144,645	
Total Professional Fees	$ 2,849,467	$ 2,728,065	$ 2,705,419	$ 121,402	144,048	$ 28,204,281	$ 21,919,595	$ 27,414,914	$ 6,284,686	789,367
Other Pro-Fees - training manager of HIM @$24k; Audit $86,063; Legal $69,712										
Total Physician fee higher due to 401k contributions -accrual was not released - will be released in May										
PHARMACY										
Per Adjust Bed Day	$ 209	$ 356		$ (147)		$ 296	$ 298		$ (1)	
Total Rx Expense	$ 225,543	$ 368,587	$ 313,258	$ (143,044)	(87,715)	$ 3,185,802	$ 3,133,021	$ 3,174,343	$ 52,781	11,459
MEDICAL SUPPLIES										
Per Adjust Bed Day	$ 432	$ 357		$ 75		$ 382	$ 266		$ 116	
Total Medical Supplies	$ 466,422	$ 370,285	$ 381,510	$ 96,137	84,912	$ 4,106,133	$ 2,799,671	$ 3,865,969	$ 1,306,462	240,164
EHR SYSTEM										
Per Adjust Bed Day	$ 137	$ 114		$ 23		$ 141	$ 102		$ 39	
Total EHR Expense	$ 147,652	$ 126,124	$ 112,705	$ 21,528	34,947	$ 1,515,948	$ 1,076,599	$ 1,142,077	$ 439,349	373,871
OTHER EXPENSE										
Per Adjust Bed Day	$ 648	$ 558		$ 90		$ 734	$ 675		$ 60	
Total Other	$ 698,962	$ 577,656	$ 805,053	$ 121,306	(106,091)	$ 7,897,169	$ 7,103,753	$ 8,157,875	$ 793,416	(260,706)
DEPRECIATION AND AMORTIZATION										
Per Adjust Bed Day	$ 316	$ 319		$ (3)		$ 316	$ 296		$ 20	
Total Depreciation and Amortization	$ 340,467	$ 329,978	$ 367,321	$ 10,489	(26,854)	$ 3,402,964	$ 3,116,473	$ 3,722,187	$ 286,491	(319,223)

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2023

	7/31/2022	7/31/2021	8/31/2022	8/31/2021	9/30/2022	9/30/2021	10/31/2022	10/31/2021	11/30/2022	11/30/2021	12/31/2022	12/31/2021	1/31/2023
Gross Patient Service Revenue													
Inpatient Patient Revenue	3,986,305	2,774,294	3,395,933	2,563,061	1,938,350	3,193,923	2,813,064	3,361,605	3,474,955	3,958,181	3,417,547	2,404,683	3,898,882
Outpatient Revenue	11,474,649	11,563,898	12,619,549	10,530,380	11,643,340	10,677,079	12,337,627	10,581,296	12,582,796	10,120,970	11,309,707	11,882,529	11,943,811
Clinic Revenue	1,112,050	1,074,051	1,281,637	1,155,594	1,298,041	1,126,962	1,312,937	1,206,362	1,616,268	1,137,285	1,602,344	1,136,568	1,552,193
Gross Patient Service Revenue	16,573,004	15,412,242	17,297,119	14,249,034	14,879,730	14,997,964	16,463,628	15,149,263	17,674,019	15,216,437	16,329,598	15,423,780	17,394,886
Deductions from Revenue													
Contractual Adjustments	(6,091,699)	(4,886,114)	(7,321,894)	(6,636,885)	(6,081,011)	(6,880,919)	(9,139,351)	(7,559,945)	(8,553,896)	(7,207,126)	(8,204,159)	(7,224,448)	(7,536,311)
Bad Debt	(1,834,762)	(1,956,168)	(2,292,073)	(524,864)	110,396	(120,841)	(789,398)	115,976	(134,138)	(132,762)	(2,354,124)	(266,596)	(687,018)
A/R Writeoffs	(378,045)	(6,801)	(717,468)	(138,222)	(739,907)	(70,088)	(325,216)	(73,605)	(338,106)	(181,117)	(344,283)	(286,045)	(380,030)
Other Deductions from Revenue	497,912	67,000	(67,000)	67,000	-	67,000	950	67,000	17,166	67,000	410	91,038	(2,429,480)
Deductions from Revenue	(7,806,594)	(6,782,083)	(10,398,435)	(7,232,972)	(6,710,522)	(7,004,848)	(10,253,015)	(7,450,574)	(9,008,974)	(7,454,005)	(10,902,156)	(7,686,051)	(11,032,838)
Other Patient Revenue													
Incentive Income	-	34,766	-	(35,500)	-	665	-	24,456	-	1,619	-	10	-
Other Oper Rev - Rehab Thera Serv	5,303	17,014	4,367	18,560	4,346	13,352	10,361	15,820	7,875	15,908	3,545	2,625	566
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	5,303	51,780	4,367	(16,940)	4,346	14,017	10,361	40,275	7,875	17,528	3,545	2,635	566
Net Patient Service Revenue	**8,771,713**	**8,681,939**	**6,903,050**	**6,999,123**	**8,173,554**	**8,007,133**	**6,220,974**	**7,738,965**	**8,672,921**	**7,779,959**	**5,430,987**	**7,740,364**	**6,362,614**
Cost of Services - Direct													
Salaries and Wages	2,175,027	2,138,510	2,269,022	2,212,918	2,195,439	2,099,073	2,179,142	2,131,194	2,262,511	2,303,918	2,158,750	2,726,796	2,338,917
Benefits	2,008,070	1,618,760	1,759,698	1,635,349	1,801,034	1,795,655	1,669,695	1,801,576	1,754,398	2,059,894	1,064,181	2,085,215	1,867,561
Professional Fees	1,381,538	1,415,923	1,438,889	1,354,663	1,650,775	1,487,469	1,797,498	1,766,505	1,963,643	1,340,719	1,652,265	1,388,736	1,652,745
Contract Labor	655,016	455,352	622,813	541,517	1,451,288	491,195	1,024,423	527,022	1,493,476	449,716	(20,338)	434,773	1,001,828
Pharmacy	211,326	274,517	671,932	354,714	54,166	344,942	136,557	405,802	596,330	392,006	268,920	380,870	360,384
Medical Supplies	315,752	277,812	290,221	255,157	578,033	358,049	366,356	369,855	474,848	451,788	448,838	497,972	476,757
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	107,979	112,267	220,753	114,869	220,408	132,491	183,047	112,342	146,908	108,392	54,304	115,958	126,194
Other Direct Expenses	546,374	589,703	667,228	544,051	808,934	585,893	572,765	689,732	793,341	618,316	471,021	679,861	598,990
Total Cost of Services - Direct	7,401,082	6,882,843	7,940,556	7,013,237	8,760,076	7,294,767	7,929,482	7,804,027	9,485,455	7,724,749	6,097,940	8,310,179	8,423,377
General and Administrative Overhead													
Salaries and Wages	360,265	319,290	365,276	323,708	370,478	319,740	381,872	305,823	373,439	355,039	373,193	412,400	401,590
Benefits	356,264	283,420	312,157	299,665	316,570	312,500	1,160,994	243,511	302,169	322,152	(788,291)	382,695	262,752
Professional Fees	535,217	342,533	190,076	351,845	318,029	177,703	265,196	194,953	274,630	188,260	191,161	360,435	291,948
Contract Labor	30,218	78,500	52,224	69,031	92,958	44,534	57,021	87,853	156,142	111,853	(102,132)	102,071	(25,859)
Depreciation and Amortization	318,087	370,335	332,153	358,995	334,828	347,178	362,317	358,655	346,018	347,192	340,523	369,148	342,452
Other Administative Expenses	79,314	234,811	164,310	117,308	199,538	140,164	119,767	134,758	314,165	154,566	152,489	190,884	191,302
Total General and Administrative Overhead	1,679,363	1,628,889	1,416,196	1,520,552	1,632,402	1,341,820	2,347,167	1,325,552	1,766,564	1,479,063	166,944	1,817,634	1,464,185
Total Expenses	**9,080,446**	**8,511,732**	**9,356,752**	**8,533,790**	**10,392,477**	**8,636,587**	**10,276,649**	**9,129,578**	**11,252,019**	**9,203,811**	**6,264,884**	**10,127,813**	**9,887,562**
Financing Expense	183,196	179,672	182,350	179,585	180,796	176,035	182,190	138,640	178,894	136,649	183,171	101,007	180,418
Financing Income	64,203	173,785	431,229	173,785	247,716	173,785	247,716	173,785	247,716	173,785	247,716	173,785	247,716
Investment Income	74,115	23,766	23,389	16,876	(18,154)	20,534	99,582	20,443	16,704	16,045	50,390	27,865	124,884
Miscellaneous Income	484,508	499,440	(364,949)	1,105,828	146,486	9,508,790	10,519	384,016	68,632	407,081	2,271,115	2,688,686	485,200
Net Income (Change is Financial Position)	**130,897**	**687,526**	**(2,546,383)**	**(417,762)**	**(2,023,671)**	**8,897,620**	**(3,880,048)**	**(951,010)**	**(2,424,941)**	**(963,590)**	**1,552,152**	**401,879**	**(2,847,566)**
Operating Income	(308,733)	170,207	(2,453,702)	(1,534,666)	(2,218,923)	(629,454)	(4,055,675)	(1,390,614)	(2,579,099)	(1,423,852)	(833,897)	(2,387,449)	(3,524,949)

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2023

	1/31/2022	2/28/2023	2/28/2022	3/31/2023	3/31/2022	4/30/2023	4/30/2022	2023 YTD	2022 YTD	Comments
Gross Patient Service Revenue										
Inpatient Patient Revenue	3,708,290	2,545,535	2,908,927	3,633,689	3,231,022	2,295,049	2,950,716	31,399,308	31,054,702	
Outpatient Revenue	8,803,380	11,030,636	8,539,211	12,610,463	11,061,511	12,236,228	11,801,078	119,788,805	105,561,331	
Clinic Revenue	1,448,892	1,266,634	1,067,009	1,550,929	1,246,889	1,390,394	1,250,044	13,983,428	11,849,655	
Gross Patient Service Revenue	13,960,561	14,842,805	12,515,147	17,795,080	15,539,422	15,921,672	16,001,838	165,171,541	148,465,688	
Deductions from Revenue										
Contractual Adjustments	(6,081,113)	(6,829,397)	(5,364,554)	(9,900,790)	(6,807,575)	(8,452,990)	(7,317,362)	(78,111,499)	(65,966,041)	
Bad Debt	(599,855)	(1,387,069)	(1,071,017)	525,913	(1,307,312)	(240,320)	(1,288,758)	(9,082,593)	(7,152,198)	
A/R Writeoffs	(211,549)	(234,813)	(417,884)	(721,088)	(362,354)	(450,123)	(611,004)	(4,629,078)	(2,358,668)	
Other Deductions from Revenue	91,039	1,998,568	1,910,955	38	67,000	-	2,886,359	18,564	5,381,391	
Deductions from Revenue	(6,801,478)	(6,452,711)	(4,942,500)	(10,095,928)	(8,410,241)	(9,143,434)	(6,330,764)	(91,804,606)	(70,095,516)	
Other Patient Revenue										
Incentive Income	(24,026)	-	(16)	-	-	-	-	-	1,974	
Other Oper Rev - Rehab Thera Serv	8,388	1,660	11,929	5,396	(10,570)	1,029	(12,701)	44,448	80,325	
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	
Other Patient Revenue	(15,638)	1,660	11,913	5,396	(10,570)	1,029	(12,701)	44,448	82,299	
Net Patient Service Revenue	**7,143,445**	**8,391,755**	**7,584,561**	**7,704,549**	**7,118,611**	**6,779,267**	**9,658,372**	**73,411,382**	**78,452,471**	
Cost of Services - Direct										
Salaries and Wages	2,346,958	1,959,005	2,047,905	2,511,015	2,305,644	2,959,084	2,108,120	23,007,910	22,421,035	
Benefits	2,199,930	1,681,176	1,799,225	1,831,123	1,750,987	1,865,650	1,630,456	17,302,586	18,377,045	
Professional Fees	1,452,179	1,942,950	1,498,674	1,716,884	1,493,507	1,923,375	1,424,558	17,120,563	14,622,933	
Contract Labor	865,229	219,870	971,010	788,024	976,833	500,915	791,458	7,737,314	6,504,104	
Pharmacy	286,978	327,171	362,249	333,474	330,943	225,543	368,587	3,185,802	3,501,607	
Medical Supplies	184,989	203,442	159,263	485,465	244,786	466,422	370,285	4,106,133	3,169,956	
Hospice Operations	-	-	-	-	-	-	-	-	-	
EHR System Expense	119,346	138,908	112,757	160,195	148,178	147,652	126,124	1,506,348	1,202,724	
Other Direct Expenses	643,886	531,119	646,224	651,545	655,135	516,125	368,774	6,157,444	6,021,576	
Total Cost of Services - Direct	8,099,494	7,003,641	7,597,308	8,477,724	7,906,014	8,604,766	7,188,362	80,124,100	75,820,980	
General and Administrative Overhead										
Salaries and Wages	361,734	368,344	334,886	458,763	363,951	520,721	344,920	3,973,940	3,441,492	
Benefits	335,529	272,374	310,036	2,870,040	310,978	367,789	366,397	5,432,817	3,166,884	
Professional Fees	225,696	278,757	198,574	260,367	159,404	403,951	443,120	3,009,332	2,642,524	
Contract Labor	103,502	27,901	95,420	27,375	116,407	21,225	68,926	337,073	878,097	
Depreciation and Amortization	334,665	344,315	298,932	341,803	331,373	340,467	329,978	3,402,964	3,446,450	
Other Administative Expenses	158,172	172,710	157,128	163,294	163,160	182,836	208,881	1,739,725	1,659,832	
Total General and Administrative Overhead	1,519,298	1,464,400	1,394,976	4,121,641	1,445,273	1,836,989	1,762,222	17,895,851	15,235,279	
Total Expenses	**9,618,792**	**8,468,041**	**8,992,284**	**12,599,365**	**9,351,287**	**10,441,755**	**8,950,584**	**98,019,951**	**91,056,258**	
Financing Expense	227,252	172,904	472,448	180,509	218,276	178,979	204,403	1,803,406	2,033,965	
Financing Income	173,785	247,716	148,687	247,716	173,785	247,716	173,785	2,477,158	1,712,749	
Investment Income	6,662	41,183	4,964	40,992	(1,624)	158,834	39,227	611,920	174,757	
Miscellaneous Income	844,798	1,810,358	856,972	5,590,718	1,871,757	236,130	58,220	10,738,717	18,225,589	
Net Income (Change is Financial Position)	**(1,677,354)**	**1,850,066**	**(869,548)**	**804,101**	**(407,035)**	**(3,198,788)**	**774,617**	**(12,584,180)**	**5,475,343**	
Operating Income	(2,475,347)	(76,286)	(1,407,724)	(4,894,817)	(2,232,677)	(3,662,489)	707,788	(24,608,569)	(12,603,787)	

Northern Inyo Healthcare District
Revenue Cycle / Margin Improvement

Weekly Leadership Meeting

June 6, 2023

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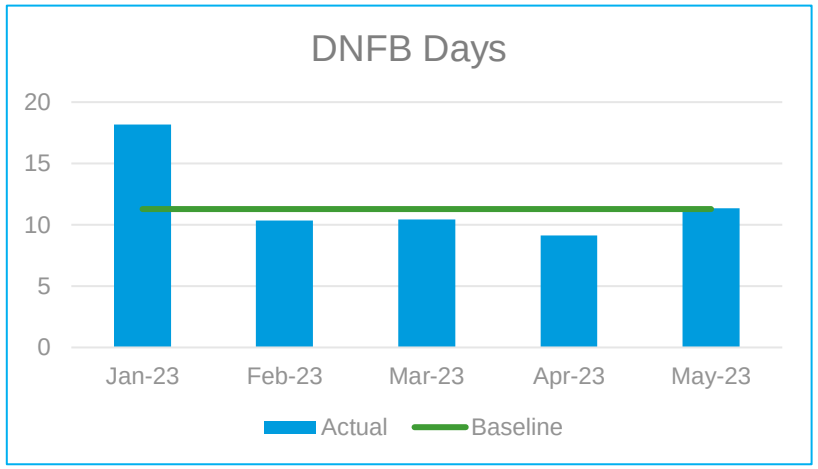
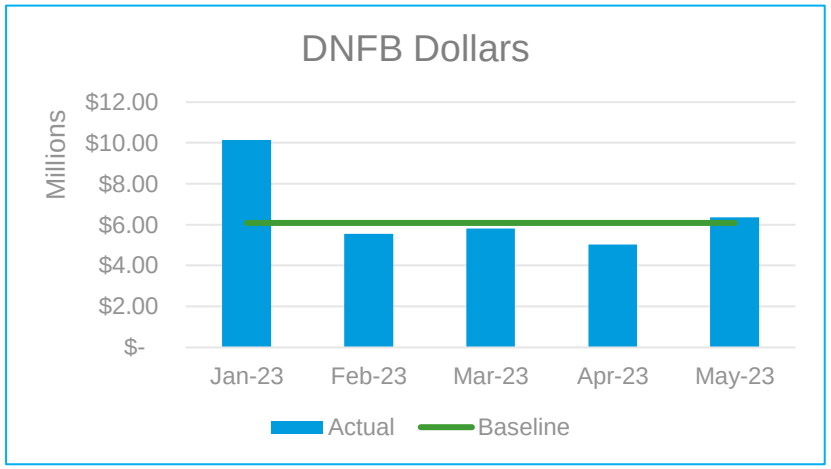
KEY PERFORMANCE METRICS

DNFB Trending





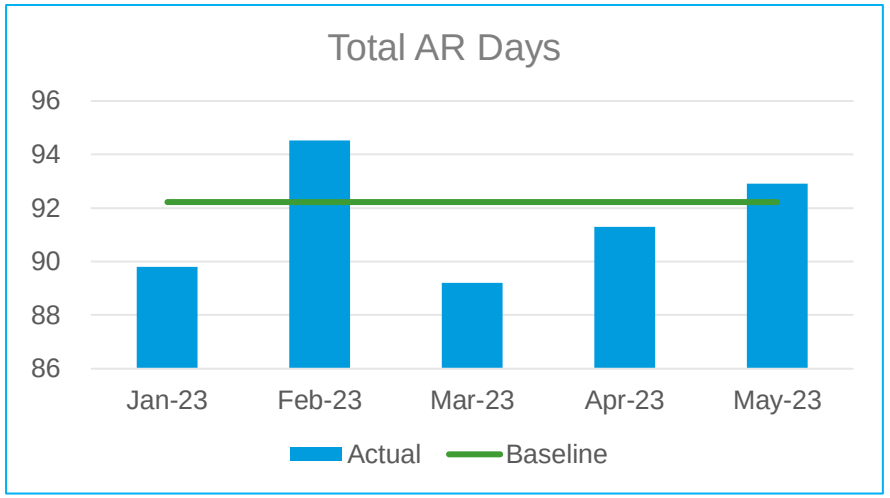
DNFB Days (11.25) are defined as outstanding A/R as of 12/31/22

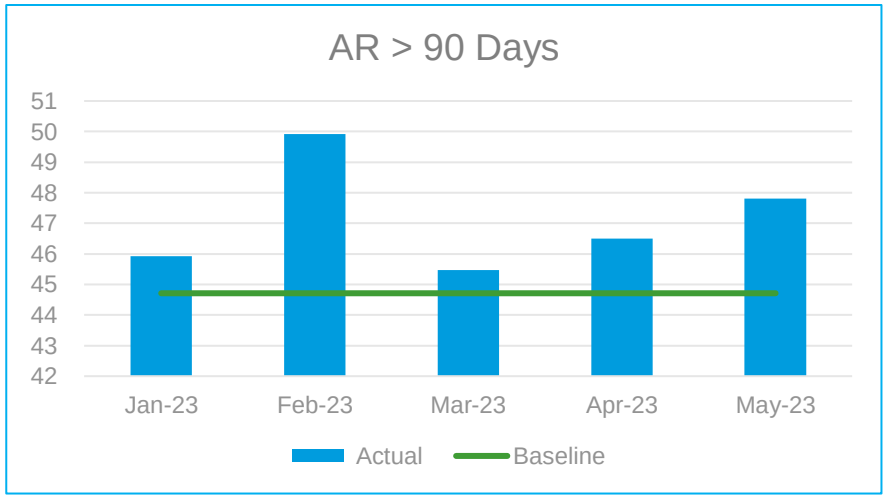
Month	Metric
January 2023	18.1
February 2023	10.4
March 2023	10.4
April 2023	9.12
May 2023	11.35

DNFB Dollars ($6,089,519) are defined as outstanding A/R as of 12/31/22

Month	Metric
January 2023	$10,140,411
February 2023	$5,535,843
March 2023	$5,801,454
April 2023	$5,029,150
May 2023	$6,349,636

ATB Trending (All Payers)





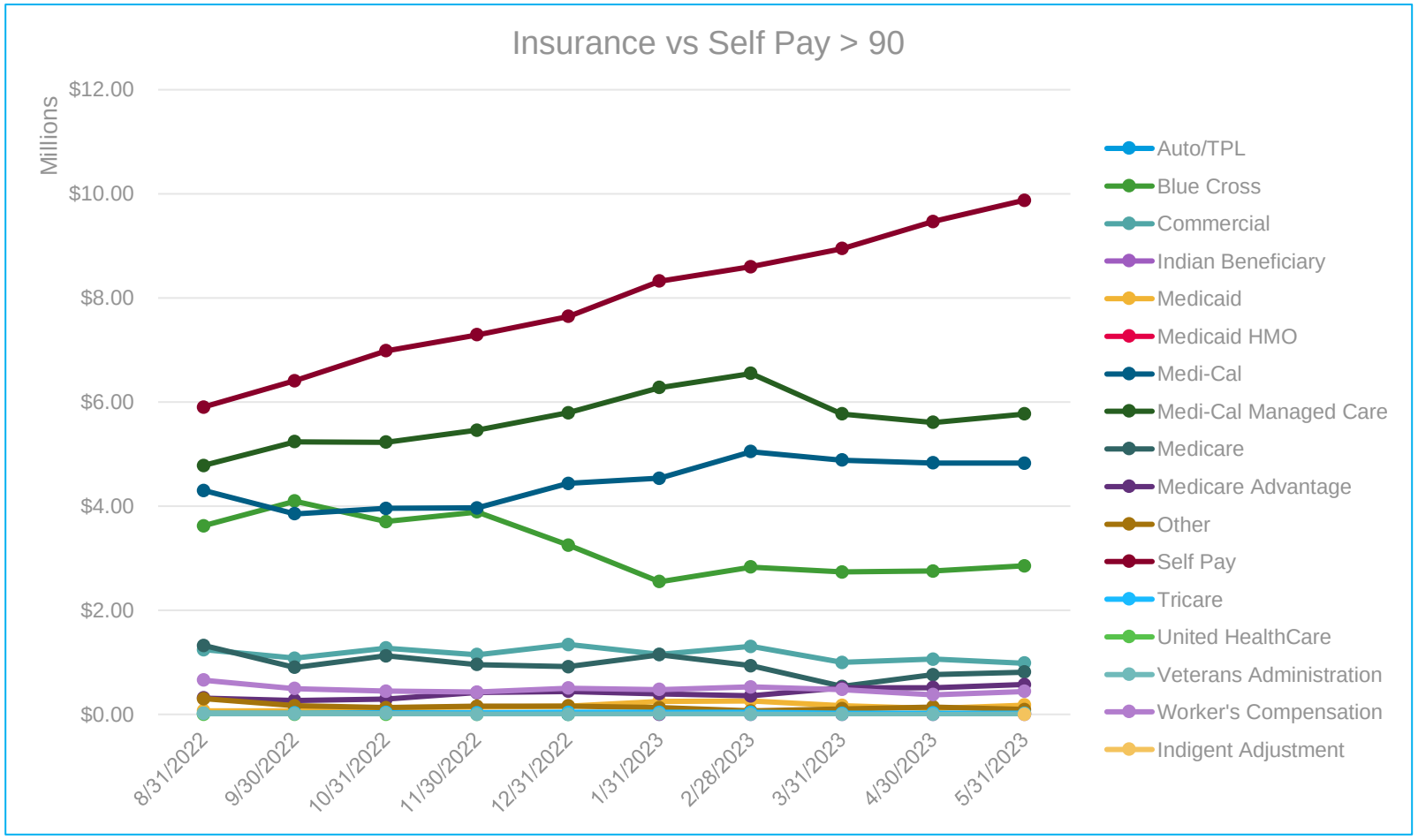
Baseline A/R Days (92.2) are defined as outstanding A/R as of 12/31/22

Month	Metric
January 2023	89.8
February 2023	94.5
March 2023	89.2
April 2023	91.3
May 2023	92.92

Baseline A/R > 90 Days (44.71) are defined as outstanding A/R as of 12/31/22

Month	Metric
January 2023	45.9
February 2023	49.9
March 2023	45.5
April 2023	46.5
May 2023	47.8

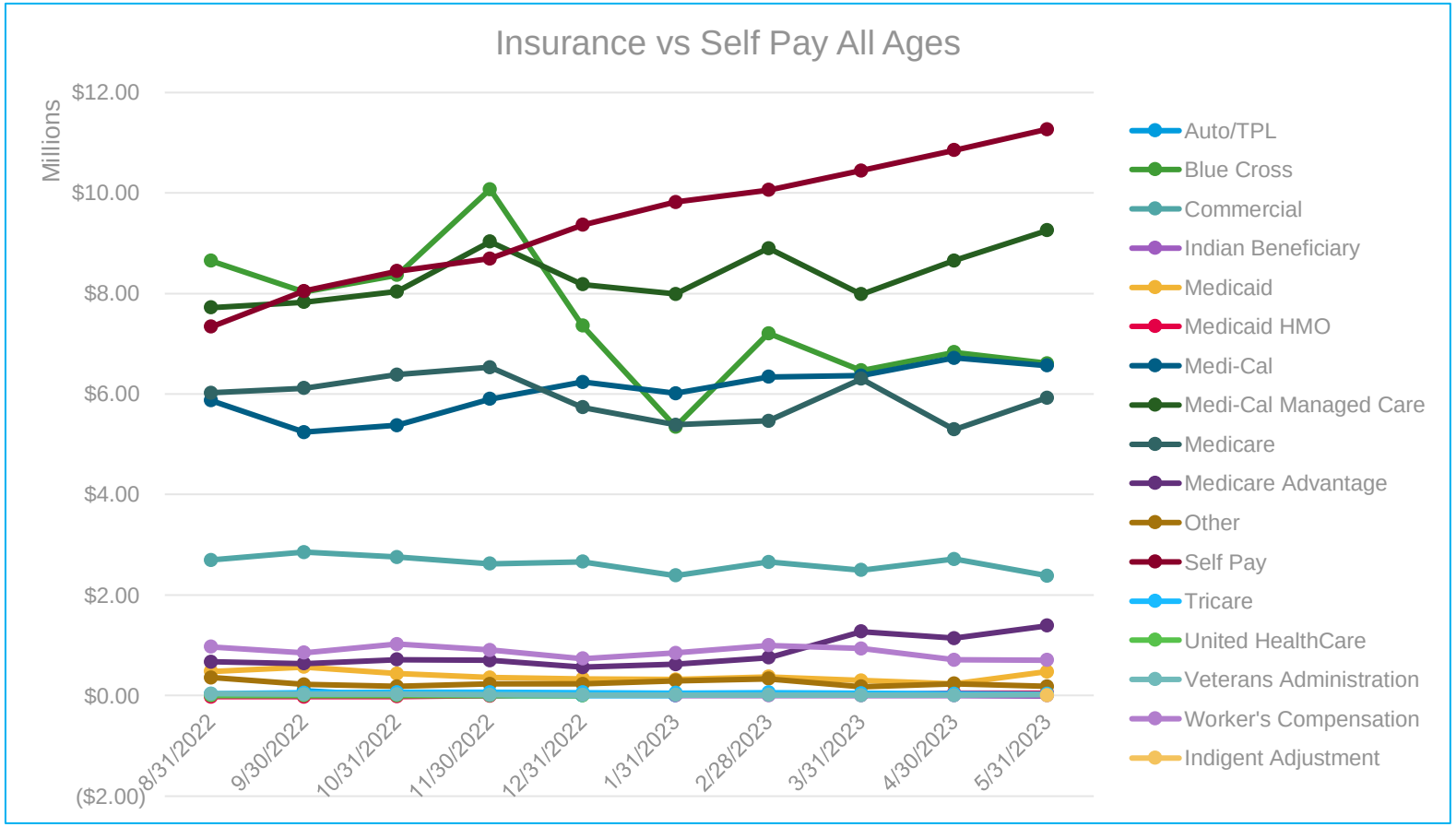
ATB Trending (Insurance vs. Self Pay > 90)



Current Fin Class	8/31/2022	5/31/2023	Net Diff
Self Pay	$5,902,867	$9,871,971	$3,969,104
Medi-Cal Managed Care	$4,782,373	$5,770,179	$987,806
Medi-Cal	$4,302,164	$4,824,418	$522,254
Medicare Advantage	$319,414	$576,034	$256,620
Medicaid	$74,556	$181,008	$106,452
Medicaid HMO	($25,630)	$29,728	$55,358
Indian Beneficiary		$738	$738
Indigent Adjustment		$118	$118
Tricare	$23,688	$23,704	$16
United HealthCare	$1,902		($1,902)
Veterans Administration	$20,765	$9,591	($11,174)
Other	$303,542	$94,415	($209,127)
Worker's Compensation	$662,241	$442,066	($220,175)
Commercial	$1,245,342	$988,686	($256,656)
Medicare	$1,327,446	$814,548	($512,898)
Blue Cross	$3,622,015	$2,854,927	($767,088)
Grand Total	**$22,562,684**	**$26,482,131**	**$3,919,447**

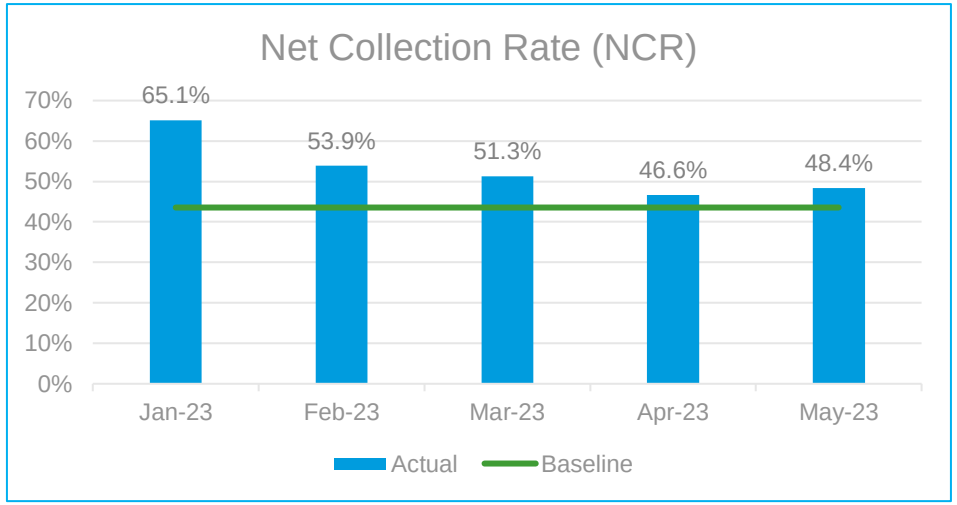
NIHD RSM

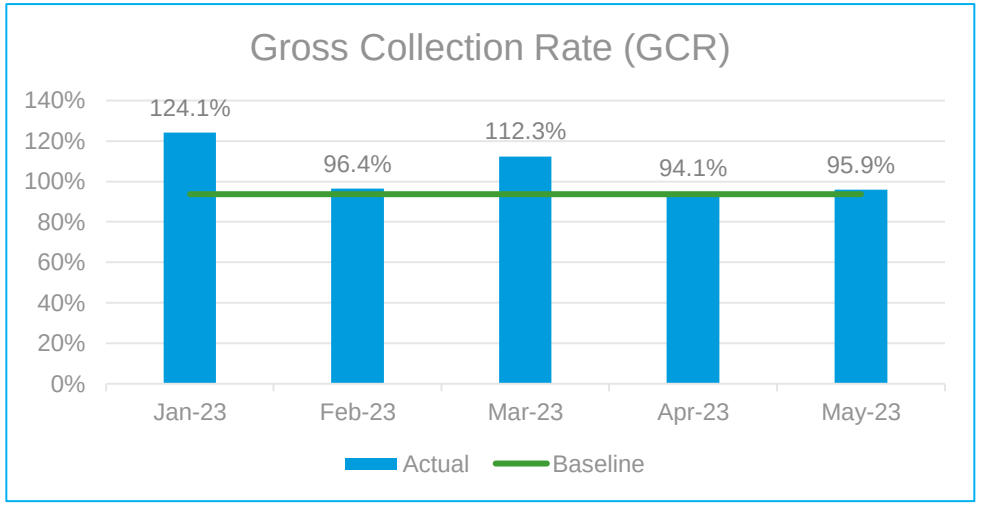
ATB Trending (Insurance vs. Self Pay)



Current Fin Class	8/31/2022	5/31/2023	Net Diff
Self Pay	$7,337,170	$11,263,378	$ 3,926,209
Medi-Cal Managed Care	$7,718,751	$9,252,915	$ 1,534,165
Medicare Advantage	$669,599	$1,391,602	$ 722,004
Medi-Cal	$5,867,962	$6,564,751	$ 696,789
Medicaid HMO	-$22,998	$50,425	$ 73,423
Indian Beneficiary		$738	$ 738
Indigent Adjustment		$118	$ 118
Auto/TPL			$ -
United HealthCare	$1,902		$ (1,902)
Medicaid	$479,776	$475,448	$ (4,328)
Tricare	$35,842	$28,517	$ (7,325)
Veterans Administration	$35,494	$18,011	$ (17,483)
Medicare	$6,019,739	$5,925,454	$ (94,284)
Other	$360,737	$180,103	$ (180,635)
Worker's Compensation	$969,376	$703,306	$ (266,070)
Commercial	$2,694,721	$2,383,477	$ (311,244)
Blue Cross	$8,649,236	$6,608,158	$ (2,041,077)
Grand Total	**$40,817,305**	**$44,846,403**	**$4,029,098**

Gross and Net Revenue Trending





Baseline Net Collection Rate (43.6%) is defined as percent of payments over charges for Q4 2022.

Month	Metric
January 2023	65.1%
February 2023	53.9%
March 2023	51.3%
April 2023	46.6%
May 2023	48.4%

Baseline Gross Collection Rate (93.6%) is defined as percent of payments & adjustments over charges for Q4 2022.

Month	Metric
January 2023	124.1%
February 2023	96.4%
March 2023	112.3%
April 2023	94.1%
May 2023	95.9%

PRIOR WEEK SUMMARY

Prior Week Summary

Meetings	Attendees	Key Takeaways
Novus Cerner Training 5/31 @ 11:30-1:00pm PST	Cynthia Sapasap Morgan Kershner Fabi Esparza Gloria Sacco Marci Williams	• NOVUS is now trained on all workflows within Cerner related to edits prior to claim generation • NOVUS staff were provided a training document for future reference • NOVUS is now responsible for managing all claim edits for Medi-Cal, Managed Medi-Cal, and Medicaid claims
NIH AMS Support Call 5/31 @ 1:00 – 2:00pm PST	Jim Dukovic NIH Team	• Non-Recurring Encounter Issue (SR#: 448512180): The functionality has been turned off in CERT. RSM performed testing and validated the change was made appropriately. Cerner has been instructed to migrate the change to PROD • Client Billing Issue (SR#: 439407864): The functionality has been turned off in CERT. RSM performed testing and validated the change was made appropriately. Cerner has been instructed to migrate the change to PROD
Combined DNFB/HDR Question 6/5 @ 1:00 – 2:00pm PST	Fabi Esparza Gloria Sacco Marci Williams	• Glora & staff were training on pulling data and generating target encounters for the DNFB and High-Dollar Review Task Force sessions • RSM delivered a training document for reference • Follow up training has been scheduled for 6/16
GL Design Session 6/5 @ 2:00 – 3:00pm PST	Andrea Mossman	• NIH does not leverage sub-accounts in Multiview • NIH to consider using sub-accounts for A/R, Revenue, & Contra-Revenue. Sub-account usage for Cash & Contra-AR will be tabled until reconciliation is complete.

COMPLETED ITEMS

Completed Items

✓ Completed

Issue Description	Department	Action Taken/ Result	
Physicians are documenting non patient visit notes on pre-registration encounters. This is causing these encounters to populate coding queues.	Coding	• NIH has created an internal policy to document all non patient related visit notes on historical encounters. • This results in less encounters populating the coding queues	✓
Novus needs training on post-billing workflows within Cerner.	Patient Accounting	• Provided Cerner training to Novus staff on May 31, 2023. • Provided workflow guide to Novus staff	✓
The NIHD Pending Write-off work item is not included in the Novus Cerner Training document.	Patient Accounting	• Update the Novus Cerner Training document to include the NIHD Pending write-off workflow. • Completed on 5/31	✓

OUTSTANDING ITEMS

Outstanding Items – Reg & Sched

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
Health Plans are not configured correctly in Cerner which is causing eligibility to not process correctly.	• Update the health plans missing eligibility ids to allow for eligibility to process as expected.	• Confirmation of changes in progress	
Auto- Reg/ Auto Discharge	• Find and fix root cause behind unused encounter getting auto-discharged and hitting coding queue	• SR 449615612 logged on 5/18	
Eligibility Effective Dates	• Find and fix root cause behind incorrect dates populating effective coverage dates from eligibility results	• SR 449433620 logged on 5/5 • Pending response from Tanya to confirm feedback on standing issue	
Orders to Scheduling Configuration	• Implement the full orders-to-scheduling workflow	• Technical build analysis for build gaps in progress	
Central Scheduling Ad-Hoc support	• Provide SME support and recommendations on request in support of efforts to centralize scheduling	• Last discussed in on-site roundtable meeting on 5/9	

Outstanding Items – Reg & Sched

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
Registration is capturing incorrect TARs because current system configuration does not include a formatting rule	• Error-proof TAR data entry in registration workflow	• SR 449684150 logged on 5/23 • Pending submission of example	

Outstanding Items – HIM / Coding

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
Coders are unable to view outpatient charge edits on ED encounters.	• An SR should be opened with Cerner to investigate functionality in 3M/Cerner to allow for coders to view these edits.	• RSM to open SR with Cerner and include Jalaine as an interested party	

Outstanding Items – Charge Services

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
Charges are not dropping on client encounters in CERT, preventing all of build related to Client Billing from being moved to PROD.	• The client prices schedule needs to be moved from PROD to CERT. • A Charge Processing Schedule for client billing needs to be created. • Once charge processing schedule should then be added to the top row of the charge tier.	• The price schedule has been moved from PROD to CERT. • SR 449575183 • Build was update in CERT 5/30	
Add-on and lab charges are not posting as expected in Cerner.	• Conduct analysis of current charge setup in Cerner. • Verify all orders that should drop a charge are dropping charges. • Document findings and provide action plan	• RSM to pull audit of charge build, maintenance tier and configuration rules	

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
An owner needs to identified by NIH as to who will be responsible for the RHC Wrap review process moving forward (NIH or Novus).	• Update work queue as needed depending on the owner of the workflow.	• Confirm with NIH that Novus will be handling RHC Wrap Claims moving forward.	
Payment and Adjustment 835 posting rules are not configured correctly in Cerner to allow for 835s to post efficiently.	• Review payment and adjustment setup with NIH staff to determine next steps. • Map out any design requirements and submit SR to Cerner	• Held design session while onsite on 5/25. • Next step to schedule follow-up session with Andrea to have further discussion surrounding contractual adjustments.	
Work queues and work items are not assigned to the correct staff to be worked. These queues are also not configured to allow for more efficient workflows.	• Review work item and work queues and discuss with Gloria and staff possibilities and document design. • Provide details to Cerner so build can be updated.	• Held design session while onsite. • Next step is to map out design and provide details to Cerner	
Current technical denials are not being routed based on CARC reason to a work queue so specific staff can work those areas.	• Review design with Gloria and staff • Update technical denial design to map by CARC code following onsite discussion	• Reviewed proposed design with Gloria and staff while onsite • Next Step is to document design and submit SR	
Gloria and staff will begin taking over leadership of the DNFB/High Dollar calls.	• Provide Training to Gloria and Staff concerning DNFB/High Dollar account identification • Create Combined DNFB/High Dollar Documentation for NIH staff to reference going forward.	• Held working session while onsite • Documentation to complete DNFB/High Dollar accounts to be worked provided on 6/1. • Question/Answer session scheduled for 6/5 • Session to be schedule for support on 6/12	

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
Denial Avoidance Program	• Identify top 5 denial reasons impacting A/R • Identify root cause • Implement corrective actions • Measure progress to baseline denials	• Baseline denial volumes and dollars identified • Registration root cause identified • Meeting to be scheduled with Sue to review registrar level reporting in RCM Intelligence	
Cerner Maintenance Training	• Provide training to NIH staff so that staff will understand Cerner setup.	• Sessions have been scheduled with Marci everyday for 2 hours starting 6/6.	
Revenue Cycle Training	• Create vignettes of workflow processes within Cerner	• Recordings to start during the week of 5/29 • Estimated Completion Date of 6/16	
There is currently not a standard cash reconciliation process for the clinics between the Business Office and Finance.	• Work with NIH to define a daily cash reconciliation process and provide guidance on workflow.	• Meeting scheduled to discuss cash reconciliation process on 6/5	
Billing staff are not trained on client billing workflows.	• Provide Marci training on client billing workflows within Revenue Cycle.	• Pending completion of client billing testing in CERT	

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
Edits are hitting the pending edit queue in Cerner preventing claims from going to the Clearinghouse upon generation.	• Review the edits in Cerner and provide recommendations to claim rules, if needed.	• Updated Admission Source Claim rule through SR. • Continuing to investigate other edits.	
Tricare West Remittance have been hitting the failure queue since April 25, 2023	• Evaluate the Clearinghouse mapping between Inovalon and Cerner • Identify any other technical defects causing failure with these remittance	• SR 449560312 was logged to Cerner on 5/15 • First Example: Cerner states remit was blank • Second Example sent 5/30/23	
Past Due and Timely Filing work queues are not configured in Cerner to allow for tracking of claims that are close to timely filing deadlines.	• Create work items and configure system to allow for timely filing to be tracked accurately in Cerner	• SR 448859948 was logged to Cerner on 3/28 • SR was updated to set timely filing to 180 days for non-contracted payers	
Currently the only way to track status of encounters with MedPlan is through a report.	• Create work items to allow for work items to trigger based on the return reason sent in the file from MediPlan. Preventing staff from having to run a report to work encounters.	• SR 449635863 was logged on 5/19.	
During discussions while onsite, NIH staff are unsure if the statement cycle job is still being utilized now the MedPlan is live in PROD. Need to understand if statement cycle job is running where the statement file is going.	• If statement cycle job is still running and does not need to be running have Cerner inactivate the ops job.	• Sent email to Lynda to confirm. Email was sent to Lynda last week on 5/29.Lynda responded on 6/5. Waiting on response from Cerner.	

NIHD RSM

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
There is Non-recurring encounter functionality in Cerner that is turned on that is causing voided benefit orders and payments/adjustments to be reversed whenever an update is made to registration.	• Non-recurring functionality should be turned off in Cerner to prevent payments/adjustments from being reversed.	• SR 448512180 was logged on 3/8. • SR was escalated. • CERT environment was updated and testing was successful. • Cerner to move build from CERT to PROD	
Work items are being routed to terminated employees at NIH.	• Update the work item assignment logic so that work item are routed to correct staff.	• SR 449120413 was logged on 4/14	
Transaction aliases are not mapped correctly to allow for accurate GL posting	• Update the Transaction alias library based on design discussion.	• SR 449109774 was logged on 4/13	
Encounter with $0 balances are populating work queues.	• Update work item logic to dequeue encounters with a $0 balance.	• SR 448536227 was logged on 3/9	

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
A PBM rule is not built for the “INYO Encounter to PreColl – BDM” work item causing the work item to not fire automatically.	Create a PBM rule and include BDM as a collection agency so this work item will be automated.	• Review documentation and combine into one design document to be included on SR ticket	☐
An 835 posting rule has not been built to determine when CO-23 posts as a contractual adjustment versus an informational remark code.	Create a PBM rule to have CO-23 to post either as contractual or informational remark code automatically.	• Schedule meeting to discuss CO-23	☐
During the work item design session, it was identified that there is no clear workflow in regards to the Documentation Review work item and when it is utilized at NIH.	• Update work item as needed	• Investigate work item and identify if work item is being used.	☐
The 835 Payment rule for Veteran’s Administration financial class is set to post payments to 10003 and 10003R which is the incorrect transaction alias.	• Update the PBM rule for Veteran’s Administration financial class to post to 10014 and 10014R. • Update the PBM rule to include financial class of CHAMPVA.	• Map out design and submit SR ticket to have build updated.	☐
The 835 Payment rule for financial class Other is posting to 10009 and 10009R.	• Confirm this can be inactivated.	• Run reports to validate this transaction alias is not being used.	☐

NIHD RSM

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
A PBM rule is not built for the “INYO Possible Two Midnight – INYO Possible Two Midnight” work item causing the work item to not fire automatically. The work item also is not assigned to the appropriate users.	• Define PBM rule criteria and include on SR to be submitted to Cerner to update logic.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “Medi-Cal Credentialing” work item is currently setup as an automated work item and encounters are populating the queue inaccurately.	• Update the Medi-Cal Credentialing work item to be a manual work item instead of automated.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “Medi-Cal Pending” is not populating all encounters that have the Medi-Cal Pending Health plan.	• Update the Medi-Cal Pending Work item trigger to be Encounter Discharge and Health Plan Change. This will allow for encounters to populate accurately.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “Medi-Cal Pending” work item is currently assigned to Faby at NIH.	• Update the work item to be assigned to Morgan Kershner at Novus.	• Review documentation and combine into one design document to be included on SR ticket	☐
The Minor Privacy work item is not firing for all encounter types.	• Remove the encounter type logic from the Minor Privacy Pbm rule for the Minor Privacy work item.	• Review documentation and combine into one design document to be included on SR ticket	☐

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
The “Bankruptcy” and “Deceased No Estate” return reasons do not adjust automatically in Cerner.	• Update SR to allow for the Bankruptcy and Deceased No Estate return reasons to auto-adjust the accounts that are returned with those comments.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “NIHD Charge Service Date Out of Bounds” is only looking at primary financial class.	• Remove the primary financial class criteria from the PBM rule to allow for the work item to fire for all financial classes.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “Charity Care” PBM rule for the Charity Care work item is excluding self pay as a financial class.	• Remove the ‘not Self pay’ Financial class component from the rule.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “NIHD Employee Health Other” work item is triggered by charge posted which is not capturing all encounter.	• Review possible list of trigger events and identity a trigger that would work best for this workflow	• Review documentation and combine into one design document to be included on SR ticket	☐
The RHC WRAP Review Process is currently a manual workflow that is triggered by a work item.	• Review the workflow and determine if there are areas that can be optimized within Cerner.	• Review documentation and determine if Cerner functionality allows for further automation	☐

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
The “NIHD Return form Pre-Collections Other” PBM rule has logic that excludes the Follow-up Exhausted return reason from the rule.	• Remove the “!= Follow-up Exhausted” from the PBM rule to allow for encounters with that return reason to populate the “NIHD Return from Pre-Collections Other’ queue.	• Review documentation and combine into one design document to be included on SR ticket	☐
The “NIHD Same Day Encounter” work item utilizes custom pbm rule logic which may prevent the rule from firing accurately.	• Research the “NIHD Same Day Encounter” work item and validate that the work item is working as intended.	• Review documentation and combine into one design document to be included on SR ticket	☐
The Voided Benefit Order work item is currently a manual work item. Meaning staff must manually identify this work item for encounters.	• Update work item if needed to be automated.	• Research automating this work item so that staff do not need to manually assign the work item.	☐
The Indian Beneficiary 835 payment logic is setup to post to the 10003 and 10003R transaction alias which is the incorrect alias for Indian Beneficiary.	• The rule should be updated to post payments to 10009 and 10009R . • The rule should also be updated to use the 10009 and 10009R alias for only the Toyaibe health plan.	• Review documentation and combine into one design document to be included on SR ticket	☐
There is currently not a transaction alias for Shoshone (Paiute) tribe, Big Pine, and Tahachi.	• Create new transaction aliases for each tribe to allow for payment tracking.	• Review documentation and combine into one design document to be included on SR ticket	☐

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
There is currently not a health plan for Shoshone (Paiute) tribe, Big Pine, and Tahachi.	• Create a health plan for each tribe to allow for payment and adjustment tracking for each tribe.	• Map out design and submit SR ticket to have build updated.	☐
The 10004 transaction type is currently Managed Care Payment.	• Update the 10004 transaction type to Medicaid payment.	• Map out design and submit SR ticket to have build updated.	☐
The 835 Payment rule for Medicaid HMO financial class is set to post payments to 10001 and 10001R which is the incorrect transaction alias.	• Update the PBM rule for Medicaid HMO financial class to post to 10005 and 10005R.	• Map out design and submit SR ticket to have build updated.	☐
The 835 Payment rule for Medicaid financial class is set to post payments to 10001 and 10001R which is the incorrect transaction alias.	• Update the PBM rule for Medicaid financial class to post to 10016 and 10016R.	• Map out design and submit SR ticket to have build updated.	☐
The 835 Payment rule for Tricare financial class is set to post payments to 10003 and 10003R which is the incorrect transaction alias.	• Update the PBM rule for Tricare financial class to post to 10015 and 10015R.	• Map out design and submit SR ticket to have build updated.	☐

Outstanding Items – Patient Accounting

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
The 835 Payment rule for financial class CHAMPVA is posting to 10014 and 10014R.	• Confirm this can be inactivated.	• Run reports to validate this transaction alias is not being used.	☐

Outstanding Items – Other Items

Not Started | In Progress | Pending NIH | Pending Cerner

Issue Description	Targeted Change	Status Update	
NIH does not currently have a process for identifying insurance underpayments or overpayments when compared to the contracts	• Implement Cerner Contract Management which includes: 1. Configuration of Contract Management and Patient Accounting Integration 2. Health Plan Configuration and Contract Modeling 3. Reimbursement Management and Variance Workflows 4. Transaction Services HUB	• SR 449776342 has been opened with Cerner. • Cerner will have a charge associated with the implementation • 6/2/23 – Stephen provided a table of payers and reimbursement rates. Sent this to Alex Duke to have it attached to the SR	
GL is routing appropriately; however, Andrea would like to separate out specific payers and service lines.	• Have design session with Andrea and staff to discuss possibilities with GL routing and document design decisions. • Once decisions are documented an SR will be submitted to have Cerner update the GL mapping.	• GL Design Session occurred on Monday 6/5 @ 2pm PST • Design considerations submitted to Stephen and Andrea on 6/6	

NIHD RSM

THE WEEK AHEAD

The Week Ahead

Meetings

- **Combined DFNB/HDR Meeting**
  - 6/7/23 11:00am – 12:00pm PST
- **Cerner Maintenance Training**
  - 6/7/23 1:00pm – 2:00pm PST
  - 6/8/23 9:00am – 11:00am PST
  - 6/9/23 1:00pm – 3:00pm PST
  - 6/12/23 11:30am – 1:30pm PST

Other Activities

- Implement Client Billing in PROD
- Remove the non-recurring encounter functionality in PROD
- Review GL Mapping Aliases
- Develop Rev Cycle Training video series

QUESTIONS AND ANSWERS?

Medrano Roofing Inc.
License #: 980695
DIR #: 1000397654
166 H Street
Bakersfield, CA 93304
Phone (661) 395-0147 Fax (661) 395-0138

BID

DATE: April 20, 2023
Bid # 38156
Quote valid thru: 5/5/2023

Bid for: Northern Inyo Healthcare District
Attn: Jason

Street Address:
150 Pioneer Street
Bishop, California 93514

Location of site: NIH Back Offices
Phone #: 760-920-9717
E-mail: Jason.Moxley@nih.org
Fax#:

SCOPE OF WORK:	
Install New GAF Timberline Reflector Series 30 year Dimensional Shingles	
1. Demolish existing shingles roof down to the wood decking	
2. Install peel and stick on valleys and roof edges	
3. Install new double layer synthetic felt underlayment	
4. Install new 2' x 2" metal drip edge flashings	
5. Install new 18" metal valley flashings	
6. Install new roof pipe flashings	
7. Install new dormer vents to meet title 24 requirements	
8. Install new GAF Timberline reflector series 30 year dimensional shingles	
9. Install new GAF 8" high definition ridge cap shingles	
10. Clean up and dispose of all roofing material from the jobsite	
11. Supply roof permit	
12. Supply 5 year contractor warranty	
13. Supply GAF System plus manufactures warranty	
SCOPE OF WORK:	
Install new Carlisle 60 mil TPO single ply roof system	
1. Install 1 layer of 2" polyiso to deck	
2. Install 1/4" coverboard on the field mechanically fastened	
3. Install Carlisle 60 mil TPO roof system Mechanically fastened heat welded	
4. Install Carlisle 60 mil adhered to parapet walls	
5. Install wall, pipe and curb Flashings	
6. Clean and remove dispose of all roof debris from jobsite	
7. Supply 5 yr contractor warranty	
8. Supply manufacturer warranty from Carlisle	
Notes	
1. An Additional charge of $75 per sheet of plywood that needs to be replaced	
2. An additional charge of $12.50 per linear foot to replace fascia board that would need to be replaced	
Labor and Materials	$ 216,044.53

If you have any questions regarding this bid, please contact the office, 661-395-0147.
E-mail: medranot@sbcglobal.net

THANK YOU FOR YOUR BUSINESS

Date
Authorized Signature

Teodulo Medrano
Supervising Estimator/Owner

Print Name

This bid including the above prices, specifications and conditions are satisfactory and are hereby accepted. Medrano Roofing, Inc. is authorized to do the work specified. Entire amount is due and payable in accordance to the contract.

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Emergency Management Plan		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 06/08/2023	Last Review Date: 04/21/2022	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2008	

PURPOSE:

Northern Inyo Healthcare District Emergency Management Plan follows the Hospital Incident Command System (HICS) format and is the foundation for the all hazards Emergency Preparedness Program. The Emergency Preparedness Program is comprised of 3 basic elements: 1) An all-hazards risk assessment, 2) Emergency Operations Plan (EOP); and 3) a training exercise program.

The Emergency management Plan is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district. Coordination of planning and response with other healthcare organizations, public health, and local emergency management will be included. The plan also addresses proper plan maintenance, communications, resource and assets management, patient care, continuity of operations, management of staff, evacuations, reunification and contingency planning for utilities failure.

The plan will undergo an annual review process to ensure any plan deficiencies are identified and addressed. An improvement plan will be instituted and maintained to ensure lessons learned and action items identified from exercises and real events are properly addresses and documented.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions or the impact on patient care and treatment activities due to such things as; the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the Incident Command System (ICS) design of HICS. HICS has defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. In the event of a communitywide emergency, the agency's incident command structure will be integrated into and be consistent with the community command structure. Staff shall receive Incident Command System training appropriate to their level of response and assigned roles and responsibilities to ensure they are prepared to meet the needs of patients in an emergency.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Healthcare District and Toiyabe Indian Health Clinic. In addition, NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and medical supply vendors.

SCOPE:

The Emergency Operations Plan is designed to guide planning and response to a variety of hazards that could threaten the environment of the NIHD campus or the safety of patient's, staff, visitors, or adversely impact the ability of the organization to provide healthcare services to the community. The plan is also designed to assure compliance with applicable codes and regulations. This plan covers all healthcare district facilities (main building, all outbuildings and clinics) and its implementation is the responsibility of all personnel.

Authority for activating the plan will rest with the designated administrator at the time of any incident in need of plan activation**.** Activation of the plan will be conducted in conjunction with agency command staff as well as local emergency management and public health personnel, when appropriate.

The Emergency Plan consists of the Emergency Operations Plan (EOP) and supporting documents. The EOP is the all hazards response overview, includes concept of operations, and organizational structure. The supporting documents provide more detail on the initial response to priority hazards, threats, and events and operational planning. In addition, this plan will define specific goals and objectives, describe preparedness activities, expand the definitions and roles of the Hospital Command Center, and outline response and recovery strategies to be implemented during an emergency event.

SITUATION OVERVIEW:

Hazard Vulnerability Analysis (HVA)

The Disaster Management Committee with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. This assessment process helps to identify the hospitals highest vulnerabilities to natural and man-made hazards so that effective preventive measures can be taken and a coordinated response plan can be developed. The results of the HVA will be reviewed with the Inyo Mono Healthcare Coalition (MIHCC) and other emergency management partners. The HVA is completed annually and results will be shared with the Disaster Management Committee, Senior Leadership, and the NIHD Board of Directors.

The critical access hospital's HVA includes the following:

- Natural hazards (such as flooding, wild fire)
- Human-caused hazards (such as bomb threats or cyber/information technology crimes)
- Technological hazards (such as utility or information technology outages)
- Hazardous materials (such as radiological, nuclear, chemical)
- Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)

The top identified hazards for this facility are found below**.** These top five hazards have been shared at the community and regional level for partner awareness.

Rank	Hazard
1	Wild Fire
2	IT Systems Failure
3	MCI
4	Chemical Exposure
5	Earthquake

PLANNING ASSUMPTIONS

The following set of assumptions governs the parameters by which this plan was developed.

- Emergencies can happen at any time.
- Emergencies will differ in type, size, scope, and duration.
- NIHD is ultimately responsible for the safety of its patients and staff. External resources may or may not be available in emergency situations. NIHD must understand how we are incorporated into local, regional, and state plans and coordination efforts to participate in available resource request processes.
- Local, state, and federal departments and other healthcare facilities may provide assistance necessary to protect lives and property, however, these resources may not be available and NIHD will plan to manage the incident ourselves, at least for a period of time.
- While this plan outlines actions that should be taken during emergency situations, staff will need to adapt their actions as appropriate for the specifics of the situation.
- No emergency plan can cover all possible contingencies, this plan should be used as a guide and a planning tool to prepare staff and the organization for the most likely hazards that could occur as based on the Hazard Vulnerability Analysis.
- The plan must be implemented in a flexible manner to be successful.
- Staff will be familiar with the plan and their expected responsibilities.
- Staff will execute their responsibilities as outlined in this plan during the emergency event.
- Proper execution of this EOP will save lives and reduce damage from the emergency event.

CONCEPTS OF OPERATIONS

Incident Management

Incident management activities are divided into four phases: mitigation, planning, response and recovery. The job action sheet of HICS includes sections addressing each phase. The four phases are described below:

Mitigation: Mitigation activities describes the actions taken to reduce or eliminate the severity of an emergency. NIHD's strategies for mitigation are to assess and prioritize specific hazards and identify means to reduce those hazards as the organization's ability allows.

Planning: Describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. NIHD's planning activities include developing emergency operations plans and procedures, conducting training for personnel in those procedures, and conducting exercises with staff to ensure they are capable of implementing response procedures when necessary.

Response: Response includes those actions that are taken when a disruption or emergency occurs. It encompasses the activities that address the short-term, direct effects of an incident. Response activities for NIHD can include activating the incident command center and emergency plans, triaging and treating patients, staff, and visitors who have been affected by an incident, and providing support to other community emergency

response agencies when needed.

Recovery: Describes the processes for restoring operations to a normal or improved state of affairs by both short and long term efforts. Recovery activities for NIHD may include the restoration of interrupted utility services, non-vital functions, replacement of damaged equipment, facility repairs, organized return of patients into the facility, and reconstitution of patient records and other vital information systems. Another key consideration in the recovery and response phases of an incident is the tracking of staff hours, expenses, and damages incurred as a result of the emergency. Detailed records will be maintained throughout an emergency to document expenses and damages for possible reimbursement or to properly file insurance claims.

Plan Activation
The Emergency Operations Plan will be activated in response to internal or external threats to the facility. Internal threats could include fire, workplace violence, and loss of power/other utility or other incidents that threaten the well-being of patients, staff, and/or the facility itself. External threats include incidents that may not affect the facility directly but have the potential to overwhelm NIHD resources or put the facility on alert.

Persons Responsible for Plan Activation
Once a threat has been confirmed, the employee obtaining the information must notify their unit supervisor or the House Supervisor immediately. Employees can use the Emergency Preparedness Procedures Quick Reference flip chart, also known as the Rainbow Chart, which is found in all areas of the hospital for immediate step by step instructions for several emergency situations.

The administrator or administrator on call, and the nursing supervisor on duty, have authority to activate the Incident Command Center (ICC) and initiate all or portions of the emergency operations plan whenever a defined emergency exists. The person activating the emergency plan or Emergency Operating Center (EOC), serves as the Incident Commander until relieved by a senior administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is better to activate the EOC early, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events.

Position Responsible for Emergency Operations Plan Activation

Position/Title	Contact Number
Primary: Administrator or AOC House Supervisor	See call sheet for AOC cell 760-920-3392 (Sup cell)

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **Advisory** is given when no system response is needed but the potential for a response exists.
- **Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **Activation** is given when a response is required.

The local Public Health Department or local emergency management office will usually receive these notifications at which time NIHD will be informed.

Important information to obtain as soon as possible should include but is not limited to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination, transporting persons)
- Estimated time of arrival of first-arriving Emergency Medical Service units.

Alerting Staff (On and Off Duty)
To notify staff that the EOP has been activated, those within the facility will be contacted first through the internal communication systems, if functioning, such as overhead paging, radios, and email.

Staff away from the facility at the time of activation will be contacted via the simplified texting alert system, and phone trees. The individuals responsible for contacting staff include the House Supervisor and individual department directors or managers.

Alerting Response Partners
NIHD works closely with several external partners. The IC or Disaster Manager will be the individual(s) responsible for contacting these external agencies to notify them that the EOP has been activated.

ORGANIZATION & ASSIGNMENT OF RESPONSIBILITIES

During an event, specific roles and responsibilities will be assigned to individual positions/titles as well as facility departments.

Essential Services
The table below identifies the department roles and responsibilities during plan activation.

Roles and Responsibilities

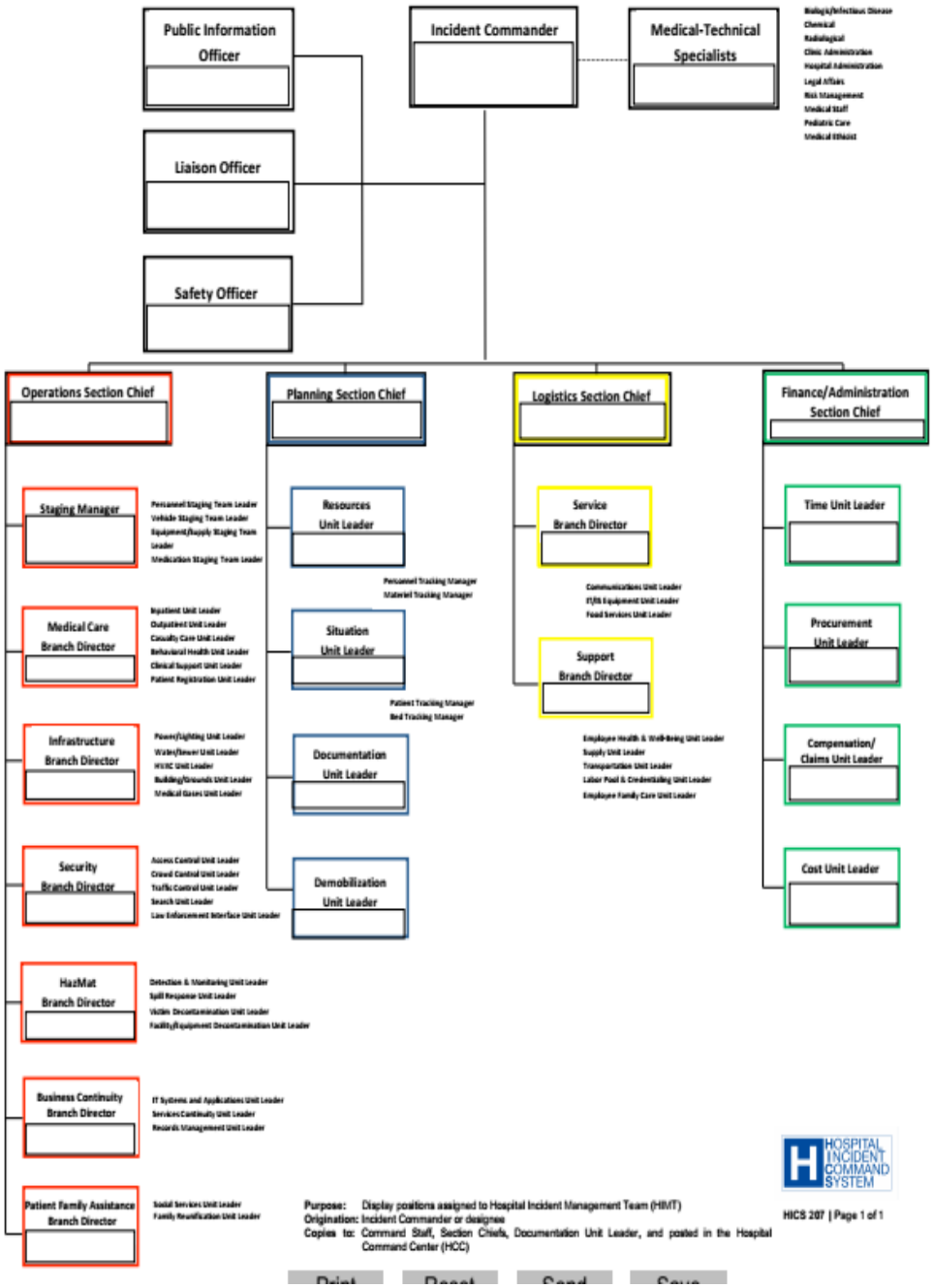
Essential Services	Roles and Responsibilities	Point of Contact by Position	Secondary Point of Contact
Administration	Incident Command	Chief Executive Officer	Chief Operations Officer
Medical Staff	Direction of Medical Staff Services	Chief of Emergency Medicine	Chief Medical Officer/Chief of Staff
Dietary	Emergency Food Provisions	Dietary Manager	Dietician
Housekeeping	Preparation and distribution of EVS related supplies.	Manager of EVS	EVS/Laundry Assistant Manager
Maintenance	Facilities Management & Utilities Operations	Director of Facilities	Maintenance Manager
Nursing	Patient Care Operations	Chief Nursing Officer	Inpatient/Outpatient Director of Nursing
Pharmacy	Emergency disposition of medications.	Pharmacy Director	Staff Pharmacist
Safety & Security	Maintain safe and secure facilities to operate under emergent situations.	Director of Facilities	Maintenance Manager
Materials Management/Supplies	Provide additional supplies as needed.	Director of Purchasing	Designated Administrator

Positions
Identifying and assigning personnel in the HICS system depends a great deal on the size and complexity of the incident. The HICS is designed to be flexible enough so that the number of staff needed to respond to an incident can be easily expanded or contracted. HICS Form 203 is used to document and assign staff to HICS specifics positions.

DIRECTION, CONTROL, AND COORDINATION

NIHD will coordinate emergency operations from the facility command center. The primary hospital command center will be located in the Second Floor Conference Room (H2063). Should an alternative location be needed off campus, NIHD can utilize one of their off-site locations (Birch Street, Joseph House, etc.) or any of alternative evacuation sites as described in the evacuation section of this document.

Command Structure
Command will be organized according to the ICS model to help manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.


Public Information Officer
Incident Commander
Medical-Technical Specialists
Biology/Infectious Disease
Chemical
Radiological
Clinic Administration
Hospital Administration
Legal Affairs
Risk Management
Medical Staff
Pediatric Care
Medical Ethicist
Liaison Officer
Safety Officer
Operations Section Chief
Planning Section Chief
Logistics Section Chief
Finance/Administration Section Chief
Staging Manager
Personnel Staging Team Leader
Vehicle Staging Team Leader
Equipment/Supply Staging Team Leader
Medication Staging Team Leader
Medical Care Branch Director
Inpatient Unit Leader
Outpatient Unit Leader
Casualty Care Unit Leader
Behavioral Health Unit Leader
Clinical Support Unit Leader
Patient Registration Unit Leader
Infrastructure Branch Director
Power/Lighting Unit Leader
Water/Sewer Unit Leader
HVAC Unit Leader
Building/Grounds Unit Leader
Medical Gases Unit Leader
Security Branch Director
Access Control Unit Leader
Crowd Control Unit Leader
Traffic Control Unit Leader
Search Unit Leader
Law Enforcement Interface Unit Leader
HazMat Branch Director
Detection & Monitoring Unit Leader
Spill Response Unit Leader
Victim Decontamination Unit Leader
Facility/Equipment Decontamination Unit Leader
Business Continuity Branch Director
IT Systems and Applications Unit Leader
Services Continuity Unit Leader
Records Management Unit Leader
Patient Family Assistance Branch Director
Social Services Unit Leader
Family Reunification Unit Leader
Resources Unit Leader
Personnel Tracking Manager
Materiel Tracking Manager
Situation Unit Leader
Patient Tracking Manager
Bed Tracking Manager
Documentation Unit Leader
Demobilization Unit Leader
Service Branch Director
Communications Unit Leader
IT/IS Equipment Unit Leader
Food Services Unit Leader
Support Branch Director
Employee Health & Well-Being Unit Leader
Supply Unit Leader
Transportation Unit Leader
Labor Pool & Credentialing Unit Leader
Employee Family Care Unit Leader
Time Unit Leader
Procurement Unit Leader
Compensation/ Claims Unit Leader
Cost Unit Leader
HOSPITAL INCIDENT COMMAND SYSTEM
Purpose: Display positions assigned to Hospital Incident Management Team (HIMT)
Origination: Incident Commander or designee
Copies to: Command Staff, Section Chiefs, Documentation Unit Leader, and posted in the Hospital Command Center (HCC)
HICS 207 | Page 1 of 1
Print
Reset
Send
Save

HICS Positions with Possible Hospital Staffing Position Candidates

HICS Position	Hospital Position
Incident Commander	Chief Executive Officer Administrator On Call Nursing Supervisor Chief Operating Officer Chief Medical Officer Director of Emergency Medicine
Public Information Officer (PIO)	Chief Executive Officer Administrator Manager of Marketing
Safety Officer	Facilities Manager Maintenance Manager DON Infection Prevention
Liaison Officer	Chief Executive Officer Manager of ED/Disaster Administrator
Operations Section Chief	Chief Nursing Officer Chief Operating Officer DON Inpatient or Outpatient Services Administrator
Medical-Technical Specialist(s)	Chief of Staff DON Infection Prevention Information Technologies

Orders of Succession

Orders of succession ensure leadership is maintained throughout the facility during an event when key personnel are unavailable. Succession will follow facility policies for key facility personnel and leadership.

Key HICS Position Assignments and Orders of Succession

Command and Control	Primary	Successor 1	Successor 2
Shift 1			
NIHD Representative	CEO	COO	CFO
Incident Commander	COO	CEO	CMO
Public Information Officer	Director of Marketing	CEO	COO
Safety Officer	Director of Facilities	Maintenance Manager	Designated Administrator
Liaison	Manager of ED/Disaster	Designated Administrator	Designated Administrator
Operations Section Chief	CMO	CNO	DON
Planning Section Chief	CNO	CMO	COO
Logistics Section Chief	Purchasing Director	Manager of ED/Disaster	Manger of Clinical Engineering
Finance/Administration Section Chief	CFO	Controller	Designated Administrator
Shift 2			
NIHD Representative	DON	House Sup	CNO
Incident Commander	House Sup	Clinical Manager	Designated Administrator
Public Information Officer	Designated Administrator	Director of Marketing	CEO
Safety Officer	Maintenance Manager	Quality Manager	Director of Facilities
Liaison	Quality Admin	HR Director	HR Manager
Operations Section Chief	Clinical Manager	DON	ED/Disaster Manager
Planning Section Chief	Clinical Manager	Designated Administrator	Quality Manager
Logistics Section Chief	Designated Administrator	Designated Administrator	Designated Administrator
Finance/Administration Section Chief	Controller	Designated Administrator	Designated Administrator

Delegation of Authority

Delegation of authority specify who is authorized to make decisions or act on behalf of NIHD leadership and personnel if they are away or unavailable during an emergency. Delegation of authority planning involves the following:

- Identifying which authorities can and should be delegated.
- Describing the circumstances under which the delegation would be exercised and including when it would become effective and terminate.
- Identifying limitations of the delegation.
- Documenting to whom authority should be delegated.
- Ensuring designees are trained to perform the emergency duties.

Emergency Authority Delegation

Authority	Type of Authority	Position Holding Authority	Triggering Conditions
Activate Facility Command Center	Emergency Authority	Administrator on call (AOC)/House Sup.	Immediate Threat, Operations Interruptions
Activate Emergency Annexes and the Emergency Operations Plan	Emergency Authority	Administrator on call (AOC)/House Sup.	Specific Incidents i.e. Power Outage, Active Shooter, etc.
Close facility	Emergency Authority	CEO/COO	Remaining in the facility is unsafe.
Represent facility when engaging Govt. Officials	Administrative Authority	CEO, COO, Compliance Officer	Unannounced Survey, local or national emergency.
Activate facility memorandum of understanding/mutual aid agreements	Administrative Authority	Senior Leadership	Additional resources necessary to operate.

Community-wide Response Involvement
Inyo County is part of the Mutual Aid Region VI (6) of the Southern District of the California Office of Emergency Services (Cal OES). The local emergency response group works with local, county and state planning agencies under Cal OES to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

Regional Healthcare Coalition Coordination
NIHD is a member of the Inyo County Unified Command and the Mono Inyo Healthcare Coalition. NIHD participates in regular planning meetings, exercises, and incident review/debriefings.

Both groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. These crucial discussions between key community stakeholders guide the development of the NIHD Emergency Operations Plan and aid in general disaster planning. These groups meet on a regular basis.

INFORMATION COLLECTION, ANALYSIS, AND DISSEMINATION

Information is vital to making good decisions during a crisis. The needed information must be collected in a timely manner, analyzed and disseminated to "need to know" parties to enable them to determine their most appropriate course of action during the incident.

Information is collected and disseminated by various systems which may include:

- Inyo Mono Healthcare Coalition, Inyo County Unified Command, and the California Health Alert Network (CAHAN)
- Local/regional dispatch center
- Local emergency operations centers
- State Public Health Emergency Response Center/State Emergency Operations Center

Essential elements of information contain situational awareness details that are critical to the initial and ongoing response and recovery operations. The elements listed below may not apply to every event, may not be all-inclusive, and may be modified as needed and adjusted per operational period. NIHD is prepared to share this information during a disaster or emergency event with relevant partners:

- Facility operating status
- Facility structural integrity
- Status of evacuations/shelter in-place operations
- Status of critical medical services (e.g., trauma, critical care)
- Critical service/infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
- Bed or patient status

- Equipment/supplies/medications/vaccine status or needs
- Staffing status
- Emergency Medical Services (EMS) status
- Epidemiological, surveillance or lab data (e.g., test results, case counts, deaths)
- Point of Dispensing (POD)/mass vaccination sites data (e.g., throughput, open/set-up status, etc.)

COMMUNICATIONS

Day to day internal communications are carried out by emails, landline telephones, cell phones, handheld radios, and the internal overhead paging system. Back up communication means include handheld radios and cell phones should landlines and overhead paging systems fail. Internal code alert systems, internal networks, and the overhead paging system are considered vital to the lifesaving functions of the facility and will be considered an emergency if they fail.

External communications are carried out by landline telephones, emails, and cell phones. In the event of a failure of these systems, backup systems such as HAM Radios and Satellite phones, will be utilized.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plain language will be used in training and tested during drill exercises.

Notification of Civil Authority
Whenever a situation adversely affects NIHD's ability to provide services to the community, the healthcare district notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIHD maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, utility companies and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Department of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Department of Health Services, Licensing and Certification Program.

Release of Information
Release of information to the news media follows procedures developed by the Public Information Officer (PIO) who act as spokesperson for the organization. The Incident Commander will release information as appropriate to the situation. In larger incidents, the assigned PIO for Inyo County EOC may act as spokesperson for the overall emergency event and report healthcare related information on behalf of the District.

Staff Notification
As previously noted, staff is notified of EOP implementation in several ways: overhead page, landline telephone, cellular phones, CAHAN notification, text message, or runners in the healthcare district. Off duty staff, physicians, and other licensed practitioners will be contacted via departmental call trees, e-mail notification, or mass notification system.

NIHD maintains an updated employee directory as well as a communication binder with all relevant authorities contact information.

In the event of an emergency or evacuation, the emergency response plan include a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation:

- Patient's family, representative, or others involved in the care of the patient
- Disaster relief organizations and relevant authorities
- Other healthcare providers

Pertinent medical information is transported with each patient as a hard-copy (HICS-260) form.

MANAGEMENT OF PATIENT CARE ACTIVITY

NIHD has a specific plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and current patients for planning, patient management, and informing relatives and others; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

- **Very High Risk** – could only be cared for in an acute facility
- **High Risk** – could be transferred to an acute care facility
- **Moderate Risk** – would be transferred to another facility
- **Low Risk** – could be transferred home
- **Minimum Risk** – could be discharged immediately

Emergency Locations for Patient Care
All patients will enter through Emergency Department, after triage outside, as appropriate.
Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of Code Triage.

- **Triage Area** – Emergency parking lot adjacent to the Emergency Department
- **Immediate Care Area** - Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Pioneer Medical Building
- **Morgue** – To be determined at the time of emergency

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – 2nd Floor Conference Room
- **Labor Pool** – Main Lobby
- **Family Center/Human Services Center** – Rehabilitation Building
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center/Pediatric-Safe Area (PSA)** – Rehabilitation Building

Patient Populations
NIHD intends to serve all populations that seek healthcare during emergencies including at-risk populations. NIHD may be forced to curtail or consolidate services offered depending on damage to facilities. Services may be transferred to undamaged areas of the hospital or other area hospitals. At-risk or vulnerable populations may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. As needed based on the situation, NIHD would coordinate with the appropriate jurisdiction to request resources from regional, state, or federal assets to augment/increase care when needed and or available.

Evacuation
A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the Administrator on Call in conjunction with senior leadership.

Shelter in Place
If NIHD administration, along with internal safety and public safety officials, determines that sheltering in place is the safest course of action for patients, staff, and volunteers, the command center will be activated to ensure patient care and staff needs are met. The command center will plan for and ensure care and sustenance needs are met along with ensuring a safe environment.

Chemical and Radioactive Isolation and Decontamination
The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

Reunification
In the event of pediatric surge, mass causality incident, or a disaster that requires activation of a surge/reunification plan, NIHD will work in conjunction with County Unified Command and other pertinent county partners to activate the Concept of Operations (CONOPS) of the Mono & Inyo Healthcare Coalition Pediatric Surge Plan. This plan outlines reunification in detail. Included in the plan is a pediatric identification and tracking system for both accompanied and unaccompanied children, rapid survey protocol to identify unaccompanied or displaced children, and defined Pediatric Safe Area (PSA) where uninjured, displaced or discharged children can be held until released to a caregiver. All forms, tools and documents are located in the CONOPS document found in the Disaster Planning Binder.

ESSENTIAL NEEDS FOR STAFF AND PATIENTS

Vulnerable Populations: Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious chronic conditions will be provided in the customary way but additional emphasis will be placed on security, safety, and mobility in terms of evacuation should it become necessary during an emergency. NIHD plans for the possibility of a surge in patients. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

Food and Other Nutritional Supplies: The Logistics Section will ensure that supplies in-stock, on campus are sufficient. Food service vendors will be notified and updated to provide for essential needs. The Dietary Department handles all food and water acquisition and delivery.

Medications and Related Supplies: Pharmacy handles both the acquisition and delivery of supplies. Pharmacy also has strategic inventory which contains counter measures for organic phosphates, nerve agents, and pesticides.

Medical/Surgical Supplies (including PPE): The Logistics Section in conjunction with the Purchasing Department handles the acquisition of supplies through its vendors and transport via its delivery personnel.

Medical Oxygen and Supplies: NIHD can provide bottles of gases supplied by normal vendors or disaster response contractors, or by a state resource request. NIHD has an emergency plan for medical gas failure.

Potable or Bottled Water: The Dietary Department handles food and water acquisition and delivery. The Dietary Department maintains an inventory of bottled water on campus for emergency use. NIHD can request local and state support for additional potable water as needed.

Personal Hygiene and Sanitary Needs: Personal hygiene and sanitary needs of patients during emergencies will be provided by NIHD. In addition, when water intended for hand washing is not available, the hospital utilizes waterless alcohol-based hand rub, which is maintained in ample supply at the hospital. The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs. The alternative means to sanitation, if toilets are inoperable, is kitty litter, red bags in toilets, or positioning of water barrels and waste collection barrels. Limit changes of bed linen to those patients who have gross soiling. Environmental Services use of daily water will be curtailed as designated by the Manager of Environmental Services.

Management of Behavior Health Patients: During an emergency, NIHD will arrange for mental health consultation to patients through prearranged county services. The NIHD social worker should be made available to attend to the emotional needs of patients while awaiting county services in the event of a disaster. If necessary, patients should be transferred to a specialized behavioral health setting. If transfer of patients is not possible, then staff should be assigned to monitor patients accordingly to NIHD policy.

Surge and Alternative Care Sites

NIHD plans for the possibility of a surge in patients. The surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; Bishop City Hall, Pine Street School Gym, and the Tri County Fairgrounds. Transportation of patients and supplies will be handled by several means, including but not limited to: NIHD care shuttles, local and county EMS, Inyo-Mono Transit Authority, local law enforcement, and local EMS air support.

The Incident Command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

Patient Tracking
NIHD tracks the location of patients on site during an emergency using wristbands, bed assignment, and electronic management systems. HICS 254-Disaster Victim Patient Tracking Form will be utilized.
In the event that the computer system is down, the registration staff will coordinate the use of the Disaster Victim Patient Tracking Form with the START Triage system, both are maintained on paper. NIHD will ensure that all patient identification wristbands (or equivalent identification) is intact on all patients. If patients are evacuated, the HICS 260 - Patient Evacuation Tracking Form will be used. When more than two patients are being evacuated, the HICS 255 - Master Patient Evacuation Tracking Form should be used to gain a master copy of all those that were evacuated. Information on forms should include, but is not limited to: patient/resident name, date of birth, Medicare/Medicaid number, if minor (accompanied or not), evacuation site location, date of evacuation, arrival time at evacuation site, date of return to facility (if known), and comments/notes.

In addition, NIHD will utilize third-party information such as local emergency response agencies and the Red Cross as appropriate to assist families in locating patients.

Staff Tracking
The management chain of command as well as incident command resource management principles will be used to track the location of on-duty staff.

NIHD uses staff identification badges to identify caregivers and other employees during mass casualty or major environmental disasters. All staff presenting to the facility will need to have a visible NIHD ID in order to enter. Staff without ID's must report to the Labor pool, be positively identified, and receive a temporary badge or other approved alternate. Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title as more senior staff become available, and during longer incidents where jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIHD emergency identification or to determine what form of identification will be required for each responding group.

SAFETY AND SECURITY

NIHD completes security assessments to address vulnerabilities campus wide. The Director of Facilities in conjunction with the in-house Security Team is responsible for the overall planning of the Security Services response in day-to-day operations and during emergency events. If insufficient security staff exists to cope with the emergency, a request for assistance from local law enforcement agencies shall be completed.

NIHD requires the facility to establish a command center, a staging or assembly area, and a perimeter with controlled or monitored access points. The on-duty Security Officer or Incident Commander shall direct other responsibilities as deemed necessary. NIHD security and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

The restriction of visitors and guests during critical incidents is a necessary procedure to maintain order, safety, and security for patients, staff and visitors. Upon the notification or realization that an imminent threat to the clinical environment exists, a decision to initiate limited facility access shall be considered through the

collaboration of the Administrator on Call, Incident Commander, House Supervisor and the on-duty Security Officer.

The extent of the limited access and entry shall be determined through careful examination of the threat and impact on facility operations.
There are 6 levels of lockdown with varying degrees of access, entry and exit. See Lockdown Policy.

CYBER SECURITY

NIHD has a Cyber Security Incident Response Manual (CSIRM) and Disaster Recovery and Planning (DRP) in place. The purpose of the plan is to have established procedures for managing cyber security incidents that may affect the hospital's information technology systems, staff, patients and visitors. The plan outlines the roles and responsibilities of hospital staff, communication protocols, and incident response procedures.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate emergency plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, HVAC, and medical gas failure. Managers and staff in all departments affected by the plans are trained as part of organizational wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the EOP and actual outages of utility systems.

LOGISTICS

Resources and Assets

Acquiring and Replenishing Food, Water, Medications and Supplies

The amounts and locations of current food, water, pharmaceuticals, medical and non-medical supplies, are evaluated to determine how many hours the facility can sustain itself before needing re-supply. This gives the facility a par value on supplies and aids in the projection of sustainability before terminating services or evacuating if needed supplies are unable to reach the facility. Supplying NIHD in an emergency will be initially satisfied by pulling from local resources. As replenishment becomes necessary, resources will be requested from vendors.

If NIHD is unable to acquire sufficient resources through outside vendors and pre-positioned arrangements to meet the healthcare needs of the community, the Logistics Chief and/or Director of Purchasing will communicate these need to the county and utilize the Medical Health Operation Area Coordination (MHOAC) to help locate resources and replenishments at the state level. If sufficient supplies cannot be acquired through regional or state medical supply, the county emergency management team will provide assistance with coordinating the transfer of patient's to other facilities upon request.

Monitoring Quantities of Resources and Assets

The Logistics Chief and/or assigned staff is responsible for monitoring quantities of assets and resources during an emergency. A Resource Accounting Record form (HICS Form 257) should be used when resources and assets are tracked during an emergency.

96 Hour Sustainability

Establishing the sustainability of resources is crucial to determining if services can be rendered during a disaster for three days, based on the facility's hazard vulnerability analysis (HVA). Resource inventory is currently maintained to provide for approximately 96 hours. If this cannot be sustained through current inventory,

agreements are in place with suppliers and vendors for the remaining days. If supplies cannot be obtained, policies and procedures are in place in the event the facility may need to evacuate or temporarily close.

Management and Assignment of Staff
Following a disaster, facility personnel must be accounted for. Their location and status should be ensured by unit supervisors, along with the status and location of all patients. They will be tracked during the emergency plan activation to ensure safety and accountability.

Facility personnel may not be assigned to their regular duties or their normal supervisor during emergency plan activation. They may be asked to perform various jobs that are vital to the operation but may not be their normal day to day duties. The Labor Pool is the designated reporting location for reassignment of available staff and volunteers and will be located in the NIHD main lobby. Staff will be assigned as needed and provided information outlining their job responsibilities and who they report to during the event.

If necessary and appropriate, staff may be reassigned to another campus location. Furthermore, staff may be needed to accompany evacuating patients. Staffing assistance from state agencies can be utilized if needed. In the case that NIHD has the need to use volunteers, NIHD has a plan in place to grant emergency privileges to providers. NIHD may use temporary staffing services or travelers to address staffing needs as well.

The Emergency Department physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The medical staff reviews the EOP at the Medical Executive Committee annually.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the emergency preparedness plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

Managing Staff Support Needs
All NIHD personnel are considered essential during emergency response situations. The healthcare district recognizes its responsibility to provide meals, rest periods, housing, and psychological support to staff. In addition, the healthcare district recognizes that providing support such as communication services and dependent care to employees' families during emergency situations allows employees to respond in support of the essential functions of the healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency lodging and meals
- Emergency transportation
- Emergency child care
- Psychological and bereavement counseling
- Staff prophylaxis or immunizations

Procedures are in place to address the transportation and housing of staff that may not be able to get to or from the facility during an emergency. In addition, a procedure is in place for incident stress debriefing. Staff who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals.

Finance
Expenditures will be tracked from the beginning of the disaster to include personnel time, supplies, equipment use, rental of equipment, etc. A designated cost center may be assigned given the duration of the disaster. The Finance Section will have processes in place to ensure the needed tracking occurs. Forms that may be used for expense tracking include HICS 252: Section Personnel Time Sheet, HICS 253: Volunteer Registration, HICS 256: Procurement Summary Report, and HICS 257: Resource Accounting Record.

RECOVERY

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc.) has been recorded for baseline.

Documentation for FEMA assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

Initiation and Recovery
The decision to enter into the recovery stage of an event is made by the CEO/Designated Administrator. In this stage, the hospital will undertake recovery procedures to return the facility to normal operations.

Recovery Protocol
In order to efficiently recover from an event, protocols must be followed. Listed below are protocols important to recovery operations.

Recovery protocols:

- Prioritize health care service, delivery, and recovery objectives by organizational essential functions.
- Maintain, modify, and demobilize healthcare workforce according to the needs of the facility.
- Work with local emergency management, service providers, and contractors to ensure priority restoration and reconstruction of critical building systems.
- Maintain and replenish pre-incident levels of medical and non-medical supplies.
- Work with local, regional, and state emergency medical system providers, patient transportation providers, and non-medical transportation providers to restore pre-incident transportation capability and capacity.
- Work with local emergency management, service providers, and contractors to restore information technology and communication systems.
- Prepare after-action reports, corrective action reports, and improvement plans.

Restoration of Services
The CEO/Designated Administrator will coordinate the restoration of services after an emergency situation affecting the hospital.

Staff/Patient Re-Entry
The CEO/Designated Administrator will work with the California Department of Public Health Licensing & Certification Unit to give approval for the return of staff and patients to the facility.

Staff Debriefing
A debriefing will be conducted within 30 days of the incident to collect lessons learned from the incident or exercise. These lessons learned will be used to revise and update the plan. The ED/Disaster Manager or designee will be responsible for coordinating the debriefing.

After-Action Report
After any real incident or exercise where the emergency operations plan is activated, an after-action report (AAR) will be written. The purpose of the AAR is to document the overall performance of the organization during the exercise or real event. It will contain a summary of the scenario or events, staff actions, strengths, issues, opportunities for improvement, and best practices.

The purpose of the after-action report is to ensure issues and opportunities for improvement are adequately addressed to improve response capabilities to future events. If necessary, an improvement plan will be developed to include a list of issues to be addressed, tasks that will be performed to address them, individuals responsible for completing the tasks, and a timeline for completion.

The ED/Disaster Manager will be responsible for coordinating the development of the after-action report and will ensure identified improvements are completed within the targeted timeframes.

Request for 1135 Wavier
The 1135 waiver allows reimbursement during an emergency or disaster even if providers can't comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or Children's Health insurance program (CHIP). The waiver applies to federal requirements only and not state licensures. Waiver requests can be made by sending an email to the CMS Regional Office in California. Information of the facility and justification for requesting the waiver is required.

PLAN DEVELOPMENT AND MAINTENANCE

The ED/Disaster Manager is the qualified individual to lead the Emergency Management Program and works under the general direction of the Chief Nursing Officer (CNO), the Chief Medical Officer (CMO) and the Chief Executive Officer (CEO). The ED/Disaster Manager in collaboration with the Disaster Management Committee, is responsible for managing all aspects of the Emergency Management Program. The Disaster Management Committee advises senior leadership regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

The Disaster Management Committee is responsible for the following:

- Oversees the emergency management program
- Provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of emergency management program.
- Meets quarterly

- Includes multidisciplinary representatives (senior leadership, nursing services, medical staff, pharmacy services, infection prevention, facilities engineering, security, and information technology)

In addition, senior leadership provides direct oversight and support of the Emergency Management Program through the Disaster Management Committee. Senior leadership reviews all after action reports (AAR) and improvement plans related to the emergency management program.

Annual Program Evaluation

The Disaster Management Committee is responsible for performing the annual evaluation of the EOP. The annual evaluation examines the objectives, scope, performance, and effectiveness of the EOP and the HVA. The annual evaluation uses a variety of information sources including reports from internal policy and procedure review, after action reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation lead to changes/improvements in the emergency management plan. The annual evaluation is presented to the Disaster Committee and to senior leadership via the Executive Committee. The emergency management plan is required reading for all NIHD workforce.

Training Program

Each new staff member of NIHD participates in a general orientation that includes information related to the EOP. Examples of such information include; emergency preparedness procedures, job-specific roles, emergency communication plans, Rainbow Chart, and location of emergency supplies and equipment.

The Human Resources Department conducts the general orientation program and is responsible for scheduling, managing and documenting staff completion.

New staff members also receive a department-specific orientation. Each department manager or Clinical Staff Educator (CSE) provides new staff members with a department-specific orientation to their role in the Emergency Management Program. Information specific to the Emergency Management Program is included in the continuing education program. The ED/Disaster Manager in coordination with the Disaster Committee, collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Exercise Program

NIHD will test its plan and operational readiness at least twice per year, utilizing high hazard scenarios per the HVA. NIHD will participate in a community full scale exercise at least annually; if such exercise opportunity is accessible. If not accessible, the hospital will conduct a full scale exercise. NIHD will also conduct one additional exercise of any type at least annually.

All exercises and real events will be documented using the AAR template. This report shall be completed within 60 days of the exercise or real event. The ED/Disaster Manager will be responsible for coordinating the exercises, after action reporting, and improvement planning. The AAR or improvement plan will be incorporated into the emergency plan as soon as it is feasible. All improvement items will be tracked.

All exercises will incorporate elements of the National Incident Management System and Hospital Incident Command System. Future exercises should be planned and conducted to reflect anticipated hazards, incorporating gaps and improvement action items identified during previous exercises and real events.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 are available to all healthcare district personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident.

DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.
b. **Emergency Operations Plan (EOP)** – The program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.
c. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.
d. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIH or on the ability of NIH to conduct normal patient care and business activities.

REFERENCES:

1. California Office of Emergency Services (CALOES), (2023) https://www.caloes.ca.gov/

2. Federal Emergency Management Agency (FEMA), ICS-100: Introduction to Incident Command System, (2023) https://www.fema.gov/national-incident-management-system

3. Joint Commission Resources, (2023) Emergency Management in Healthcare: An All Hazards Approach. https://www.jointcommission.org/resources/patient-safety-topics/emergency-management

4. Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), (2023) Emergency Management Reference Guide https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

5. Centers for Medicare Services (2023) 1135 Waivers Emergency Preparedness https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135Waivers

CROSS REFERENCED POLICIES AND PROCEDURES:

1. HICS Organization Chart
2. Credentialing Health Care Practitioners in the Event of a Disaster
3. Emergency Room Overcrowding
5. Capacity Management: Patient Surge

6. Evacuation Policy
7. Emergency Response Plan-Medical Gas Failure
8. Emergency Response Plan-HVAC Failure
9. Lockdown Plan
10. Active Shooter
11. Disaster Management Committee
12. Disaster Plan Perioperative Unit
13. Sterile Processing Disaster Plan
14. Triage of Patients Suspected of Ebola
15. Cyber Security Incident Response Manual

RECORD RETENTION AND DESTRUCTION: Emergency Operation Plan documents need to be retained for 15 years.

Supersedes: v.5 Emergency Management Plan

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Pediatrics		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Practitioners Privileged in Pediatrics		
Date Last Modified: 04/27/2023	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/21/2021	

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

POLICY: All practitioners granted privileges in the department of pediatrics will adhere to the following protocols.

PROTOCOL:

1. Call:
    a. Practitioners participating in call coverage shall return phone calls as soon as possible and within 10 minutes and be at bedside as soon as possible and within 30 minutes if needed in an emergency. Non-emergent consults will be completed within 24 hours and within a reasonable amount of time as agreed upon by the pediatric practitioner and the practitioner requesting consult.
    b. All pediatrics patients admitted will be rounded on in the hospital within 24 hours of admission and everyday thereafter.
        i. Healthy term newborns born before 5pm will be examined before the end of the day.
        ii. Healthy newborns born after 5pm may be examined the next day unless nursing or OB provider request sooner assessment.
        iii. Newborns with complications will be examined as soon as reasonably possible or as agreed upon by the pediatric practitioner and the staff member identifying the concern.
        iv. Pediatric patients will have orders placed at the time of admission and be examined prior to admission in the clinic or emergency department.
2. Meeting attendance:
    a. Attend monthly pediatric provider meetings and monthly pediatric team meetings.
    b. Attend additional meetings per medical staff bylaws requirements or assignment to committees.
    c. Advanced Practice Providers (APPs) can vote at pediatric department meetings and vote for department Chief.
3. Credentialing:
    a. Physician practitioners in the department of pediatrics must be board certified or board eligible by the American Board of Pediatrics and are strongly encouraged to be members of the American Academy of Pediatrics.
4. Focused Professional Practice Evaluation (FPPE):
    a. Practitioners new to NIHD will be expected to complete FPPE as per policy. For clinic work FPPE is expected to include at least eight days of chart review of all patients seen. Inpatient work will include chart review of at least the first eight newborn admissions and eight inpatient pediatric admissions.

5. Ongoing Professional Practice Evaluation (OPPE):
    a. Practitioners will be expected to participate in all requirements of OPPE as per medical staff policy. Providers must average eight neonatal encounters and four pediatrics encounters every six months over the OPPE cycle. Every two years at re-credentialing if this average has not been met additional proctoring may be assigned in order to maintain admitting privileges.
6. Peer Review:
    a. Inpatient charts identified by critical indicators will all be subject to peer review as per the peer review policy.
    b. This will include ongoing peer review of 10 outpatient encounter charts each month.
7. Re-Entry:
    a. Pediatric practitioners working in the outpatient clinic setting may be eligible for re-entry per policy. Due to the low volume of inpatient pediatric and nursery patients re-entry in these areas will require training at an outside facility to re-obtain competency.

REFERENCES:

1. None

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCE POLICIES AND PROCEDURES:

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

Supersedes: v.1 Medical Staff Department Policy - Pediatrics

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Plan for the Provision of Nursing Care		
Owner: Chief Nursing Officer-Interim COO	Department: Nursing Administration	
Scope: Nursing Executive Committee		
Date Last Modified: 01/09/2023	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/15/2014	

INTRODUCTION:

The Chief Nursing Officer (CNO) is a Registered Nurse who is responsible for the practice of nursing as detailed in the State of California Nurse Practice Act. An overall Plan for Provision of Nursing Care is developed, implemented, and evaluated by the CNO. Nursing Services supports the Northern Inyo Healthcare District (NIHD) mission statement. Cooperation and coordination of care activities is performed collaboratively with all departments within and outside nursing to support the NIHD patients with the same nursing needs regardless of where they are cared for in the facility.

PURPOSE:

1. The Purpose of the Plan for the Provision of Nursing Care is:
   a. To assure that nursing practice at NIHD is consistent with "nursing" as defined by law and specifically as detailed in the State of California Nurse Practice Act.
   b. To serve as a written document that defines what nursing is and how nursing will be practiced and recognized. This description will be available for hospital administration, all nursing and medical staff, and other health care professionals at NIHD.
   c. To identify for hospital leadership, The Joint Commission (TJC), and other regulatory agencies what constitutes "nursing", and to identify and recognize where nursing is practiced within the hospital. This will also assist the Chief Nursing Officer to explain why a nurse, rather than an alternate health care provider is required in a given position.
   d. To articulate the scope of practice difference between a Registered Nurse (RN), Licensed Vocational Nurse (LVN), and other nursing personnel, especially as it relates to the application of the nursing process.

POLICY:

1. The plan for the Provision of Nursing Care will be evaluated and revised during the annual Nursing NIHD Strategic Planning/Budget Process.
2. Annual and as needed adjustments to the plan for the Provision of Nursing Care will be based on information gathered from the following sources:
   a. Hospital Mission, Vision, Values Statements
   b. Philosophy of Nursing Services
   c. Objectives of Nursing Services

d. Staffing Management Plan
e. Quality Improvement Monitoring/Evaluation Process
f. NIHD Committee Feedback
g. Patient and/or family/caregiver satisfaction feedback
h. Nursing Staff (dialogue sessions)
i. Medical Staff (Medical Executive Committee)
j. Executive Leadership
k. Risk Management
l. Board of Directors

PLAN:

1. The Plan for the Provision of Nursing Care:
    a. Allows for a sufficient number of RN's to plan, delegate, and coordinate nursing care on all nursing departments. RN's will practice the nursing process as defined in the State of California Nurse Practice Act.
    b. Allows for an adequate total number of competently trained nurses and nursing personnel to meet the unique needs for patient's/families and/or significant others to be cared for on each individual nursing department.
    c. Allows for the same level of care to be given to patients with the same nursing care needs regardless of where the patients are cared for in the facility. The quality of care given to all patients will be consistent throughout the hospital based on established standards of patient care and nursing practice.
    d. Supports the improvement of nursing practice based on evidence based standards and patient safety initiatives.

2. Guiding principles used for the development of the Plan for Providing Nursing Care and Supporting nursing structure and process standards include:
    a. Allows for a sufficient number of RNs to plan, delegate, and coordinate nursing care on all nursing departments. RN's will practice the nursing process as defined in the State of California Nurse Practice Act.
    b. Deployment of nursing staff based on patient care hours that establishes a systematic staffing pattern for patient care allowing all members of nursing to function within their skill levels for the maintenance of continuity of nursing care and the management of nursing service.
    c. Promoting progressive nursing practice and research to support changing trends that improve the quality of patient care.
    d. The ability of NIHD to attract and retain the quantity and type of nursing personnel required in the Staffing Management Plan.
    e. Participation of nursing staff on committees, and in formal and informal educational opportunities (including on-going competency testing).
    f. Feedback from Case Management, Patient Safety, QA/PI, Compliance, and other District-wide activities that relate to nursing practice.
    g. Nursing staff involvement in activities that promote improvement, evidence based practice, and/or provisions in the provision of care.
    h. The delivery of nursing care to patients with the same nursing care needs as defined by practice standards will be consistent between departments.

3. Components of the Plan for Providing Nursing Care are:
    a. Philosophy of Nursing
    b. Definition of Nursing
    c. Organization of Nursing Services including organizational charts
    d. Deployment of Staff and Delegation of Responsibility
    e. Staffing Management Plan
    f. Clinical Consistency (Process Standards)
    g. Nursing Standing Committee participations
    h. Nursing Budget
    i. Department specific Defined Method of Practice

REFERENCES:

1. (January 2023). Comprehensive Accreditation Manual for Critical Access Hospitals.
2. TJC Nursing Functional Chapter NR.02.01.01
   The nurse executive coordinates the development of hospital-wide plans to provide nursing care, treatment, and services.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Nursing Services Philosophy
2. Acute/Subacute Care Services Method of Practice: Patient Coordinated Care
3. NIHD Mission Statement (see District Intranet)

RECORD RETENTION AND DESTRUCTION:

The minutes of the Nurse Executive Committee will contain information key to the "Plan for the Provision of Nursing Care" and they shall be maintained for a minimum of 39 months.

Supersedes: v.2 Plan for the Provision of Nursing Care

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Trophon® Environmental Probe Repressor (EPR)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Ultrasound, Perinatal, RHC Women's Clinic, Emergency Department, Infection Prevention		
Date Last Modified: 04/10/2023	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 09/20/18	

PURPOSE:

Provide guidance for achieving high level disinfection (HLD) using the Trophon® EPR in accordance with the manufacturer's recommendations and infection control guidelines.

The sole purpose of the Trophon® EPR is to provide high level disinfect on all ultrasound transducers.

POLICY:

1. High Level Disinfection of the ultrasound probes will be performed after each patient use to ensure it is properly sanitized for the next patient.
2. Trophon EPR system will be used only by trained healthcare professionals.
3. The Trophon EPR system will be used according to manufacturer's safe operation
4. Trophon EPR system and user training will be completed upon hire and annually. District Education to assign in Relias. Departments to receive training is Ultrasound Technicians, RHC Women's Health Clinic, and the Specialty Clinic Registered Nurses and Medical Assistant's.
5. Personal Protective Equipment (PPE) required: gloves and standard precautions
6. The Chemical indicator chart and Trophon EPR user chart must be posted where the Trophon is being utilized.
7. The Trophon® EPR must be left connected to power and switched ON at all times.

DEFINTION:

1. **High-Level Disinfection**: Destruction/removal of all microorganisms except bacterial spores

BACKGROUND:

High level disinfection is the minimal requirement for semi-critical items as outlined by the Spaulding Classification System and the Centers for Disease Control and Prevention (CDC). Semi-critical items are those items that have been exposed to non-intact skin or mucous membranes and should receive a minimum of HLD. High level disinfection must be performed by staff members who have had appropriate training and can demonstrate competency in performing HLD.

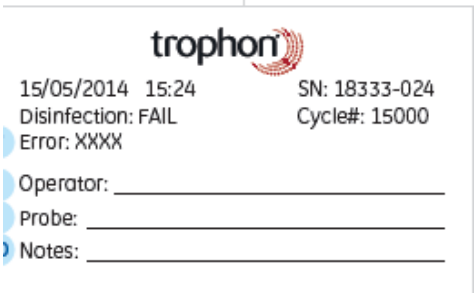
DISINFECTION PROCESS:

At the beginning of the cycle, the Trophon® EPR creates an aerosol of concentrated hydrogen peroxide. This is quickly and evenly distributed over the surface of the probe, including very small crevices. This process provides thorough, high level disinfection of the shaft and the handle of the probe. The device breaks down the hydrogen peroxide into small particles of water and oxygen, and then safely vents them into the external environment. The only required personal protective equipment for this HLD process is clean gloves.

PROCEDURE:

1. PREPARING AND POSITIONING THE PROBE:
   - Don gloves
   - The probe must be pre-cleaned and dried BEFORE the HLD process can commence in the Trophon® EPR. Use a hospital approved alcohol-free cleaning disinfecting wipe, following directions of cleaning and disinfecting product being used, and ensure the cleaner being used is approved by the probe manufacturer.
   - A chemical indicator must be used for each disinfection cycle and can only be used one time. A chemical indicator shall be placed into the holder on the floor of the device chamber.
   - *Load Probe and Indicator* screen message will be displayed when Trophon EPR system is ready.
   - Open chamber door, and use the two clamps to hold the probe securely to the chamber
   - After correctly loading the probe into the chamber the door will automatically lock at the start of the HLD cycle. Note: If door not properly closed a "Close Chamber Door" message will be displayed.
2. DISINFECTING THE PROBE SCREEN MESSAGE
   - If the probe has been pre-cleaned and dried press YES and then Press Start
   - If the probe has not been pre-cleaned and dried press NO, remove probe, clean and dry with approved alcohol-free cleaning disinfecting wipe. Reload probe into chamber
   - High Level Disinfection process will take 7 minutes to complete.
3. REMOVING THE PROBE:
   - When the cycle has been completed, the trophon will sound an audible alarm. Put on gloves and follow the screen instruction message
     - Message 1 Cycle complete, remove and wipe probe
     - Message 2: Attention wear gloves and wipe probe. (This message indicates that some hydrogen peroxide may not be broken down and extra care should be taken when removing the probe.
     - Immediately remove the used Chemical Indicator from the trophon and verify the color change against the chart on the Chemical Indicator carton. Discard Indicator. Record the result using the printer and label.

Sample label:



1. *trophon logo*
2. *Date and time*
3. *trophon EPR serial number*
4. *Disinfection result (PASS)*
5. *trophon cycle number*
6. *Chemical indicator result*
7. *Error code*
8. *Operator name ID (manual entry field)*
9. *Probe information ID (manual entry field)*
10. *Notes (manual entry field)*

 # 10 Notes (manual entry field) to include patients Medical Record Number

- Remove the probe carefully using minimal contact after the cycle is complete. Avoid touching the probe against the chamber's hot surface.
- Wipe the probe with a clean, low lint, absorbent, single-use, dry cloth/ wipe. Visually inspect the probe and ensure any disinfectant residue present is removed.
- If a pass was verified by the Chemical Indicator color AND the trophon screen displayed *cycle complete*, the HLD has been successful. If one or both of these items do not occur, repeat HLD cycle beginning at procedure Step 1

NOTE: *After HLD cycle completion, the trophon performs a rapid cooling cycle until the probe is removed from the chamber to prevent overheating of the probe. If the probe is not removed immediately this will increase the warm-up time required by the subsequent cycle. It is therefore recommended to remove the probe as soon as possible after HLD cycle has been completed.*

4. REMOVING AND DISPOSING OF USED DISINFECTANT CARTRIDGES

NOTE: *Cartridges are punctured at the top and on the side near the bottom when the cartridge door is closed and locked. A small amount of disinfectant may remain in the cartridge, even when it has been fully used. Follow the instructions carefully to avoid injury.*

1. Removing the Cartridge
   - Wear gloves

Screen message: REPLACE THE CARTRIDGE AND CLOSE CARTRIDGE DOOR

NOTE: *Cartridge door opens automatically. DO NOT Force the cartridge door open.*

- Lift the cartridge out by touching the areas exposed while the bottle is in the holder and avoid touching pierced area
- DO NOT shake or change the orientation of the cartridge
- Refer to IFU enclosed with the trophon NanoNebulant for detailed instructions on how to install a new cartridge

2. Disposing of Empty Cartridge
   Empty used cartridges should be disposed of in the nearest waste receptacle or according to the disposal guidelines of your institution
   NOTE: *DO NOT insert empty cartridges into the device*
3. Expired Cartridge containing disinfectant
   - Environmental Services will take to Maintenance Department for disposal.
   - Maintenance Department will follow NIHD procedure for the disposal of corrosive or oxidizing materials.
4. Deformed Cartridge
   - Turn disinfectant cartridge the right way up, to allow the cartridge to degas.
   - Contact your customer service representative.

Note: *After completion of a successful high level disinfection cycle, the ultrasound probe and chamber may have surface temperatures up to 45ºC/ 113ºF and 60ºC/ 140ºF respectively.*

5. SLEEP MODE AND SHUTDOWN PROCEDURES

- The trophon is not used for 120 minutes or a probe has been left inside the trophon for an extended amount of time, it will automatically enter sleep mode in order to save power. To restart the trophon from sleep mode press *Restart.*
- While the trophon is in sleep mode it will perform self-maintenance functions and will display the messages: *Warming Up* or *System Refresh.* Do not switch the trophon off during these processes.
- System refresh during sleep will only occur for low use customers and does not impact the number of disinfection cycles that can be performed per cartridge. This process will typically take 13 minutes.

6. WARM-UP CYCLE:

The warm up cycle prepares the trophon for operation and will begin automatically when the machine is powered on or restarted from sleep.

Screen Message	Approximate Warm Up Time (minutes)
Quick Warm Up	< 2
Warming Up	2–30
Extended Warm Up	> 30

7. PURGE CYCLE:

- Removes any remaining disinfectant from the cartridge and inside the device, this process will take about 35 minutes.
- After completion, remove waste container and empty contents into sink, rinse and dry with a clean cloth.

8. INCOMPLETE OR FAILED CYCLES

- Refer to manual page 19 titled Part D- Troubleshooting

9. ROUTINE CARE AND MAINTENANCE

- Wipe all accessible surfaces of the trophon with a hospital approved alcohol free germicidal wipe

REFERENCES:

1. Society of Diagnostic Medical Sonography. (October 2022). Sonographer Best Practices for Infection Prevention and Control: Reprocessing the Ultrasound Transducer. Retrieved from https://www.sdms.org/docs/default-source/Resources/8756479320933256.pdf
2. Centers for Disease Control and Prevention.(2019) Disinfection and Sterilization, https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html
3. General Electric Healthcare. (2022).Trophon EPR for High Level Disinfection for Ultrasound Probes. Retrieved from https://www.gehealthcare.com/products/ultrasound/ultrasound-transducers
4. Infection Control Today. (2015) Human Papilloma Virus the New Challenge For Infection Prevention. Retrieved fromhttps://www.hkdm.hr/pic_news/files/hkdm/human-papilloma-viruses.pdfJoint

Commission E-dition. February 19, 2023. Infection Prevention and Control (IC.02.02.01 EP 2) The Critical Access hospital reduces the risk of infections associated with the medical equipment, devices and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

CROSS REFERENCE P&P:

1. Endovgainal Ultrasound Probe Storage Transportation and Disinfection
2. **Cleaning and Disinfecting of Transesophageal ECHO (TEE) Probe Using Glutaraldehyde Use Station (GUS) Disinfection Soak Stations**

RECORD RETENTION AND DESTRUCTION:

Supersedes: v.1 Trophon® Environmental Probe Reprocessor (EPR)*

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
Ted Gardner, Treasurer
Jody Veenker, Member-at-Large
Stephen DelRossi, MSA, Interim Chief Executive Officer / Chief Financial Officer
Allison Partridge RN, MSN, Chief Nursing Officer / Chief Operations Officer
Stefan Schunk, MD, Chief Medical Officer

OPPORTUNITY FOR PUBLIC COMMENT

Chair Kilpatrick reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. 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. Comments were heard from:
Jerry McKinzey

NEW BUSINESS

AD HOC COMMITTEE REPORTS

Chair Kilpatrick called attention to Ad Hoc Committee reports.

Jean Turner reported the Governance Committee needs to review Board policies and she proposed bringing them to the whole board a few at a time.

Melissa Best-Baker reported she attended the Finance Committee meeting and most of the items discussed are on this agenda.

CHIEF EXECUTIVE OFFICER REPORT

Chair Kilpatrick introduced the Chief Executive Officer Report. Interim CEO Stephen DelRossi provided updates on the following items:

- Sentinel Event: CEO DelRossi introduced Dr. Schunk, CMO, who stated sentinel events are very rare and when they occur hospitals need to perform immediate investigations. When this sentinel event happened, there was internal suspicion that two results were not matching. NIH staff contacted the affected patients, contacted appropriate agencies, and performed root-cause analysis to look at the incident from start to finish. They identified the exact moment

where specimens were mislabeled, and found a few other points where improvements could be made. Dr. Schunk emphasized there was no provider error, it was a process error. As a result of the investigation, procedures have been implemented to ensure this type of error can never happen again.

- CIP Update: The Pharmacy project is on track to be completed by December 2023 and the Chiller project will be completed by mid-July.
- PMA Building: They are working to move services currently housed in trailers to the PMA building. The building needs a new roof and CEO DelRossi will come back with a request for funds for the new roof next month. Internal Medicine will move to RHC which will provide a 22% increase in reimbursements.
- CEO/CFO Segregation of Duties, check signing: At the last Board meeting a member of the public brought up potential conflict of interest. To mitigate this risk, the Controller will approve all routine expenditures; non-routine expenditures are reviewed and approved through the CNO/COO, CMO, and Director of Human Resources – DelRossi will only authorize in exigent circumstances when the others are not available. Further, CEO DelRossi stated he includes the Executive Team in every decision.

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

2022 AUDIT RESULTS

David Showalter, Eide Bailly presented the 2022 Audit results.

FINANCIAL & STATISTICAL REPORTS

CFO DelRossi reviewed the financial and statistical reports. He stated the hospital has lost $25M this year. However, the whole turnaround program was implemented as of May 1, 2023 and it will show a return and start building over the next 60-75 days.

It was motioned by Melissa Best-Baker to approve the financial and statistical reports, seconded by Jody Veenker and the motion passed 5-0.

TAG UPDATE

CFO DelRossi provided an update on TAG:

- The reduction in force has yielded $1.5M in savings. The Revenue Sub-Committee is working on enhancements which have generated $2.5M in revenues to date with a target of $20M.

MED-PLAN/HAUGE IMPLEMENTATION

CFO DelRossi reported cash flow will start to increase as a result of the Med-Plan/Hauge implementation.

CLA SCOPE OF WORK

CFO DelRossi reported he vetted four audit firms. He would like to move forward with CliftonLarsonAllen LLP (CLA) for the 2023 financial audit.

Melissa Best-Baker motioned to approve retaining CLA for the 2023 audit, Jody Veenker seconded, and the motion passed 5-0.

APPROVAL OF SIGNERS FOR FINANCIAL NORTHEASTERN COMPANIES

CFO DelRossi brought attention to the corporate resolution for FNC who holds the District's CDs. Allison Partridge, Alison Murray and Stephen DelRossi need to be added to the signature sheets.

Jean Turner motioned to approve Allison Partridge, Alison Murray and Stephen DelRossi as signers for FNC, Melissa Best-Baker seconded, and the motion passed 5-0.

RSM UPDATE

Chair Kilpatrick called attention to RSM Update. CFO Stephen DelRossi reported RSM has helped the District see an increase in cash. Michael Brown provided an update. There are six weeks left in their engagement. During the remaining time they will provide technical training on Cerner and will create training vignettes for all key staff involved in revenue cycle which will be available in Relias.

PIONEER HOME HEALTH

Chair Kilpatrick called attention to Pioneer Home Health. Noel Caughman stated this is the final piece of a long process and there will no longer be any affiliation between the two entities.

Jody Veenker motioned to approve items E-a, b, and c, Amended and Restated Articles of Incorporation for Pioneer Home Health Inc, Amended Bylaws for Pioneer Home Health Inc, and Memorandum of Understanding for Un-Affiliation as presented, Jean Turner seconded, and the motion passed 5-0.

PENSION PLAN CHANGES

Chair Kilpatrick called attention to pension plan changes. Alison Murray presented Resolution 2023-04, Amendment No. 2 and Amendment No. 6.

Jean Turner motioned to approve items F-a, b, and c, District Board Resolution 2023-04 Authorizing Implementation of the Provisions of Section 414(h)(2) of the Internal Revenue Code to Tax Defer Employee Retirement Contributions to the Northern Inyo County Local Hospital District Retirement Plan, Amendment No. 2 to the Northern Inyo Healthcare District 401(a) Retirement Plan, and Amendment No. 6 to the Northern Inyo County Local Hospital District Retirement Plan as presented, Ted Gardner seconded, and the motion passed 5-0.

CHIEF OF STAFF REPORT

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

EXTENSION OF TEMPORARY PRIVILEGES FOR GOOD CAUSE

Dr. Bourne introduced the extension of temporary privileges for good cause.

Jody Veenker motioned to approve the extension of temporary privileges

for good cause, Mary Mae Kilpatrick seconded, and the motion passed 5-0.

POLICIES AND PROCEDURES

Dr. Bourne provided an overview of the policies and procedures for approval.

a. *Bloodborne Pathogen Exposure Control Plan*
b. *Discharge Planning for Homeless Patients*
c. *Discharge Planning for the Hospitalized Patient*
d. *Interdisciplinary Plan of Care Coordination*
e. *Management of Discharge Disputes from Medicare Patients*
f. *Plan for the Provision of Social Services at NIHD*
g. *Standardized Procedure – General Policy for the NP or CNM*
h. *Standardized Procedure for Admission of the Well Newborn*
i. *Standardized Procedures for Medical Functions by RN in the Emergency Department*
j. *Standardized Protocol – Adult Health Maintenance for the Physician Assistant*
k. *Utilization Review Plan*
l. *Access to ePHI by Third Party*
m. *Informed Consent Policy – Practioner's Responsibility*
n. *Medical Staff Department Policy – Outpatient Medicine*
o. *Patient Rights and Responsibilities*

Melissa Best-Baker motioned to approve the policies as written, Jody Veenker seconded, and the motion passed 5-0.

MEDICAL EXECUTIVE COMMITTEE REPORT

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

CONSENT AGENDA

Chair Kilpatrick called attention to the consent agenda which contained the following items.

1. *Approval of minutes of the April 19, 2023 Regular Board Meeting*
2. *Chief Nursing Officer/Chief Operations Officer Report*
3. *Chief Medical Officer Report*
4. *Compliance Department Quarterly Report*
5. *Department Reports*

Ted Gardner motioned to approve the Consent Agenda with the stated correction to the minutes of the April 19, 2023 Regular Board Meeting, Jody Veenker seconded, and the motion passed 5-0.

REPORTS FROM BOARD MEMBERS

Chair Kilpatrick opened up reports to Board Members.
Chair Kilpatrick reported she had the honor of installing new officers to the Ladies Auxiliary.

ADJOURNMENT Adjournment at 7:21 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

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

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

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: 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 AND PROCEDURE

Title: DI Timeliness for Critical Results*		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Radiologist		
Date Last Modified: 08/05/2021	Last Review Date: 08/05/2021	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/01/2013	

PURPOSE:

As a Critical Access Hospital we are required to define the acceptable length of time for reporting critical results to the ordering physician (provider).

POLICY:

The Radiologist, or radiologist's designee, shall communicate critical results to the ordering physician (provider) within 1 hour of determining the results of the test.

In the event that the provider is unavailable in the timeframe set out in this program, an agent (nurse or provider's staff member) may be notified.

The following tests and results will be tracked for monitoring of critical result delivery trends.

Critical Tests that fall under the policy are:

- CT Brain
- Nuclear Medicine VQ scans or CT Pulmonary Angiogram
- OB Ultrasound
- Myocardial Perfusion Imaging

Critical Results that fall under this policy are new or acute findings of the following:

- Intracranial Hemorrhage
- Subdural Hematoma
- Pulmonary Embolus
- Critical AFI (Amniotic Fluid Index) (below 6)
- Reversible Perfusion Defect

All results that fall under this policy shall be tracked, trended and reported to the Medical Staff and NIH Performance Improvement Committee.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

Supersedes: v.3 DI Timeliness for Critical Results*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: DI - NM P&P - Daily Area Surveys		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Nuclear Medicine		
Date Last Modified: 12/06/2022	Last Review Date: 06/16/2022	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12-02-2015	

PURPOSE:
To provide guidance to the technologist to ensure that radiation exposure levels, in areas used by nuclear medicine, are checked daily.

POLICY:
Daily surveys shall be done, with a GM survey meter, at the end of each normal workday, when radioactive materials are in use, to check for areas of contamination.

PROCEDURE:
- Using a GM survey meter, survey the hot lab, injection area and waiting area (BKG).
- These surveys are recorded in mR/hr at the bottom of the dose dispensation log.
- Areas outside the hot lab that are more than twice background should be checked for removable contamination (wipe test.) Areas of contamination should be cleaned and resurveyed.

REFERENCES:
- 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,
- 10 CFR 35

RECORD RETENTION AND DESTRUCTION: Duration of license +30 years

CROSS REFERENCED POLICIES AND PROCEDURES:
- Radiation Safety Plan
- DI – NM P&P – Area Surveys and Wipe Tests

Supersedes: v.1 DI NM Daily Area Surveys

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: DI - MRI Safety Plan		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: All Hospital Staff		
Date Last Modified: 04/21/2022	Last Review Date: 06/16/2022	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 07-25-2005	

Introduction

MAGNETIC RESONANCE (MR) Safety Manual's purpose is to establish MR safe practices from a growing awareness of the MR environment's potential risks and adverse events involving patients, equipment, and personnel. The American College of Radiology (ACR) manual on MR Safety remains the key document on industry standards for safe and responsible guidelines in clinical MR environments. Northern Inyo Healthcare District (NIHD) MR department's intent is to follow ACR Guidance Document on MR Safe Practices from 2020. The intent of this plan and cross referenced procedures is to assist NIHD staff, physicians, and departments to help prevent adverse staff and patient outcomes relating to medical procedures in MRI.

A. Establish, Implement, and Maintain Current MR Safety Policies and Procedures:

1. NIHD's MR Department will maintain and implement safety procedures regarding our current GE Signa 1.5-tesla magnet. This MRI safety plan is directly associated with and inclusive of all MRI Safety Procedures listed in the cross referenced policy and procedures section of this plan.
2. Cross referenced procedures will be reviewed annually as part of this MRI Safety Plan.
3. Cross referenced procedures and MRI Safety Plan will be reviewed with the introduction of any significant changes in safety parameters of the MR site (e.g., adding faster or stronger gradient capabilities, higher RF duty cycle studies, etc.)
4. NIHD's Magnetic Resonance Medical Director(MRMD) is responsible for ensuring that MR safe guidelines and operations are established and maintained as current and appropriate for the site. The MRMD shall be responsible for the formulation and application of policies and procedures that ensure the safety of patients, MRI staff, and others in the MRI environment.
5. The MRMD is responsible to delegate MRI safety-related tasks to the Magnetic Resonance Safety Officer (MRSO) who is responsible for the day-to-day implementation of the site's safety policies.
6. The MRSO must be trained and experienced in MRI and MRI safety, but need not be a medical physician. It is the responsibility of the site's administration to ensure that the policies and procedures that result from these MR safe practice guidelines are implemented and adhered to at all times and by all of the site's personnel.

7. Procedures will be in place to ensure that any and all adverse events, MR safety incidents, or "near incidents" that occur in the MR suite are reported to the MRMD in a timely manner and used in continuous quality improvement efforts. MRI incidents will be reported to the Radiology Services Committee through the Radiation Safety / MR Safety Committee meeting.

REFERENCES:

MRI Safety References

1. ACR Manual on MRI Safety (2020 edition)
2. Dr. Kanal, Emmanual "Kanal's MRMD/MRSO MR Safety Training Course – Orlando, FL". Nov 3, 2019 – Nov 6, 2019. North West Imaging Forums, INC.
3. Kanal E, Barkovich AJ, Bell C, et al. ACR guidance document on MR safe practices: 2007. AJR AM J Roentgenol 2007;188:1447-1474
4. Kanal E, Barkovich AJ, Bell C, et al. ACR guidance document on MR safe practices:2013. J Magn Reson Imaging 2013;37;501-530.
5. U.S. Department of Health and Human Services Food and Drug Administration,
6. Center for Devices and Radiological Health. Criteria for significant risk investigations of magnetic resonance diagnostic devices.Guidance for industry and Food and Drug Administration staff.
7. International Commission on Non-Ionizing Radiation Protection. Guidelines on limits of exposure to static magnetic fields. Health Phys 2009;96:504–514.
8. The Joint Commission: Diagnostic imaging requirements, issued August 10, 2015. Available at https://www.jointcommission.org/diagnostic_imaging_standards/.
9. The ACR Guidance Statement on MR Safe Practice, issued 2013, 2018, 2019 https://www.acr.org/Clinical-Resources/Radiology-Safety/MR-Safety

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI - MRI Safety - Burn/Thermal Incident Reduction Policy
- DI - MRI Safety – Special Patient Population Management
- DI – MRI Safety – Noise Protection
- DI – MRI Safety – Patient and Caretaker Screening
- DI – MRI Safety – MRI Access Control – NIHD Staff
- DI – MRI Safety – MRI Safety Organizational Structure
- DI – MRI Safety – NIHD Specific Zone Identification
- Cylinder Safe Handling

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: DI - NM P & P - Area Surveys and Wipe Tests		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Nuclear Medicine		
Date Last Modified: 12/06/2022	Last Review Date: 06/16/2022	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 01-19-2016	

PURPOSE:
The purpose of this guideline is to provide guidance for the nuclear medicine technologist to ensure that there are no areas of contamination (exposure level and removable contamination) in the nuclear medicine department on a regular basis.

POLICY:
Area surveys shall be performed with a GM survey meter in multiple areas of the nuclear medicine department to check for radiation exposure levels, weekly.
Wipe tests shall be taken in multiple areas of nuclear medicine to check for removable contamination, weekly.

PROCEDURE:
Area Surveys:
Using a GM survey meter, survey the designated areas in which radioactive materials are used or stored (see ASWT maps).
All surveys should be taken at waist height or 4" above the surface.
All surveys are recorded in mR/hr on the weekly ASWT form.
Surveys must be less than 0.05 mR/hr in unrestricted areas and less than 2.0 mR/hr in restricted areas.
Wipe Tests:
Using a cotton swab for each area, wipe the designated areas in which radioactive materials are used or stored (see ASWT maps).
The swabs are placed in plastic tubes and counted for activity in the well counter.
All results are recorded in dpm/cm2 on the ASWT form (located in nuclear medicine department). Any area with a wipe count over 2000 dpm/cm2 needs to be decontaminated and rewiped, repeating the process until the wipe test is less than 2000 dpm/cm2.

REFERENCES:
- 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,
- 10 CFR 35

RECORD RETENTION AND DESTRUCTION: Duration of license +30 years

CROSS REFERENCED POLICIES AND PROCEDURES:
- Radiation Safety Plan
- DI – NM P&P – Daily ~~wipe tests~~Area Surveys

Supersedes: v.1 DI NM Area Surveys and Wipe Tests*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Radiology Technologists		
Date Last Modified: 12/06/2022	Last Review Date: 06/16/2022	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12-13-2016	

PURPOSE: To define radiation events and radiation exposures in Computed Tomography (CT), Nuclear Medicine (NM), and fluoroscopy that are recordable or reportable to regulatory and accreditation bodies; To outline the process for investigation and reporting of these events

DEFINITIONS:

Action Plan - The product of the root cause analysis, which identifies the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future.

Byproduct material – any radioactive material (except enriched uranium or plutonium) produced by a nuclear reactor; material that has been made radioactive through the use of a particle accelerator or any discrete source of radium-226 used for commercial, medical, or research activity.

CT scan - axial or helical acquisition acquired on computed tomography equipment

CT study – Scan(s) of a region of interest intentionally acquired for a single diagnosis, does not include repeat imaging due to operator or machine error; (CT Study and Examination are used interchangeably in CDPH RHB regulations)

Effective Dose – reflects the risk of a non-uniform exposure in terms of an equivalent whole body dose; quantity defined in ICRP Publication 60 as a weighted sum of equivalent doses to all relevant tissues and organ with the purpose "to indicate the combination of different doses to several different tissues in a way that is likely to correlate well with the total of the stochastic effects". This is, therefore, applicable even if the absorbed dose distribution over the human body is not homogeneous. The unit is the joule per kilogram ($J\ kg^{-1}$) and is given the special name sievert (Sv). Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

Examination – One or more scans of a region of interest intentionally acquired for a single diagnosis, performed during a single visit/appointment, does not include repeat imaging due to operator or machine error (CT Study and Examination are used interchangeably in CDPH RHB regulations)

Organ dose - quantity defined in ICRP Publication 60 in relation to the probability of stochastic effects (mainly cancer induction) as the absorbed dose averaged over an organ, i.e., the quotient of the total energy imparted to the organ and the total mass of the organ. The unit is the joule per kilogram and is given the special name gray (Gy). Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

Patient movement or interference – voluntary or involuntary movement by the patient; patient, patient family, or other caregiver interference interrupting or disrupting study; abnormal patient anatomy or injury requiring additional scan when routine procedures were followed but did not provide adequate imaging of area of interest

Radiology Report – formal documented interpretation of diagnostic test

Rad - One of the two units used to measure the amount of radiation absorbed by an object or person, known as the "absorbed dose" which reflects the amount of energy that radioactive sources deposit in materials through which they pass. The radiation-absorbed dose (rad) is the amount of energy (from any type of ionizing radiation) deposited in any medium (e.g., water, tissue, air). An absorbed dose of 1 rad means that 1 gram of material absorbed 100 ergs of energy (a small but measurable amount) as a result of exposure to radiation. The related international system unit is the gray (Gy), where 1 Gy is equivalent to 100 rad.

REM - One of the two standard units used to measure the dose equivalent (or effective dose), which combines the amount of energy (from any type of ionizing radiation that is deposited in human tissue), along with the medical effects of the given type of radiation. For beta and gamma radiation, the dose equivalent is the same as the absorbed dose. By contrast, the dose equivalent is larger than the absorbed dose for alpha and neutron radiation, because these types of radiation are more damaging to the human body. Thus, the dose equivalent (in rems) is equal to the absorbed dose (in rads) multiplied by the quality factor of the type of radiation [see Title 10, Section 20.1004, of the *Code of Federal Regulations* (10 CFR 20.1004), "Units of Radiation Dose"]. The related international system unit is the sievert (Sv), where 100 rem is equivalent to 1 Sv.

Recordable event – an event involving radiation or radioactive material where radiation or a radiopharmaceutical is administered without a written directive where a written directive is required; a radiopharmaceutical or radiation where a written directive is required without daily recording of each administered radiopharmaceutical dosage or radiation dose in the appropriate record; event is recorded, investigated, reviewed by Radiation Safety Committee and documentation maintained by facility

Reportable event – an event involving radiation or radioactive material where the dose or exposure meets the standards or is associated with significant deviation from the usual processes as outlined by regulatory and/or accreditation bodies; event is recorded, investigated, reviewed by Radiation Safety Committee; documentation maintained by facility and reported to regulatory and/or accreditation bodies

Root Cause Analysis - A root cause analysis is defined as a process for identifying the basic and casual factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause is the most fundamental reason a problem (a situation where performance does not meet expectation) has occurred.

Sievert (Sv) = 100 rem

Single field – as it relates to fluoroscopy, single field refers to a location on the skin through which the stationary fluoroscopic beam is directed.

Shallow dose to skin - The external exposure dose equivalent to the skin or an extremity at a tissue depth of 0.007 centimeters (7 mg/cm^2) averaged over an area of 1 square centimeter. Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

POLICY:

1. Except for an event that results from patient movement or interference, NIH shall report to the California Department of Public Health Radiologic Health Branch (CDPH RHB) an event in which the administration of radiation results in any of the following:

   A. Repeating of a CT examination, unless otherwise ordered by a physician or a radiologist, if one of the following dose values is exceeded:
      a. 0.05 Sv (5 rem) effective dose.
      b. 0.5 Sv (50 rem) to an organ or tissue.

c. 0.5 Sv (50 rem) shallow dose to the skin.

B. A CT examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.
b. 0.5 Sv (50 rem) to an organ or tissue.
c. 0.5 Sv (50 rem) shallow dose to the skin.

C. A CT for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.
b. 0.5 Sv (50 rem) to an organ or tissue.
c. 0.5 Sv (50 rem) shallow dose to the skin.

D. CT or fluoroscopic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

E. A CT dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

NIH shall, no later than **five business days** after the discovery of an event described in section 1, paragraph E, and no later than **10 business days** after discovery of an event described in section 1, paragraphs A to D, provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

2. NIH shall record any of the following events, except for an event that results from patient intervention, in which the administration of byproduct material or radiation from byproduct material *does not* result in a dose that exceeds 0.05 Sv (5 rem) effective dose equivalent, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) shallow dose equivalent to the skin:

A. An administration of a wrong radioactive drug containing byproduct material;
B. An administration of a radioactive drug containing byproduct material by the wrong route of administration;
C. An administration of a dose or dosage to the wrong individual
D. An administration of a dose or dosage delivered by the wrong mode of treatment; or
E. A leaking sealed source.

Recordable events involving byproduct material shall be documented as outlined in the procedure section of this policy. Recordable events shall be discussed and analyzed in the NIH Radiation Safety Committee. Discussion shall be documented in the minutes, as should actions taken, if any.

3. NIH shall report any event, except for an event that results from patient intervention, in which the administration of byproduct material or radiation from byproduct material results in a dose that exceeds 0.05 Sv (5 rem) effective dose equivalent, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) shallow dose equivalent to the skin from any of the following:

A. An administration of a wrong radioactive drug containing byproduct material;
B. An administration of a radioactive drug containing byproduct material by the wrong route of administration;
C. An administration of a dose or dosage to the wrong individual
D. An administration of a dose or dosage delivered by the wrong mode of treatment; or

E. A leaking sealed source.

NIH shall report any event resulting from intervention of a patient in which the administration of byproduct material or radiation from byproduct material results or will result in unintended permanent functional damage to an organ or a physiological system, as determined by a qualified physician.

NIH shall notify by telephone the CDPH RHB **no later than the next calendar day** after discovery of the medical event described in section 3. NIH shall provide notification of the event described in section 3 to the referring physician and also notify the individual who is the subject of the medical event no later than **24 hours** after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful.

NIH shall submit a written report to the CDPH RHB (RAM section) within **15 days** of discovery of the medical event described in section 3. The written report may not contain the individual's name or any other information that could lead to the identification of the individual. NIH shall annotate the individual's name and identification number to the report and provide the annotated report to the referring physician within **15 days** of the discovery of the event.

4. Except for an event that results from patient movement or interference, NIH shall report to the California Department of Public Health Radiologic Health Branch (CDPH RHB) an event in which the administration of radiation results in any of the following:

A. A fluoroscopic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

NIH shall, no later than **10 business days** after discovery of an event described in section 4 provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

5. NIH shall report to the Joint Commission any cumulative fluoroscopic exposure of 1500 rads or more to a single field of skin. The Joint Commission defines "cumulative" for the purposes of this event as "dose over a period of six months to a year."

PROCEDURE:

1. Any potential reportable/recordable event is to be reported immediately to the Chief Performance Excellence Officer or Administrator. Upon notification, this individual, or designee, will direct an initial investigation to determine if the occurrence is indeed a reportable/recordable event as defined by this policy.

2. A Medical Radiation Physicist shall be consulted for dose and exposure calculations and methodology.

3. Upon determination that a reportable/recordable event has occurred, the Chief Performance Excellence Officer or Administrator will notify the Chief of Staff or his/her representative.

4. A team is to be formed to respond to a reportable/recordable event. The team should include, but not necessarily be limited to, the following:
    a. Appropriate representatives of Administration, Medical Staff, Safety, Performance Improvement, and departments directly involved in event.

    b. Those individuals directly involved in the event.

5. The team will undertake those actions necessary to remediate any immediate threat or likelihood of the sentinel event/unusual occurrence recurring.

6. The team will follow the actions outlined in the PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure.

7. Joint Commission shall be notified as deemed appropriate by the team and Administration.

8. Once a **recordable event** has been identified, the following steps shall be taken:

    a. The technologist involved in the recordable event shall complete a hospital incident report.
    b. The employee, supervisor and department director shall sign the incident report.
    c. Notify the Radiation Safety Officer immediately.
    d. Notify the ordering physician immediately.
    e. Make a copy of the following items to be placed in the "Recordable Events" file in the Nuclear Medicine Department:
        i. Signed physician order
        ii. Patient's facesheet
        iii. A description of the occurrence in full detail, including names of all involved
        iv. A description of what was done as follow-up to the incident
        v. Review action plan, if developed
    f. The Radiation Safety Committee shall analyze the situation at the quarterly meeting and document actions taken, if any.

9. Once a **reportable event** involving CT or fluoroscopy has been identified, the following steps shall be taken:
    a. NIH shall, no later than five business days after the discovery of an event described in section 1, paragraph 5, and no later than **10 business days** after discovery of an event described in section 1, paragraphs 1 to 4, provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

    b. The information provided to the CDPH RHB should include the following:
        i. Radiation generating equipment specifics (i.e. manufacturer, model number, and software version)
        ii. Radiation generating equipment settings
        iii. Operator's name
        iv. Patient's physician name and contact information
        v. Copy of physician's order for CT or fluoroscopic exam
        vi. Explanation as to reason for reporting event
        vii. Prepared internal investigation reports (include cause and corrective action to prevent reoccurrence), as appropriate
        viii. Patient dose calculations (include methodology)
        ix. Copies of letters sent to the patient and physician

    c. Notify CDPH RHB of CT and fluoroscopic events via letter to the following address:
        i. Chief X-Ray ICE
        Event Notification
        Radiologic Health Branch
        California Department of Public Health
        P.O. Box 997414, MS 7610
        Sacramento, CA 95899-7414

        ii. Overnight address:
        Chief X-Ray ICE

Event Notification
Radiologic Health Branch
California Department of Public Health
1500 Capitol Avenue, MS 7610
Sacramento, CA 95814

d. The Radiation Safety Committee shall analyze the situation and action plan at the quarterly meeting and document actions taken, if any.

10. Once a **reportable event** involving byproduct material has been identified, the following steps shall be taken:
    a. The technologist involved in the reportable event shall complete a hospital incident report.
    b. The employee, supervisor and department director shall sign the incident report.
    c. Notify the Radiation Safety Officer and NIH administration immediately.
    d. Notify the CDPH RHB no later than the next calendar day following discovery.
    e. Notify the ordering physician.
    f. Submit, within **15 days,** a written report to CDPH RHB including:
        i. Facility's (licensee's) name
        ii. The name of the prescribing physician
        iii. A brief description of the event
        iv. Why the event occurred
        v. The effect, if any, on the individual(s) who received the administration
        vi. What actions, if any, have been taken or are planned to prevent recurrence
        vii. Certification that the licensee notified the individual (or the individual's responsible relative or guardian), and if not, why not.
        viii. The report may not contain the individual's name or any other information that could lead to identification of the individual.
    g. NIH shall provide notification of the event to the referring physician and also notify the individual who is the subject of the medical event no later than **24 hours** after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful. The licensee is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within 24 hours, the licensee shall notify the individual as soon as possible thereafter. The licensee may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the medical event, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual (who is the subject of the medical event) may be made to that individual's responsible relative or guardian. If a verbal notification is made, the licensee shall inform the individual, or appropriate responsible relative or guardian, that a written description of the even can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.
    h. NIH shall:
        i. Annotate a copy of the report provided to the CDPH RHB with the:
            1. Name of the individual who is the subject of the event; and
            2. Social security number or other identification number, if one has been assigned, of the individual who is the subject of the event; and
            3. Provide a copy of the annotated report to the referring physician no later than **15 days after** the discovery of the event.
    i. Notify CDPH RHB of RAM/byproduct material events via letter to the following address:
        Department of Public Health
        Radiologic Health Branch
        California Department of Public Health
        500 S Kraemer Blvd.
        Radioactive Materials, Suite 235

Brea, CA 92821

j. The Radiation Safety Committee shall analyze the situation and action plan at the quarterly meeting and document actions taken, if any.

11. Records of reportable and recordable events shall be maintained at the facility in the custody of the Radiation Safety Committee for the life of the patient plus 10 years.

REFERENCES:

- CA SB 1237, Health and Safety Code Section 115113
- NRC Regulations, 10 CFR 35.3045
- The Joint Commission Sentinel Event Alert, Issue 47, August 24, 2011
- CA-RHB Radiologic Technology Certification Committee Meeting Minutes, October 23, 2013
- Russell, L. & Pizzutiello, B. Radiation Safety Webinar on California State Law and Joint Commission Sentinel Event Alert #47. CDPH-Radiologic Health Branch.
- CDPH RHB, Information Notice Regarding Senate Bill (SB) 1237, California Health and Safety (H & S) Code Section 115113. 14 Jan 2011.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE P&P:

- PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure
- DI – Radiation Safety Committee Charter
- DI – ALARA Program

Supersedes: v.1 DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*