Northern Inyo Healthcare District

Board Meetings

March 15, 2023 Regular Board Meeting

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

March 15, 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 comments on closed session items.
3. Adjournment to Closed Session to/for:
    a. Discussion of Public Employment (Gov. Code § 54957(b)(1))
    Title: CEO Candidate
    b. Conference with Labor Negotiators (Gov. §54957.6) Agency Designated Representative:
    Northern Inyo Healthcare District Human Resources Director
    Unrepresented Employee: CEO Candidate
4. Return to open session and report on any actions taken in closed session.
5. ***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.

6. New Business:
   A. Ad Hoc Committee Reports
      a. Governance (Jean Turner)
      b. HR (Mary Mae Kilpatrick)
      c. Finance (Melissa Best-Baker)
      d. Compliance (Jody Veenker)
   B. Chief Executive Officer Report
   C. Chief Financial Officer Report
      a. Financial & Statistical Reports (*Board will consider the approval of these reports*)
      b. RSM Update *(Board will receive this report)*
      c. TAG Update *(Board will receive this report)*
      d. Audit Firm Discussion (*Board will consider the approval of staff's recommendation*)
   D. Interim CEO Remote Work Days
      a. The following dates are approved for Interim CEO Chadwick to work remotely in accordance with his agreement. *(Board will consider approval of the Interim CEO's remote work days)*
         - 12/23/2022 – 12/30/2022
         - 1/23/2023 – 1/27/2023
         - 2/28/2023 – 3/2/2023
         - 3/27/2023 – 3/31/2023
   E. Interim CEO Contract Extension, Alison Murray *(Board will consider approval of the Interim CEO's contract extension)*
   F. Board Education, Noel Caughman
      a. Med Staff / Hospital Structure *(Board will receive this information)*
   G. Symplr Contract Software, Stephen/Patty
      a. Return on Investment presentation (*Board will consider the approval of this software purchase)*
7. Chief of Staff Report, Sierra Bourne MD:
   A. Medical Staff Appointments 2023 – 2024 *(Board will consider the approval of these Medical Staff Appointments)*
      a. Lucienne Bouvier, MD *(obstetrics & gynecology)* – Active Staff
      b. Darren Dennis, PA-C *(physician assistant, family practice)* – APP Staff

c. Daniel Kirkham, MD *(radiology)* – Courtesy Staff
d. Shawn Marvin, MD *(radiology)* – Telemedicine Staff
e. Aviva Regev, MD *(anesthesiology)* – Courtesy Staff

B. Medical Staff Appointments 2023 – 2024 Proxy Credentialing *(Board will consider the approval of these Medical Staff Appointments)*
   a. Mike Khieu, MD *(cardiology, Renown)* – Telemedicine Staff
   b. Rahesh Vaid, MD *(radiology, Quality Nighthawk)* – Telemedicine Staff

C. Additional Privileges *(Board will consider the approval of these additional privileges)*
   a. Carolyn Tiernan, MD– *(emergency medicine)* – privileges in Advanced Wound Care

D. Change in Staff Category *(Board will consider the approval of this change in staff category)*
   a. Michael Dillon, MD– *(emergency medicine)* – change from Active to Honorary Staff

E. Medical Staff Resignations *(Board will consider the approval of these Medical Staff Resignations)*
   a. Jon Bowersox, MD (*general surgery*) – effective 01/31/2023
   b. Geoffrey McWilliams, MD (*radiology*) – effective 12/29/2022
   c. Carolyn Saba, MD *(anesthesiology)* – effective 01/31/2023
   d. Leena Sumitra, MD (*psychiatry*) – effective 12/31/2022

F. New Privilege Forms *(Board will consider the approval of these new privilege forms)*
   a. Nurse Practitioner – Psychiatry
   b. Neurology

G. Policies (*Board will consider approval of these policies*)
   a. *Direct Notification of Abnormal Microbiology Findings*

H. 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.

8. Approval of minutes of the February 8, 2023 Special Board Meeting *(Board will consider the approval of these minutes)*
9. Approval of minutes of the February 15, 2023 Regular Board Meeting *(Board will consider the approval of these minutes)*
10. Approval of minutes of the February 21, 2023 Special Board Meeting *(Board will consider the approval of these minutes)*
11. Chief Medical Officer Report *(Board will consider accepting this report)*
12. Compliance Department Quarterly Report (*Board will consider the accepting this report)*

13. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*
    a. *Use of Hospital Issued Notice of Noncoverage (HINN)*
    b. *Verifying and Securing Authorizations*
    c. *Advance Beneficiary Notice (ABN)*

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14. Reports from Board Members (*Board will provide this information*)
15. 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

January 2023 – Financial Summary

	MONTH	PY Month	YTD	PY Month
IP Gross Revenue	3,898,882	3,708,290	22,925,035	21,964,037
OP Gross Revenue	11,943,811	8,803,380	83,911,478	74,159,531
Clinic Gross Revenue	1,552,193	1,448,892	9,775,470	8,285,713
Net Patient Revenue	6,362,614	7,143,445	46,221,892	54,090,928
IP Days:	273	279	1,530	1,565
IP Days w/o Newborns	247	252	1,366	1,399
OP Visits	3,647	3,513	25,420	25,570
RHC Visits	2,816	3,426	18,592	19,700
NIA Clinics				
Surgeries IP	19	18	135	133
Surgeries OP	108	4	703	595
Diagnostic Imaging	1,999	1,895	14,160	13,672
Emergency	753	724	5,779	5,082
Rehab	77	120	579	887
Nursing Visits	248	338	1,782	2,031
Observation Hours	1,738		12,692	

REVENUE

Payor mix

Blue Cross	8.8%	12.5%	18.4%	20.0%
Commercial	9.9%	6.5%	6.0%	4.9%
Medicaid	24.2%	21.9%	26.0%	30.0%
Medicare	54.9%	58.4%	46.8%	42.7%
Self-pay	0.4%	0.7%	2.7%	2.0%
Workers' Comp	0.0%	0.0%	0.1%	0.3%

Deductions

Contract Adjust	7,536,311	6,081,113	56,811,330	46,476,550
Bad Debt	687,018	599,855	7,981,117	3,485,112
Write-off	380,030	211,549	3,223,053	967,427
Other	2,429,480	91,039	2,410,954	517,077

Other deductions is favorable due to a gain in the Hospital Quality Assure Revenue Fund receipts. This category is moving from deductions to other revenue.

CENSUS

Patient Days	273	279	1,530	1,565
Adjusted Days	1,218	1,050	7,781	7,754
Employed FTE	352	323	355	347
Contract FTE	29	44	42	39
Total FTE	381	367	397	385
EPOB	1.54	1.46	2.01	1.63

DENIALS under review

CHARITY under review

BAD DEBT under review

CASH

Cash collections were $13,287,985 for January.
Disbursements were $9,858,312 for January.
Year-to-date change in cash position is ($8,141,418)

Payor Issues

Blue Cross owes $1.3 million of non-routine collections. We have reported to the insurance commissioner's office.
MCR Cost Settlement payable (January) $2,429,480 – secondary audit on-going

SALARIES				
Per Adjust Bed Day	$2,250	$2,579	$2,340	$2,367
Total Salaries	$2,740,507	$2,708,692	$18,204,920	$18,357,100
BENEFITS				
Per Adjust Bed Day	$1,749	$2,415	$1,780	$1,983
Total Benefits	$2,130,312	$2,535,459	$13,847,252	$15,375,850
PROFESSIONAL FEES				
Per Adjust Bed Day	$1,597	$1,598	$1,748	$1,554
Total Physician Fee	$1,289,298	$510,404	$9,102,677	$7,623,967
Total Contract Labor	$1,001,828	$1,033,945	$6,565,896	$3,963,482
Total Other Pro-Fees	$363,447	$231,485	$2,434,676	$1,841,974
PHARMACY				
Per Adjust Bed Day	$296	$273	$296	$315
Total Rx Expense	$360,384	$286,978	$2,299,614	$2,439,828
MEDICAL SUPPLIES				
Per Adjust Bed Day	$391	$176	$379	$309
Total Medical Supplies	$476,757	$184,989	$2,950,805	$2,395,622
EHR SYSTEM				
Per Adjust Bed Day	$104	$114	$136	$105
Total EHR Expense	$126,194	$119,346	$1,059,592	$815,664
OTHER EXPENSE				
Per Adjust Bed Day	$649	$764	$730	$707
Total Other	$790,292	$802,058	$5,679,540	$5,482,105
DERECIATION AND AMORTIZATION				
Per Adjust Bed Day	$281	$319	$305	$311
Total Other	$342,452	$334,665	$2,376,379	$2,486,168

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	1/31/2022	2023 YTD	2022 YTD
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	3,708,290	22,925,035	21,964,037
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	8,803,380	83,911,479	74,159,531
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	1,448,892	9,775,470	8,285,713
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	13,960,561	116,611,984	104,409,281
Deductions from Revenue																
Contractual Adjustments	(9,974,707)	(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)	(6,081,113)	(56,811,330)	(46,476,550)
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)	(599,855)	(7,981,117)	(3,485,112)
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)	(211,549)	(3,223,053)	(967,427)
Other Deductions from Revenue	67,000	67,000	(67,000)	67,000	-	67,000	950	67,000	17,166	67,000	410	91,038	(2,429,480)	91,039	(2,410,954)	517,077
Deductions from Revenue	(12,120,514)	(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)	(6,801,478)	(70,426,454)	(50,412,011)
Other Patient Revenue																
Incentive Income	-	34,766	-	(35,500)	-	665	-	24,456	-	1,619	-	10	-	(24,026)	-	1,990
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	8,388	36,362	91,668
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other 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	(15,638)	36,362	93,658
Net Patient Service Revenue	4,457,793	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	7,143,445	46,221,892	54,090,928
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	2,346,958	15,578,807	15,959,366
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	2,199,930	11,924,638	13,196,378
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	1,452,179	11,537,353	10,206,193
Contract Labor	992,406	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	865,229	6,565,896	3,764,803
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	286,978	2,299,614	2,439,828
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	184,989	2,950,805	2,395,622
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	119,346	1,059,592	815,664
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	643,886	4,458,655	4,351,442
Total Cost of Services - Direct	7,738,472	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	8,099,494	56,375,359	53,129,296
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	361,734	2,626,113	2,397,735
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	335,529	1,922,615	2,179,473
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	225,696	2,066,257	1,841,425
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)	103,502	260,572	597,344
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	334,665	2,376,379	2,486,168
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	158,172	1,220,885	1,130,662
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	1,519,298	10,472,821	10,632,807
Total Expenses	9,417,836	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	9,618,792	66,848,180	63,762,103
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	227,252	1,271,015	1,138,839
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	173,785	1,734,010	1,216,493
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	6,662	370,911	132,190
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	844,798	3,101,511	15,438,640
Net Income (Change is Financial Position)	**(4,520,413)**	**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)**	**(1,677,354)**	**(16,690,870)**	**5,977,309**
Operating Income	(4,960,043)	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)	(2,475,347)	(20,626,288)	(9,671,175)

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2023

	Jan 2023	Jan 2022
Assets		
Current Assets		
Cash and Liquid Capital	9,828,615	10,869,882
Short Term Investments	16,922,335	34,103,636
PMA Partnership	-	-
Accounts Receivable, Net of Allowance	12,132,383	23,422,744
Other Receivables	6,856,285	8,858,544
Inventory	3,039,453	3,375,509
Prepaid Expenses	1,645,043	1,651,594
Total Current Assets	50,424,114	82,281,909
Assets Limited as to Use		
Internally Designated for Capital Acquisitions	-	-
Short Term - Restricted	162,508	61,236
Limited Use Assets		
LAIF - DC Pension Board Restricted	774,348	1,316,833
DB Pension	14,044,924	18,395,253
PEPRA - Deferred Outflows	-	-
PEPRA Pension	-	-
Total Limited Use Assets	14,819,272	19,712,086
Revenue Bonds Held by a Trustee	1,087,201	14,073,128
Total Assets Limited as to Use	16,068,980	33,846,450
Long Term Assets		
Long Term Investment	2,749,221	989,654
Fixed Assets, Net of Depreciation	76,738,947	76,833,219
Total Long Term Assets	79,488,168	77,822,872
Total Assets	**145,981,262**	**193,951,231**
Liabilities		
Current Liabilities		
Current Maturities of Long-Term Debt	953,873	1,596,844
Accounts Payable	5,116,954	3,252,430
Accrued Payroll and Related	5,348,020	9,408,509
Accrued Interest and Sales Tax	168,763	200,365
Notes Payable	2,133,708	-
Unearned Revenue	168,418	14,439,154
Due to 3rd Party Payors	2,429,480	-
Due to Specific Purpose Funds	-	(25,098)
Other Deferred Credits - Pension	2,146,080	2,124,655
Total Current Liabilities	18,465,295	30,996,860
Long Term Liabilities		
Long Term Debt	33,455,530	47,102,947
Bond Premium	218,948	350,677
Accreted Interest	16,648,086	15,987,335
Other Non-Current Liability - Pension	47,821,876	45,570,613
Total Long Term Liabilities	98,144,440	109,011,572
Suspense Liabilities	-	(70,699)
Uncategorized Liabilities	561,672	703,159
Total Liabilities	117,171,407	140,640,892
Fund Balance		
Fund Balance	42,910,729	44,833,874
Temporarily Restricted	2,589,995	2,499,156
Net Income	(16,690,870)	5,977,309
Total Fund Balance	28,809,855	53,310,339
Liabilities + Fund Balance	**145,981,262**	**193,951,231**
(Decline)/Gain	(1,918,204)	(2,115,089)
	-	-

Turnaround Action Group

We are using a three-pronged approach: Financial (revenue improvements), expenses (salaries, wages, benefits, supplies, services), and tax support.

Finance Subcommittee

- RSM moved to process mapping which is precursor for workflow improvement
- Billing (OS) started the weekly denial review meetings
- UASI Clinical Documentation Specialist continues to review and train
- Billing Office fully staffed
    - Working all claims less than $250, refunds, Medicare Bad Debt
    - AR clean-up in Athena and Cerner on-going
- Patient Access is increasing up-front collections

Labor Subcommittee

- All Departments have been interviewed and schedules scrutinized
- Analysis of Full Time Equivalent staff under way
- Directors continue to reduce contract labor
- FTE management

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	FYTD
Employee FTEs	**331.39**	**345.37**	**336.29**	**342.25**	**334.17**	**328.56**	**351.95**	**354.82**
FTE factor	177.14	177.14	171.43	177.14	171.43	177.14		1,228.57
Contract Labor Hours	8,174	7,403	8,737	8,219	7,154	6,489	5,138	51,314.22
Accrual reversal (prior month accrual)		-	(7,822)	(5,221)				
Accrual for ME		7,822	5,221	1,725				
Contract FTEs	**46.14**	**41.79**	**35.79**	**46.40**	**41.73**	**36.63**	**29.00**	**41.77**
Total FTEs	**378**	**387**	**372**	**389**	**376**	**365**	**381**	**397**
EPOB (employee per occupied bed)	**1.72**	**2.18**	**2.77**	**2.63**	**1.51**	**1.81**	**1.54**	**2.01**

Service/Operations Subcommittee

- Service line analyses on-going

Purchasing Subcommittee

- Identified 5 areas to review – analysis on-going

- Microbiology through GPO
- Surgery Clinic purchase
- Physical therapy purchase
- Supply chain

FIRST ADDENDUM TO EMPLOYMENT AGREEMENT
Of
INTERIM CHIEF EXECUTIVE OFFICER

This First Addendum to Employment Agreement of Interim Chief Executive Officer (the "First Addendum") is entered into between the Northern Inyo Healthcare District ("District") and Lionel Chadwick ("Chadwick") effective April 1, 2023 (the "Effective Date of First Addendum", in reference to the following facts:

WHEREAS, the District entered into an Employment Agreement (the "Interim CEO Employment Agreement") with Chadwick on or about October 24, 2022, wherein Chadwick would serve as the Interim Chief Executive Officer ("Interim CEO") of the District from December 1, 2022 until March 31, 2023;

WHEREAS, the District desires to provide Chadwick with an extension to the term set forth in the Interim CEO Employment Agreement;

WHEREAS, the parties have agreed to amend the Interim CEO Employment Agreement as set forth herein; and

WHEREAS, capitalized terms used, but not defined, herein shall have the meaning set forth in the Interim CEO Employment Agreement.

NOW, THEREFORE, in consideration of the mutual covenants set forth below, the District and Chadwick mutually agree that the Interim CEO Employment Agreement shall be modified as follows:

I. RESPONSIBILITIES.

The final two sentences of Paragraph 1.1 of Article I shall be stricken in their entirety.

A new Paragraph 1.3 shall be added to Article I, and shall read as follows.

"*1.3 Work Schedule*

Chadwick further agrees to perform the services of Interim CEO in accordance with the following work schedule requirements. Chadwick's onsite District work schedule shall constitute approximately twenty percent (20%) of total work time or four (4) days per month, notwithstanding any unanticipated emergent circumstances which may arise and which may require additional onsite work time. The balance of Chadwick's work schedule shall permitted to be performed offsite and/or remotely (i.e. performed from outside of the District) and may be scheduled at the sole discretion of Chadwick, subject to the aforementioned unanticipated emergent circumstances and provided that Chadwick shall schedule onsite work periods to include regularly scheduled Board of Directors meetings. During such offsite/remote periods, Chadwick shall be reasonably available by telephone, email, and/or for virtual meetings (e.g. zoom) as may be necessary to fulfill leadership duties and obligations. Chadwick and the District acknowledge and agree that actual time which must be devoted by Chadwick to the duties of the Interim CEO of the District will likely be less than forty (40) hours per week during offsite/remote periods and that adequate performance of the duties is based upon responsibilities rather than specific time

availability. Additionally, Chadwick shall not participate in Administrator on Call ("AOC") responsibilities."

A new Paragraph 1.4 shall be added to Article I, and shall read as follows.

"***1.4 Interim Chief Operating Officer***

*An Interim Chief Operating Officer ("**Interim COO**") shall be appointed during the term of this First Addendum. Such Interim COO shall formally assume onsite executive leadership and assist with onsite obligations and duties during Interim CEO's physical absence from District. Anything to the contrary notwithstanding, Interim CEOs overall responsibilities as set forth in this Article I shall remain unchanged.*"

II. TERM AND TERMINATION.

The parties agree that the Interim CEO Employment Agreement shall be amended to provide for an extension of the original Employment Term, which shall commence on the Effective Date of First Addendum and be referred to herein as the "Contract Extension Term".

Paragraph 2.2 of Article II shall be modified to read as follows:

"*Chadwick shall commence performing the services of CEO under the First Addendum of the Effective Date of First Addendum and shall continue to provide these services through the earlier of (i) June 30, 2023, or (ii) the commencement of a permanent Chief Executive Officer's employment with the District (the "**Extended Employment Term**"), unless the Parties mutually agree in writing to an earlier Effective Date or the Employment Term is sooner terminated in accordance with this Article II. The Employment Term and the Extended Employment Term shall collectively be referred to as the "**Employment Term**. The Employment Term may be extended upon mutual written agreement by the parties to this Agreement."*

In the last sentence of Paragraph 2.3, the reference to Section 3.4 shall be changed to Section 3.5.

Paragraph 2.4 shall be deleted in its entirety.

In the third sentence of Paragraph 2.5, the reference to Completion Incentive shall be removed and the reference to Section 3.4 shall be changed to Section 3.5.

A new Paragraph 2.6 shall be added to Article II, and shall read as follows.

"*2.6 Termination by Employment of Permanent CEO*

In the event Chadwick's Employment Term ends prior to June 30, 2023 due to the District's employ of a permanent Chief Executive Office, in accordance with Paragraph 2.1, above, District shall provide Chadwick with 30-days written notice of termination. Notwithstanding anything to the contrary herein, for the purposes of this Paragraph 2.6, notification to Chadwick by email shall suffice for purposes of notice. In lieu of giving all or a portion of the 30-day notice, the District may make payment to Chadwick of base compensation, in the amount which would have been earned by Chadwick during said 30-

day notice period. Other than base compensation during the 30 day notice period, Chadwick will not be entitled to any severance pay upon termination of this First Addendum and the Interim CEO Employment Agreement"

III. COMPENSATION.

The first sentence of Paragraph 3.1 of Article III shall be modified to read as follows:

"*In consideration for all services to be performed by Chadwick, the District agrees to pay Chadwick base compensation at a rate of Seven Thousand and Five Hundred Dollars ($7,500) per week (or pro rata for any partial week worked) ("**Base Compensation**").*"

The Heading of Paragraph 3.2 of Article III shall be modified to read "*[Reserved]*", and the text of said Paragraph 3.2 shall be stricken in its entirety. Additionally, any and all references to the "Completion Incentive" in the Interim CEO Employment Agreement shall be deemed not to apply during the Contract Extension Term which begins April 1, 2023. The parties hereby acknowledge and agree that in recognition of successful completion of the original Employment Term the Completion Incentive earned by Chadwick during the original Employment Term shall be fully paid to Chadwick in full on March 31, 2023, and that Chadwick shall not be entitled to any additional Completion Incentive during the term of this First Addendum.

Subsections a) and c) of Paragraph 3.5 of Article III shall stricken in their entirety.

The following sentence shall be added to the end of subsection e) of Paragraph 3.5:

"*Additionally, during the Extended Employment Term, travel expenses actually incurred for travel from Chadwick's permanent residence to and from the District for purposes of performing the services of Interim CEO, which travel is expected to be on a monthly basis."*

A new subsection f) shall be added to read as follows:

"Actual incurred costs for Chadwick's reasonable housing, car rental, and meals while Chadwick is performing services on site at the District during the Extended Employment Term."

Except as expressly modified above, all other language in the Interim CEO Employment Agreement shall remain unchanged.

This First Addendum is hereby approved by the District as of March 15, 2023.

NORTHERN INYO HEALTHCARE DISTRICT	**INTERIM CEO**
By_____	_____
Name_____	Lionel Chadwick
Title_____	

Ensuring Quality of Care in the Hospital

The Governing Board/Medical Staff Relationship

March 15, 2023 Board Meeting

Best Best & Krieger

Company/BestBestKrieger

@BBKlaw

BEST BEST & KRIEGER LLP
ATTORNEYS AT LAW

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Presenter

Noel Caughman, Esq.
Partner

Disclaimer: BB&K presentations and webinars are not intended as legal advice. Additional facts, facts specific to your situation or future developments may affect subjects contained herein. Seek the advice of an attorney before acting or relying upon any information herein. Audio or video recording of presentation and webinar content is prohibited without express prior consent.

The governing board of a hospital has the legal, regulatory and fiduciary duty to ensure that medical care provided in the hospital is safe and that quality standards are met

The OIG and DOJ have increased their interest in and surveillance of quality and patient safety because it is linked to reimbursement for Medicare and Medicaid and the government wants to be sure patients receive the quality of care for which they pay

How Does a Hospital Board Ensure Quality of Care is Rendered?

- *Oversight function –*
  - ✓ Example -- regular patient safety/medical staff reporting, overseeing a compliance program
- *Delegation function –*
  - ✓ *Example* -- the CEO is directly accountable to the board for quality and patient safety and the Board is responsible for monitoring the CEO's performance
- *Decision making function –*
  - ✓ Example – board approval of competent providers practicing in the hospital and all hospital policies

California's Doctrine Against the Corporate Practice of Medicine

- Physicians practicing in hospitals are *independent contractors*
- The California doctrine against the Corporate Practice of Medicine (CPM) prohibits lay entities like a hospital from practicing medicine. The result of this means hospitals generally cannot employ physicians to provide professional services in their facilities (Limited exceptions for Critical Access Hospitals)
- The rationale underlying CPM is that physicians, as the only persons licensed to practice medicine, should control clinical decisions; the concern is that, if business entities owned by non-physicians are permitted to control the rendering of care, they will subordinate clinical care to commercial considerations and profits. The objective, therefore, is to prevent non-physicians and non-physician-owned business entities from influencing treatment decisions
- Given this, hospitals don't have any direct control over the physicians providing services in their facilities

The Role of the Hospital's Medical Staff

- Hospitals are licensed under Title 22 of the California Code of Regulations
- Title 22 requires that all hospitals have an *organized medical staff* (22 CCR 70703)
- Title 22 requires that the medical staff have its own *bylaws*, which must be approved by the governing body
- Title 22 requires that the hospital board *approve* the appointment and reappointment of physicians to that medical staff (22 CCR 70701)

Title 22 CCR 70703

(a) Each hospital shall have an *organized medical staff responsible to the governing body for the adequacy and quality of the care rendered to patients*.

(1) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists.

(b) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written by-laws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its by-laws. Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting right of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O., D.P.M., or D.D.S. degree or clinical psychology license.

Cal. Code Regs. tit. 22, § 70703

Title 22 CCR 70701

(a) The governing body shall:

(1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:

……

(B) *Appointment and reappointment of members of the medical staff.*

(C) *Appointment and reappointment of one or more dentists, podiatrists, and/or clinical psychologists to the medical staff respectively, when dental, podiatric, and/or clinical psychological services are provided*.

(D) *Formal organization of the medical staff with appropriate officers and bylaws*.

(E) Membership on the medical staff which shall be restricted to physicians, dentists, podiatrists, and clinical psychologists competent in their respective fields, worthy in character and in professional ethics. No hospital shall discriminate with respect to employment, staff privileges or the provision of professional services against a licensed clinical psychologist within the scope of his/her licensure, or against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O. or D.P.M. degree. Wherever staffing requirements for a service mandate that the physician responsible for the service be certified or eligible for certification by an appropriate American medical board, such position may be filled by an osteopathic physician who is certified or eligible for certification by the equivalent appropriate American Osteopathic Board.

(F) *Self-government by the medical staff with respect to the professional work performed in the hospital*, periodic meetings of the medical staff to review and analyze at regular intervals their clinical experience and requirement that the medical records of the patients shall be the basis for such review and analysis.

Cal. Code Regs. tit. 22, § 70701

HOSPITAL MEDICAL STAFF

- The medical staff is responsible for reviewing the *qualifications* of physicians who will practice in the hospital and for recommending to the board the granting of privileges with respect to physician applicants i.e. “to give hospital privileges” to practice in the hospital
- The medical staff is self-governing with its own medical staff bylaws, (which bylaws must be approved by the board) and its own medical staff officers i.e. chief of staff
- The medical staff is responsible for peer-review activities with respect to privileged physicians practicing in the hospital to ensure quality and patient safety

Does this Mean that the Medical Staff is Independent?

The medical staff is self-governing, **but**:

- It cannot unilaterally amend its own medical staff bylaws.
- It cannot appoint or terminate its own members – it can only recommend appointment and termination to the hospital board, which makes the final decision.
- The medical staff's peer review must be overseen by the hospital, which has a legal duty to ensure the medical staff's competence.
- The medical staff relies on the hospital to "indemnify the medical staff and its individual members from and against losses and expenses [arising from] litigation-related costs…relating or pertaining to any alleged act or failure to act within the scope of peer review… activities." This is a universal requirement in medical staff bylaws throughout California.
- If any hospital ceased to exist, so would its medical staff.

Does this Mean that the Hospital is Independent?

The hospital governing body (board) has ultimate authority over the hospital, **but**:

- It cannot unilaterally amend the medical staff bylaws.
- When withholding approval of bylaws amendments, the board cannot do so unreasonably.

The hospital board appoints members of the medical staff and grants privileges, **but**:

- It may do so only on the medical staff's recommendation.
- It may not take action against a medical staff member's privileges or membership without the medical staff's recommendation, except in extreme circumstances when the medical staff has failed or refused to act.
- The hospital board has final approval authority over a medical staff member's appeal of a reportable adverse peer review decision, **but** it still must give great weight to the medical staff's recommendations and decisions. It must reach a decision by applying the standard of review provided in the bylaws, and in most cases not by exercising its independent judgment.

The Hospital and Medical Staff are *Interdependent*

(1) the medical staff and hospital are indeed separate legal entities;

(2) the medical staff enjoys statutory independent *rights*; and

(3) because the hospital and the medical staff depend on one another to advance the hospital's mission, they are mostly **interdependent**. This is clear from both a practical and legal standpoint

Keys to success

- *Partnership* where both medical staff and hospital work closely together to provide quality care for patients
- *Alignment* creates a number of positive outcomes that are vital to success in meeting the needs of patients and the community
- Culture of *collaboration*
- *Shared mission and core values*

Questions and Discussion

Best Best & Krieger

Company/BestBestKrieger

@BBKlaw

BEST BEST & KRIEGER LLP
ATTORNEYS AT LAW

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

Date: March 4, 2023

Title: **Purchase agreement for Symplr sContract Software**

Synopsis: It is recommended that the Board of Directors approve the purchase of the contract life-cycle management software as presented.

Contract management at NIHD is a manual process at this time. It is highly inefficient, consuming in excess of 15-20 hours of Compliance Team time weekly. Lack of life-cycle management automation causes termination and non-renewal letters to be missed, causing the District to incur costs for automatic renewal of contracts that may no longer be needed. This currently costs the District tens of thousands of dollars a year. The current process also makes it a challenge for Directors and Managers to reconcile invoices to contracts. The Accounting team has additional needs for contract reporting for budgets, audits and reconciliation that are not met by the current process. I have also attached a "Return on Investment" document and quote.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

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

ORDER FORM

Customer:
NORTHERN INYO HOSPITAL
150 Pioneer Ln
Bishop, CA 93514-2599
Patty Dickson
+1.760.873.5811
patty.dickson@nih.org

Prepared By:
TractManager, Inc., a symplr company
("symplr")
315 Capitol Street, Ste. 100
Houston, TX 77002
Brandon Murray
bmurray@symplr.com

Order Details:
OppID: OP-121182
Quote #: Q-93092-1
Expires On: 6/1/2023
Tax Exemption #:

SaaS Subscriptions	Billing Frequency	QTY	Total Annual Subscription Fees
symplr Contract - 500 Contracts	Monthly	1	$24,000.00
		Total:	$24,000.00

Service	Quantity	Billed as	Services Total
Hourly Services	76.25	T&M with 50% Billed Upfront	$13,343.75
		Total:	$13,343.75

Pricing Summary

Category	Year 1	Year 2	Year 3	Year 4	Year 5
Services	$13,343.75	$0.00	$0.00	$0.00	$0.00
SaaS Subscriptions	$24,000.00	$24,960.00	$25,958.40	$26.996.74	$28,076.61
Annual Cost	**$37,343.75**	**$24,960.00**	**$25,958.40**	**$26.996.74**	**$28,076.61**

symplr may increase the recurring Fees set forth above by the rate set forth in the Agreement.

TERMS AND CONDITIONS

This Order Form, effective as of the date of last signature hereto ("**Order Form Effective Date**") is governed by the prevailing Agreement between symplr and Customer. Capitalized terms used in this Order Form and not otherwise defined herein shall have the meanings assigned to them in the Agreement.

SOFTWARE DELIVERY
symplr, or its agent, will deliver non-customized On-Premise Software and/or SaaS electronically following the Order Form Effective Date either (i) via secure file transfer, (ii) by providing access codes, or (iii) by creating Customer's initial global admin user account, that allows Customer to access or download the Software or SaaS ("**Delivery**").

SOFTWARE LICENSE LIMIT
The Licensed Software and/or SaaS is licensed by either: (a). "**Licensed Facilities**" which means those facilities specifically identified in an Order Form and whose Users are licensed to use the SaaS; (b) "**Contracts**" which means the number of Active, Expired, and/ or Archived Contracts stored in the Software; (c) "**Vendor Evaluation Forms**" which means the unique evaluation forms being tracked for the contract that require evaluation; or (d) "**Provider(s)**" which means an individual health professional licensed by the state in which the provider practices to provide health care diagnosis and treatment services, including medication, surgery, and medical devices, and who is employed or contracted by Customer or any of its Affiliates. .

SERVICE SUBSCRIPTIONS BILLING TERMS
Customer shall be billed for the initial period of the Service subscriptions upon the Order Form Effective Date. The Service subscriptions shall be billed in advance, pursuant to the billing frequency stated in the applicable Order Form and thereafter at least thirty (30) days in advance of the renewal date

SOFTWARE/SERVICE SUBSCRIPTIONS
The term of recurring Licensed Software, SaaS, Remote Hosting, Managed Services, and Services subscriptions and Software Support and Maintenance and Equipment Maintenance will be coterminous with the Agreement Term. Fees for incremental Licensed Software, SaaS, Remote Hosting, Managed Services and Services subscriptions and Software Support and Maintenance and Equipment Maintenance purchased under Additional Order Forms will be prorated based on the remaining portion of the Agreement Term.

SOFTWARE BILLING TERMS
Customer shall be billed for the Licensed Software and/or the initial period of the SaaS Software subscriptions the first day of the calendar month following one hundred and twenty (120) days following the Order Form Effective Date. The SaaS Software subscriptions shall be billed in advance, pursuant to the billing frequency stated in the applicable Order Form and thereafter at least thirty (30) days in advance of the renewal date.

SERVICES BILLING TERMS
All Services fees are exclusive of travel and incidental project-related expenses. Customer shall be billed for hourly based Services and travel expenses, as performed, and incurred, and non-hourly based Services as follows: Fifty percent (50%) of the Services fees upon the Order Form Effective Date and the remaining fifty (50%) of the Services fees on the earlier of the following: (a) Customer's initial access to its symplr Contract database; or (b) six (6) months following the Order Form Effective Date.

Handwritten or electronic modifications on this Order Form (except an indication of the form of payment, Customer purchase order number and signatures on the signature blocks below) are void.

EACH PARTY HERETO UNDERSTANDS, ACCEPTS AND AGREES TO BE BOUND BY THIS ORDER FORM AND THE AGREEMENT.

IN WITNESS WHEREOF, the parties have caused this Order Form to be executed by their duly authorized representative as of the Order Form Effective Date.

NORTHERN INYO HOSPITAL		**TractManager, Inc., a symplr company ("symplr")**	
Signature:	_____	Signature:	_____
Name (Printed):	_____	Name (Printed):	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____
PO Required?			
PO Number:	_____		
	_____		

Statement of Work for symplr
No. Q-93092 , OppID OP-121182

This Statement of Work No. Q-93092 (this "SOW") is governed by the agreement ("**Agreement**") by and between symplr and Customer and is effective on the Order Form Effective Date ("**SOW Effective Date**").

In the event of any conflict between the terms of the Agreement and this SOW, this SOW will govern, but only with respect to the subject matter of this SOW and not any other subject matter covered by the Agreement. Capitalized terms not otherwise defined in this SOW will have the meaning assigned to them in the Agreement.

GENERAL SCOPING TERMS:

Definitions:
Assistance – Customer is completing the task with recommendations and a review by a symplr representative.
Consulting – Leveraging symplr knowledge of Customer business needs and processes in order to provide recommendations for the effective and efficient use of symplr solutions to improve Customer's business process.

symplr Obligations:
General Project Management and Consulting Support Services:
- Provide Customer with timeline for delivery of services
    - All Service dates are allocated on a first come, first served basis and are subject to change until symplr receives written confirmation from the Customer, along with a purchase order, if needed. Mutual agreement of the timeline constitutes confirmation by Customer
- Project milestone monitoring
- Status updates as appropriate

Configuration/Software Support Services:
- Discovery process to determine the build needs (including review of any discovery surveys and workbooks when appropriate).
- Testing support – This includes assisting Customer with the resolution of issues discovered during the testing process. Customer is responsible for the testing/troubleshooting of the Software.

Training Support Services:
- Implementation/Project Sessions may be offered onsite or remote, according to symplr's established implementation methodology.
    - Onsite Implementation Session will occur in a centralized location, at one of Customer's facilities.
- Attendance in all symplr hands-on sessions is limited to ten (10) attendees. It is in Customer's best interest to limit attendance to maximize the opportunity for learning to occur. If Customer wishes to have more than ten (10) attendees participate in a session, additional Services may be purchased.

Customer Obligations:
General Project Management Support Services:
- Coordination, scheduling, and monitoring of Customer related tasks to completion in alignment with the mutually agreed upon System Implementation Plan.
- Development and execution of the change management plan.

Configuration/Software Support Services:
- Definition and interpretation of all solution requirements and organizational policies.
- Creation and execution of a test plan (including test case scenarios and integration testing) as needed to complete the Software acceptance process.

Training Services:
- Development of facility specific training guides and manuals if desired.
- Training for all supervisors and employees on all applicable components of Customer's symplr Software.

SCOPING ASSUMPTIONS:
symplr's ability to provide the Services herein for the fees set forth in this SOW is predicated upon the following assumptions:

IMPLEMENTATION SERVICES STATEMENT OF WORK
Net New- Implementation Services (Base)

A. Services Description

1. Applications: For each of the following modules, the Company will implement and provide consulting for the standard functionality contained within the symplr Contract platform for one (1) Contracting Team designated by Customer comprised of an Executive Sponsor, Project Manager, and Subject Matter Experts per workflow package. The symplr Contract platform will be delivered in one (1) phase inclusive of all purchased workflow packages.
    - Contract Library
    - Add Docs Workflow
2. Company will assist Customer with the project coordination associated with the services outlined in this Statement of Work. ("SOW").
3. Company will conduct up to twelve (12) project status meetings (60 minutes each) during the implementation.
4. Company will assist Customer with the integration of digital signature services within Company's application. (Integrating to Customers pre contract digital signature services/Integrating with Company's reseller digital signature service).
5. Company will provide self-paced Design and Admin Foundations classes through the Company's Learning Management System (LMS) for up to 12 key
Customer
stakeholders during the early stages of the implementation.
6. Company will provide Customer with up to Twelve (12) TractManager Learning Management System (LMS) licenses for the duration of the terms of this agreement.

B. Customer Obligations

1. Customer will provide required leadership support and overall management responsibility to implement process and procedures to accomplish the organization's objectives.
2. Customer will assign a project sponsor and a dedicated project manager to be responsible for Customer's project resources, assignments, and deliverables who is representative of Customer's stakeholder's strategic objectives.
3. Customer will ensure Customer's technical and functional resources have the necessary process knowledge and are empowered to make decisions.
4. Customer will provide in a timely manner all materials required to complete this SOW.
5. Customer will review any Company provided materials and provide required approval within five (5) business days of receipt to complete tasks within this SOW.
6. Customer will provide safe access, suitable office space, supplies, furniture, high speed connectivity to the internet, and other facilities for Company's personnel while working.
7. Customer is responsible for delivering all defined Contract Data in Company provided format within Readiness Phase.
8. Customer is responsible for planning, executing, and managing all aspects of End-to-End and Final reviews, including, but not limited to preparing and executing test cases and plans, and reviewing test results.
9. Customer is responsible for organizational Change Management, including, but not limited to the development and execution of End-User Training. End-User Training may be purchased separately from Company as needed. This also includes training any external users that gain access and use the Customer symplr system.

C. Assumptions

1. If Company provided materials are not returned within expected timelines, project timeframes may increase beyond initial expectations.
2. Company will deliver this engagement as one (1) collective project.
3. Implementations halted by Customer for greater than thirty (30) consecutive days will initiate an additional engagement and an adjustment to the fee structure will be made via an Amendment.
4. No data conversion or integration is required beyond what is listed in this SOW.
5. If the number of contracts is more than 10% (change to 1% if greater than 50,000 files) higher than estimated, an adjustment will be made to fee structure via an amendment.
6. Company will have access to Customer's project team members as needed to perform the service.
7. Customer is willing and able to modify Customer's business practices as necessary to comply with the best practice standard functionality in Company's applications.
8. Sign off on First Access Use (FAU) and the receipt of a Production URL constitutes Go-Live.
9. Company will have the ability to make audio recordings of Company-led project sessions.

Should Customer desire to add or continue services outside of the services specified in this SOW, or exceed the estimated time as outlined herein, an additional mutually agreed upon SOW will be entered into by and between Customer and Company.

SOW TERM:

The term of this SOW (the "SOW Term") shall commence on the SOW Effective Date and shall continue until the Services hours are depleted or the Services are completed

ADDITIONAL PROVISIONS:

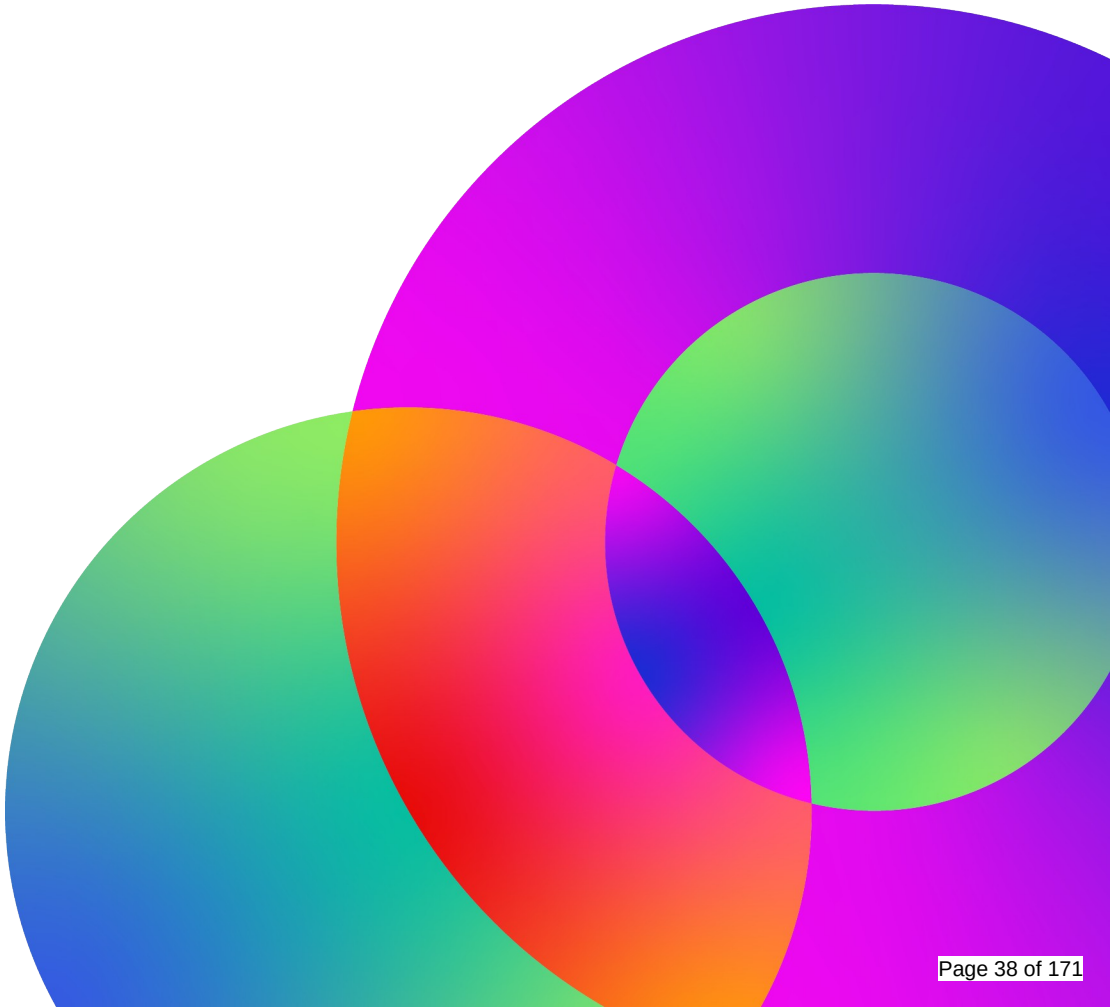
Customer agrees to reimburse symplr all reasonable costs incurred in connection with the Services. Reimbursable costs include, but are not limited to, all costs associated with travel, subcontractors' fees and delivery expenses that are attributable to the Services provided hereunder ("Reimbursable Costs"). Travel costs shall include, without limitation, air travel, lodging, meals and incidentals, and ground transportation. symplr will provide Customer with written copies of all Reimbursable Costs incurred.

Changes in the scope of Services to be provided under this SOW shall only be made in writing and executed by authorized representatives of both parties (a "Change Request"). symplr shall have no obligation to commence any work in connection with any change until the cost and schedule impact of such Change Request is approved by the parties. Approval of Change Requests shall not be unreasonably withheld or delayed by either party.

NORTHERN INYO HOSPITAL		**TractManager, Inc., a symplr company ("symplr")**	
Signature:	_____	Signature:	_____
Name (Printed):	_____	Name (Printed):	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

Northern Inyo Hospital District

District Board Review



sContract & Compliance Suite Annual Uplift Savings

Solution Pricing					
Solution	Year 1	Year 2	Year 3	Year 4	Year 5
sContract	$24,000.00	$24,960.00	$25,958.40	$26,996.74	$28,076.61
Implementation Services	$13,343.75				
Total @ 4%	$37,343.75	$24,960.00	$25,958.40	$26,996.74	$28,076.61
Total @ CPI + 5% *Variable CPI not factored	$37,343.75	*$25,200.00	*$26,460.00	*$27,783.00	*$29,172.15
				sContract Uplift Savings	*$2,623.40*
symplr Compliance Suite	Year 1	Year 2	Year 3	Year 4	Year 5
Total 4%	30,000.00	$31,200.00	$32,448.00	$33,745.92	$35,095.76
Total @ 8%	30,000.00	$32,400.00	$34,992.00	$37,791.36	$40,814.67
				Compliance Uplift Savings	*$13,508.35*
				Total Uplift Savings w/o Variable CPI	**$16,131.75**

symplr

ROI Analysis Summary Report

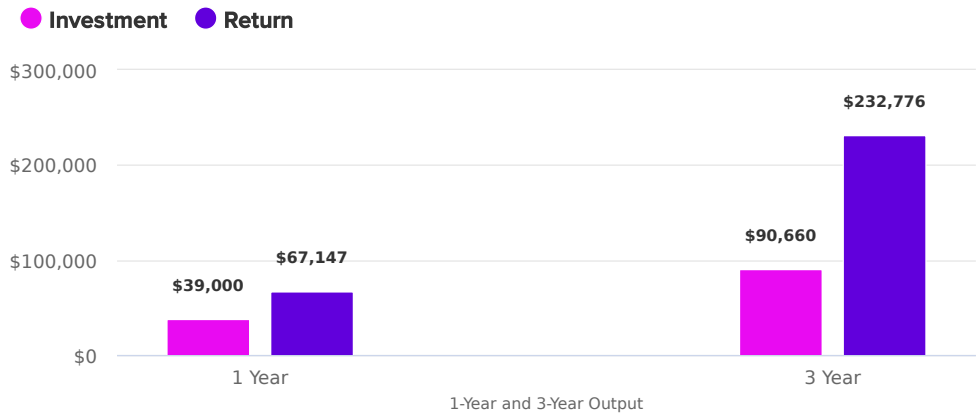
Governance, Risk Management, and Compliance Solutions for Healthcare

ROI SUMMARY

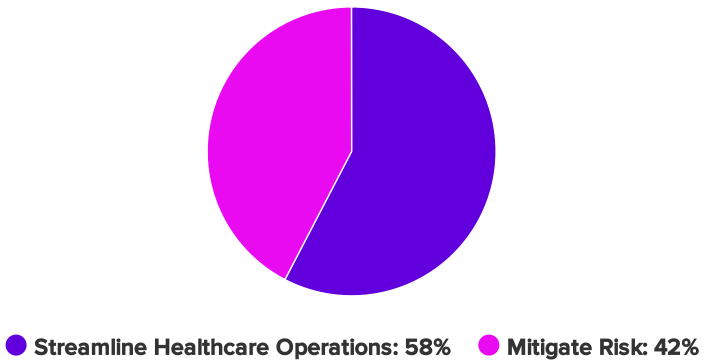
Prepared for: Northern Inyo Healthcare District

Your 3-year ROI is:	157%
Months until investment pays back:	7.0
Overall 3-year value created:	$232,776
Monthly cost of waiting:	$3,948

Your Investment vs. Your Return (Cumulative)



How symplr Can Help You



The Return-on-Investment (ROI) and other financial calculations performed by this tool are based on data provided by symplr customers and various assumptions—and produce estimates only. The actual ROI realized by customers may vary from the estimates provided. symplr offers this tool to assist customers with governance, risk management and compliance; however, symplr and Hobson & Company (the firm that created the tool) are not responsible for the accuracy of any estimates.

BENEFIT SUMMARY

Streamline Healthcare Operations	
Reduce time spent managing contract documents by **50%**	$110,386
Reduce time spent on contract related reporting by **35%**	$23,775
Mitigate Risk	
Helps reduce the probability of penalties/fines by **75%**	$98,615
TOTAL VALUE OVER 3 YEARS	**$232,776**

symplr

BENEFIT DETAIL

	3 year value
Reduce time spent managing contract documents by 50%	$110,386

symplr Contract provides a central repository for all healthcare related contracts allowing users to quickly and easily access critical contract information directly from the contract landing page.

symplr Contract reduces the time spent managing contract documents by 50%

Validation of Key Assumptions

- 50% reduction in time spent managing contracts (Customer #8)
- 70 – 73% reduction in time spent managing contracts (Customer #9)

"We spend about 50% less time managing contracts than we did prior to having symplr. We used to spend a lot of time pulling contracts and sending them out. symplr has really streamlined that process and the paralegals can focus their time on other work." (Customer #8)

"Prior to having symplr Contract, I would spend 10 – 15 hrs per week scanning and uploading contracts, and now I spend 3-4 hrs per week and can focus my time on drafting contracts." (Customer #9)

"We don't have to go to multiple places to find all of the information associated with one contract. It is all stored in symplr giving us one centralized location for everything." (Customer #13)

Reduce time spent on contract related reporting by 35%	$23,775

symplr Contract's reporting automates the process of identifing, managing, tracking, and notifying business owners of expiring contracts.

symplr Contract reduces the time spent on contract related reporting by 90%

Validation of Key Assumptions

- 99% reduction in time spent (Customer #8)
- Saves 5 – 10 hrs per month (Customer #13)

"Prior to using symplr, each of our seven markets managed contracts in a siloed environment. I would spend 1-2 weeks 5-6 times per year running reports on contracts. Now it only takes 2 minutes per report." (Customer #8)

"Being able to run reports on expiring contracts is a big deal for us." (Customer #13)

Helps reduce the probability of penalties/fines by 75%	$98,615

symplr Contract helps avoid penalties and fines with simplified data gathering, activity monitoring, and compliance reporting, so organizations can evaluate and manage vendors and associated compliance risks, track provider time reporting, avoid conflicts of interest, and record gifts or other non-monetary compensation.

symplr Contract help reduce the probability of penalties/fines by 40%

Validation of Key Assumptions

- Helps avoid 90% of penalties (Customer #8)

- Avoid 1 penalty (Customer #13)

"symplr Contract helps us avoid 90% of potential penalties associated with non-monetary gifts to physicians." (Customer #8)

"Physician contracting is a high risk. If we pay a physician that doesn't have a contract, or we pay more than the contract allows us to pay, or we pay for something we are not supposed to pay for, the fine would be hundreds of thousands of dollars, and symplr helps us avoid these types of fines." (Customer #13)

Total Projected Value	▶	**$232,776**

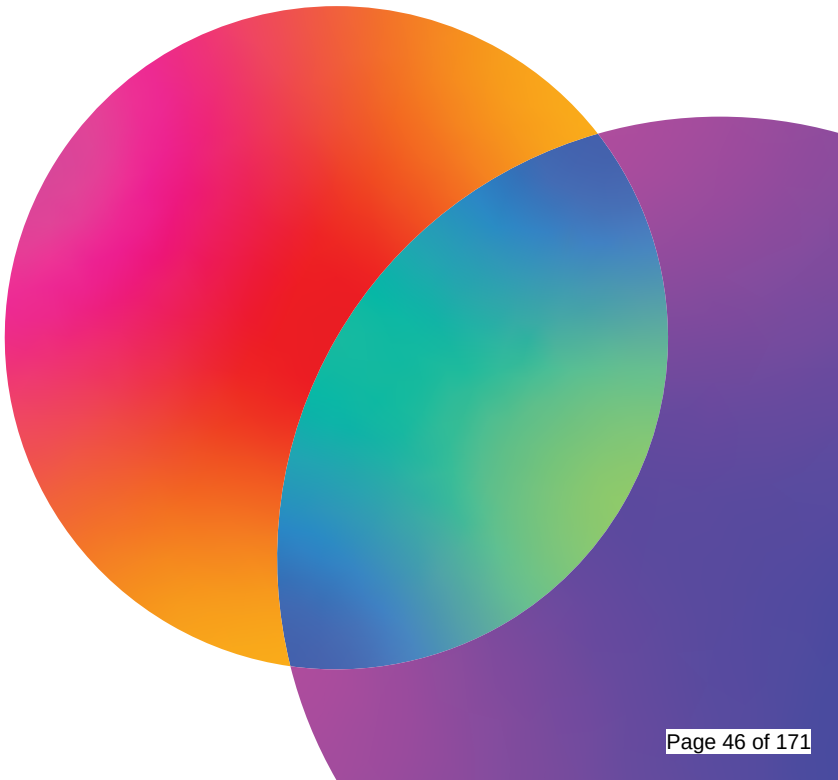
USER INPUTS

Select Product	☑ symplr Contract ☐ symplr Compliance
# of contracts	600
Total number of FTE's managing contract documents	1
Avg time spent on contract related reporting (hrs/mo/FTE)	40
Est. size of potential penalty	$ 632,149

About symplr

symplr is the leader in enterprise healthcare operations software and services. For more than 30 years and with deployments in 9 out of every 10 U.S. hospitals, symplr has been committed to improving healthcare operations through its cloud-based solutions, driving better operations for better outcomes. Our provider data management, workforce management, and healthcare governance, risk management, and compliance (GRC) solutions improve the efficiency and efficacy of healthcare operations, enabling caregivers to quickly handle administrative tasks so they have more time to do what they do best — provide high-quality patient care.

Learn how at **symplr.com**



symplr

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

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

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: March 7, 2023
RE: Medical Executive Committee Report

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

A. Medical Staff Appointments 2023- 2024 (*action item*)
    1. Lucienne Bouvier, MD (*obstetrics & gynecology*) – Active Staff
    2. Darren Dennis, PA-C (*physician assistant, family practice*) – APP Staff
    3. Daniel Kirkham, MD (*radiology*) – Courtesy Staff
    4. Shawn Marvin, MD (*radiology*) – Telemedicine Staff
    5. Aviva Regev, MD (*anesthesiology*) – Courtesy Staff

B. Medical Staff Appointments 2023-2024 – Proxy Credentialing (*action item*)
    As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon the entities' credentialing and privileging decisions.
    1. Mike Khieu, MD (*cardiology, Renown*) – Telemedicine Staff
    2. Rajesh Vaid, MD (*radiology, Quality Nighthawk*) – Telemedicine Staff

C. Additional Privileges (*action item*)
    1. Carolyn Tiernan, MD (*emergency medicine*) – privileges in Advanced Wound Care

D. Change in Staff Category (*action item*)
    1. Michael Dillon, MD (*emergency medicine*) – change from Active to Honorary Staff

E. Medical Staff Resignations (*action item*)
    1. Jon Bowersox, MD (*general surgery*) – effective 01/31/2023
    2. Geoffrey McWilliams, MD (*radiology*) – effective 12/29/2022
    3. Carolyn Saba, MD (*anesthesiology*) – effective 01/31/2023
    4. Leena Sumitra, MD (*psychiatry*) – effective 12/31/2022

F. New Privilege Forms (*action item*)
    1. Nurse Practitioner – Psychiatry
    2. Neurology

G. Policies (*action item*)
    1. *Direct Notification of Abnormal Microbiology Findings*

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

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

Nurse Practitioner - Psychiatric/Mental Health

Delineation of Privileges

Applicant's Name: ,

Instructions:

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

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of a master's/post-master's or doctorate degree in an accredited nursing program with emphasis in his or her specialty area
Certification	Current certification by a nationally accredited professional nursing organization such as the American Nurses Credentialing Center (ANCC), American Academy of Nurse Practitioners (AANP), or National Certification Board of Pediatric Nurse Practitioners & Nurses **OR** Successfully passed the certification exam of the American Nurses Credentialing Center, or other certifying organizations approved by the California Board of Nursing relative to the NPs designated specialty.
Clinical Experience (Initial)	Applicant must provide documentation of provision of clinical services in the specific privileges requested during the previous 24 months (waived for applicants who completed training within the past year).
Clinical Experience (Reappointment)	Applicant must have provided clinical services in the specific privileges requested during the past 24 months.
Additional Qualifications	Current California furnishing certificate and DEA Registration with schedules 2, 2N, 3, 3N, 4 and 5 **AND** Applicant must have a supervising or collaborating relationship with a psychiatrist. **AND** The NP must abide by the applicable Northern Inyo Healthcare District Standardized Procedures.

Core Privileges in Nurse Practitioner - Psychiatric/Mental Health	
Description: Assessment, Diagnosis and Management of Mental Health Problems and Psychiatric Disorders	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Currently Granted privileges
☐	Perform history and physical examination

☐	Complete comprehensive psychiatric assessment - psychiatric evaluation, including mental status, current and past history of violence, suicidal or self-harm behavior, substance use, level of functioning, health behaviors, trauma, sexual behaviors and social and developmental history
☐	Perform, order and interpret preventive and non-invasive diagnostic tests
☐	Formulate a diagnosis and establish priorities to meet the patient's health and mental health needs
☐	Furnish/order appropriate pharmacologic and nonpharmacologic interventions
☐	Conduct individual, group, and family psychotherapy

FPPE (Department Chief to select)	
☐	Retrospective evaluation of 5 cases representing a variety of medical conditions.
☐	Feedback from involved clinician

Acknowledgment of Applicant

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

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

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

Practitioner's Signature NIHD

Department Chief Recommendation - Privileges

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

Privilege	Condition/Modification/Deletion/Explanation

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

Neurology

Delineation of Privileges

Applicant's Name: ,

Instructions:

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

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of an ACGME or AOA accredited Residency training program in Neurology.
Certification	Current certification or active participation in the examination process leading to certification in Neurology by the American Board of Psychiatry & Neurology or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of neurology services representative of the scope and complexity of the privileges requested during the previous 24 months (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must have provided clinical services representative of the scope and complexity of privileges requested during the past 24 months.

Core Privileges in Neurology	
Description: Diagnosis, treatment and consultation related to disease or impaired function of the brain, spinal cord, peripheral nerves, muscles and autonomic nervous system, as well as the blood vessels that relate to these structures.	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Currently Granted privileges
☐	Perform history and physical examination
☐	Evaluate, diagnose, provide consultation, medically manage and treat patients with acquired or congenital disease, disorders or impaired function of the neurological system.

FPPE (Department Chief to select)	
☐	Three retrospective chart reviews chosen to represent a diversity of medical conditions and management challenges.
☐	Reference from a referring physician (related to whether consultation was timely, appropriate and complete).

Telemedicine/Telehealth Privileges	
Description: Practitioners should request this privilege when all of the privileges they are granted are to be exercised via an electronic link, such as with a proxy credentialing agreement in which the practitioner is at the Distant Site. This restriction for remote clinical services applies to any privileges granted on this privilege form.	
Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group. ☐ - Currently Granted privileges
☐	Privileges granted to be provided remotely via an electronic telemedicine link only.

Acknowledgment of Applicant

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

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

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

_____

Practitioner's Signature NIHD

Department Chief Recommendation - Privileges

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

Privilege	Condition/Modification/Deletion/Explanation

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Direct Notification of Abnormal Microbiology Findings		
Owner: Clinical Microbiology Lead	Department: Laboratory	
Scope: Laboratory Services		
Date Last Modified: 02/25/2023	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
This policy defines abnormal findings in Microbiology that have to be reported to appropriate providers, medical personnel and specified entities such as Department of Public Health, NIHD Infection Prevention and Pharmacy. It establishes a communication/documentation process for Clinical Laboratory Scientists (CLS) to follow when reporting these findings.
*Note: Please also refer to Standard Operating Procedure (SOP) Critical Value Reporting of Lab Results for critical Microbiology findings indicated by "**critical**" in the table below*

POLICY:
1. A current listing of abnormal findings in Microbiology and who to notify will be maintained in this policy
2. All abnormal findings will be called and documented in the Laboratory Information System (LIS) by a CLS
3. When a patient is transferred to another healthcare facility: Abnormal findings will be called to the primary care nurse by the emergency provider, if patient was inpatient notify hospitalist, pediatrician, or surgeon. If unable to deliver abnormal findings to the appropriate personnel, the results may be given to a CLS at that facility.

DEFINITION:
1. Abnormal findings are those findings whose occurrence have a crucial impact on treatment decisions, infection prevention and disease surveillance that require direct communication of results
2. Abnormal findings can be relayed to licensed providers (such as Medical Doctors [MD], Physician Assistants [PA], Registered Nurses [RN], Licensed Vocational Nurses [LVN]) or medical/clinical/clerical office staff as determined by the outpatient clinic or call facility, infection prevention personnel, pharmacist, Public Health officer and Public Health microbiologist.
3. The following abbreviations (Modes) will be used in the table below that define the abnormal findings by organism and warrant direct notification to the indicated personnel/entities (Roles) as follows:

Mode	Role	Notes
A	Physician	• If inpatient (IP): report to physician or primary care RN *Note: MDRO results have to be called to the provider* • If outpatient (OP): report to physician (if urgent on-call) or emergency department RN or office nurse/designated staff • If Southern Inyo Hospital (SIH) patient: report to SIH Clinical Laboratory or primary care RN
B	NIHD Perinatal RN	Inpatient
C	NIHD Pharmacy	Inpatient
D	NIHD Infection Preventionist	Inpatient and Outpatients 1 = Call notification 2 = Electronic Laboratory Reporting (eLR) – direct notification not required
E	Public Health Department	1 = Call notification to Inyo County Public Health Officer 2 = Call notification to San Bernardino Public Health LRN (Laboratory Response Network) Microbiologist, or designee (after hours, weekends, holidays)
F	NIHD House Supervisor	N/A

4. Overview of Organisms and Course of Action:

Organism	Site/Source	Circumstance	Mode(s)
Acid Fast Bacilli - stain **(critical)**	Any	Positive by referral laboratory; ensure culture is on order unless prior <=30 days culture positive	A (OP on call), D-1 (IP), E-1
Acid Fast Bacilli - culture **(critical)**	Any	Preliminary and final acid fast bacilli and/or possible Mycobacterium sp. isolated by referral laboratory	A (OP on call), D-1 (IP), E-1
Bacillus anthracis **(critical)**	Any	Suspected or confirmed Refer to **SOP Bioterrorism Agents**	A (OP on call), D-1, E-1, E-2
Group A Beta Streptococci	Abscess, Sputum, Sterile site, Throat or Wound	Suspected or confirmed in any amount in culture PCR confirmed	A (OP on call)
Group B Beta Streptococci	Any	Suspected or confirmed in any amount on any site for anyone in Perinatal Department (e.g. post-partum women and neonates)	B
Bordetella pertussis	Any	Suspected or confirmed *Note: Unusual to recover in culture due to growth requirements*	A (OP on call), D-1, E-1
Brucella species **(critical)**	Any	Suspected or confirmed Refer to **SOP Bioterrorism Agents**	A (OP on call), D-1, E-1, E-2
Burkholderia mallei/pseudomallei (**critical**)	Any	Suspected or confirmed Refer to **SOP Bioterrorism Agents**	A (OP on call), D-1, E-1, E-2
Campylobacter species	Any	Suspected or confirmed	A (OP on call), D-1 (IP), E-1
Candida auris	Any	Confirmed by referral laboratory	A (OP on call), D-1 (IP), E-1
Carbapenem-resistant Enterobacterales (CRE) and others	Any	Suspected or confirmed	A (IP hospitalist, OP on call), C, D-1, E-1
Clostridioides difficile toxin	Stool	PCR and Toxins A&B confirmed	A, D-2
Clostridium botulinum **(critical)**	Any	Suspected or confirmed Refer to **SOP Bioterrorism Agents**	A (OP on call), D-1, E-1, E-2

continued on next page

Organism	Site/Source	Circumstance	Mode
EHEC Shiga toxin (**critical**)	Any	Suspected or confirmed	A (OP on call), C, D-1, E-1
Escherichia coli O157 **(critical)**	Any	Suspected or confirmed	A (OP on call), C, D-1, E-1
Escherichia coli, Extended Spectrum Beta-lactamase (ESBL)	Any	Suspected or confirmed	A (IP hospitalist), C, D-2
Francisella tularensis **(critical)**	Any	Suspected or confirmed Refer to **SOP Bioterrorism Agents**	A (OP on call), D-1, E-1, E-2
Haemophilus influenzae	CSF, Sterile site, Sputum, Throat	Suspected or confirmed Under the age of 5 years in sterile site Any age when patient has epiglottitis or meningitis	A (OP on call), C, D-1, E-1
Influenza A	Any	PCR confirmed	A, D-2
Klebsiella oxytoca/ pneumoniae, ESBL	Any	Suspected or confirmed	A (IP hospitalist), C, D-2
Listeria species	Any	Suspected or confirmed	A (OP on call), D-1, E-1
Monkeypox	Any	Suspected or PCR confirmed by referral laboratory	A (OP on call), D-1, E-1, F
Multi Drug Resistant Organism (MDRO)	Any	Suspected or confirmed	A (OP on call), C, D-1, E-1
Neisseria gonorrhoeae	Any	Suspected or confirmed	A, C, D-2
Neisseria meningitidis	Eye, Sterile site, Moderate to Heavy in Sputum	Suspected or confirmed	A, C, D-1 (IP), E-1
Proteus mirabilis, ESBL	Any	Suspected or confirmed	A (IP hospitalist), C, D-2
Pseudomonas aeruginosa	Abscess, Sterile site, Wound, Heavy in Sputum	Suspected or confirmed IP Suspected or confirmed OP – sterile site only	A

continued on next page

Organism	Site/Source	Circumstance	Mode
Salmonella species, except typhi	Any	Suspected or confirmed	A, D-1 (IP), E-1
Salmonella typhi **(critical)**	Any	Suspected or confirmed	A (OP on call), D-1 (IP), E-1
SARS Coronavirus 2 (CoV-2)	Respiratory	PCR confirmed	A, D-2, E-1 by fax
Shigella species	Any	Suspected or confirmed	A, D-1 (IP), E-1
Staphylococcus aureus	Abscess, Sterile site, Wound, Heavy in Sputum	Suspected or confirmed IP	A
Staphylococcus aureus, Vancomycin intermediate/resistant	Any	Suspected or confirmed	A (IP hospitalist, OP on call) D-1, E-1
Vibrio species	Any	Suspected or confirmed	A, D-1 (IP), E-1
Yersinia pestis **(critical)**	Any	Suspected or confirmed Refer to **SOP Bioterrorism Agents**	A (OP on call), D-1, E-1, E-2

PROCEDURE:

1. Laboratory
   A. Inpatients and Emergency Department: **Report within 60 minutes** of the availability of result.
   B. Outpatient clinics: **Report same day** of the availability of the results. On weekends and holidays notify on call physician if indicated (OP on call) or as soon as the clinic hours of operation allow unless policy "Critical Value Reporting of Lab Results" applies
   C. Clinical Laboratory Scientists (CLS) are responsible for notifying the appropriate staff member or entities. The notification (and any attempts) must be documented.
   D. Once a contact has been found:
      i. Report the patient's name and date of birth
      ii. Report the ordering provider's name if speaking with an on-call contact or a clinic
      iii. Report the name of the test and the abnormal finding
   E. Required information to be documented in the Laboratory Information System (LIS) by the CLS:
      i. Name of contact person
      ii. Location of contact person (e.g. ED, RHC, M/S, etc.)
      iii. Date and time contact notified
      iv. Reporting CLS initials
      v. Documentation of any delays or problems in notification
   F. To ensure all necessary documentation is included, use the order comment field and Cerner comment "Result called to _ on _ by _. (template 29MBCALL**)**

2. Nursing/Staff
   A. The nurse or designated clinic staff is responsible for notifying the ordering provider of abnormal findings that are reported from the CLS

B. The nurse is responsible for documenting the conversation with the provider. Documentation will include:
   i. Date and time nurse was notified by lab
   ii. Date, time and name of provider notified
   iii. Abnormal finding reported
   iv. Documentation of any delays or problems in notification

REFERENCES:

1. ASM Clinical Microbiology Procedures Handbook
2. A Guide to Utilization of the Microbiology Laboratory for Diagnosis of Infectious Diseases: Infectious Diseases Society of America and the American Society for Microbiology; *Clinical Infectious Diseases,* Volume 67, Issue 6, 31 August 2018, Pages e1–e94
3. The Joint Commission; National Patient Safety Goals; Implement evidenced-based practices to prevent health-care associated infections due to multidrug-resistant organisms in critical access hospitals.
4. The Joint Commission. Infection Prevention and Control
5. Title 17, California Code of Regulations (CCR), Section 2505; Reportable Conditions: Notifications by Laboratories

RECORD RETENTION AND DESTRUCTION:

Documentation of abnormal findings in Microbiology is kept in the patient's medical record, which is maintained by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Critical Value Reporting of Lab Results
2. Bioterrorism Agents
3. Multi-Drug Resistant Organism (MDRO) Control Plan
4. California Hospital Record and Data Retention Schedule
5. Records Retention and Disposition/Archive of Records and Documents

Supersedes: Not Set

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 Lionel Chadwick PhD, Interim Chief Executive Officer Allison Partridge RN, MSN, Chief Nursing Officer Joy Engblade, MD, Chief Medical Officer (present via zoom)
ABSENT	Stephen DelRossi, MSA, Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Chair Kilpatrick reported that at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No public comments were heard.
CEO SEARCH UPDATE	Chair Kilpatrick called attention to the Chief Executive Officer (CEO) search update. Interim CEO Chad Chadwick commended the Human Resource (HR) team's efforts and provided an update on the process.
CEO RETAINED SEARCH FIRM	There was discussion on the possibility of retaining a search firm if the current search does not produce a viable candidate.
PUBLIC COMMENTS ON CLOSED SESSION ITEMS	Chair Kilpatrick announced that at this time, persons in the audience may speak only on items on the Closed Session portion of this meeting. Public comments were heard from the following:
ADJOURNMENT TO CLOSED SESSION	At 5:59, Chair Kilpatrick announced the meeting would adjourn to Closed Session to allow the District Board of Directors to: *a. Public Employee Performance Evaluation pursuant to Government Code Section 54957 (b)(1). Title: Interim CEO* *b. Conference with Labor Negotiators pursuant to Government Code Section 54957.6. Agency Designated Representatives: HR/Board Chair. Unrepresented employee: Interim CEO* Chair Kilpatrick announced there would be no reportable action.
ADJOURNMENT	Adjournment at 6:38 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

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

CALL TO ORDER

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

PRESENT

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

ABSENT

Jody Veenker, Member-at-Large

OPPORTUNITY FOR PUBLIC COMMENT

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

CHIEF EXECUTIVE OFFICER REPORT

Chair Kilpatrick introduced the Chief Executive Officer Report. Interim Chief Executive Officer Chad Chadwick provided updates on the following items:

- Pioneer Home Health
- Symons Ambulance Closure
- Position Consolidations

CEO Chadwick led a discussion about email access for community members to reach out to the Board of Directors. Bryan Harper, ITS Director, stated there is already email contact available on the District's website.

CEO Chadwick reported that he met with representatives of Mammoth Hospital. They had a positive meeting regarding collaboration and opportunities to work together.

Additionally, CEO Chadwick brought attention to educational materials he provided to the Board of Directors.

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

CFO DelRossi provided an overview of the financial and statistical reports.

It was motioned by Melissa Best-Baker to approve the financial and

statistical reports, seconded by Ted Gardner and the motion passed 4-0.

CFO DelRossi introduced Michael Brown who provided an update on RSM.

CFO DelRossi provided an update on TAG. CEO Chadwick commended the willingness of a wide range of leaders in the organization to engage in this work. It was determined this will be a standing agenda item on future regular Board of Director meetings.

CONTRACT LABOR UTILIZATION

Chair Kilpatrick called attention to Allison Partridge, CNO, who reported on Contract Labor Utilization.

MAT PRESENTATION

Chair Kilpatrick called attention to Jannalyn Lawrence, Director of Outpatient Clinics, who presented information on the MAT (Medication for Addiction Treatment) program.

AD HOC HR COMMITTEE VACANCY

Chair Kilpatrick called attention to the Ad Hoc HR Committee vacancy. CEO Chadwick asked the Board of Directors if they wanted to fill the vacancy on the Ad Hoc HR Committee. Chair Kilpatrick nominated Ted Gardner to fill the position.

It was motioned by Jean Turner to approve Ted Gardner fill the vacancy on the Ad Hoc HR Committee, seconded by Melissa Best-Baker and the motion passed 4-0.

AD HOC COMMITTEE REPORTING

CEO Chadwick led a discussion on report-outs of ad hoc committees and recommended the Board approve this to be a standing agenda item for regular Board of Director meetings.

It was motioned by Jean Turner to approve staff's recommendation to include ad hoc committee reporting as a standing agenda item for regular Board of Director meetings, seconded by Melissa Best-Baker and the motion passed 4-0.

CHIEF OF STAFF REPORT

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

Dr. Engblade provided and overview of the policies for approval.

a. *Admission Procedure of a Pediatric Patient*
b. *Clinic Emergency Response Kit*
c. *Critical Value Reporting of Lab Results*
d. *DI – CT Contrast Administration*
e. *DI – CT Premedication for Contrast Sensitivity*
f. *Floating Nursing Workforce*
g. *Infant Feeding Policy*
h. *Lippincott Procedure Manual Adoption Policy*
i. *Misoprostol for Cervical Ripening*

j. Nursing Quality Assurance Performance Improvement Plan
k. Orthopedic Hardware
l. Oxytocin (Pitocin) Administration
m. Patient Identification for Clinical Care and Treatment/Armband Usage
n. Sentinel Event/Serious Harm Reporting and Prevention

It was motioned by Ted Gardner to approve the policies, seconded by Jean Turner, and the motion passed 4-0.

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Engblade provided an update on the Medical Executive Committee.

CONSENT AGENDA

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

1. *Approval of minutes of the January 18, 2023 Regular Board Meeting*
2. *Approval of Policies and Procedures*
   a. *Sending Protected Health Information by Fax*
   b. *Nursing Certification*
   c. Used Equipment Sales
   d. Cross-Training of RN Staff
   e. Check Signing
   f. Capitalization of Assets
   g. Smoking Tobacco Policy
   h. Prompt Pay Discounts

Chair Kilpatrick brought attention to a correction of the January 18, 2023 meeting minutes.

A discussion ensued regarding the policies and procedures.

Treasurer Turner motioned to approve the Consent Agenda with the proposed correction to the minutes, Vice Chair Best-Baker seconded and the motion passed 4-0

REPORTS FORM BOARD MEMBERS

Chair Kilpatrick opened up reports to Board Members.

Treasurer Gardner reported that he went through the onboarding process and found it to be valuable.

Secretary Turner reported she will attend her first ACHD meeting on February 16, 2023 and the annual ACHD conference for Board Members and CEOs will be held September 13-15 at Olympic Valley.

Chair Kilpatrick noted that anyone who is interested in cannabis operations in Bishop should attend the next City Council meeting.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

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

ADJOURNMENT TO CLOSED SESSION

At 6:53, Chair Kilpatrick announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

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

Chair Kilpatrick announced there would be no reportable action.

ADJOURNMENT

Adjournment at 7:47 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

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

CALL TO ORDER	The meeting was called to order at 5:30 p.m. by Mary Mae Kilpatrick, Northern Inyo Healthcare District (NIHD) Board Chair.
PRESENT	Mary Mae Kilpatrick, Chair Melissa Best-Baker, Vice Chair Jean Turner, Secretary Ted Gardner, Treasurer Jody Veenker, Member-at-Large Lionel Chadwick PhD, Interim Chief Executive Officer Stephen DelRossi, MSA, Chief Financial Officer Allison Partridge RN, MSN, Chief Nursing Officer Joy Engblade, MD, Chief Medical Officer (present via zoom)
OPPORTUNITY FOR PUBLIC COMMENT	Chair Kilpatrick reported that at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No public comments were heard.
TENTATIVE AGREEMENT BETWEEN NIHD AND AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES (AFSCME) TECHNICAL UNIT	Chair Kilpatrick called attention to the Tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) Technical, Business Office Clerical and Service Unit. CEO Chadwick stated is was staff's recommendation to approve the agreement. Jean Turner thanked the parties involved in the negotiations. It was motioned by Jean Turner to approve the Tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) Technical, Business Office Clerical and Service Unit, seconded by Jody Veenker, and the motion passed 5-0.
DISTRICT BOARD RESOLUTION 23-02	Chair Kilpatrick called attention to the proposed District Board Resolution 23-02, a resolution of the governing Board of the Northern Inyo Healthcare District providing for adoption of a tentative agreement between the Northern Inyo Healthcare District and District Council 57, American Federation of State, County, and Municipal Employees (AFSCME), AFL-CIO Patient Care Technical, Business Office Clerical and Service Unit. Chair Kilpatrick read aloud District Board Resolution 23-02, a resolution of the governing Board of the Northern Inyo Healthcare District providing for adoption of a tentative agreement between the Northern Inyo Healthcare District and District Council 57, American Federation of State, County, and Municipal Employees (AFSCME), AFL-CIO Patient Care Technical, Business Office Clerical and Service Unit. It was motioned by

Jody Veenker to approve District Board Resolution 23-02, seconded by Ted Gardner, and the motion passed 5-0 via roll call vote.

Chair Kilpatrick - yes
Ms. Best-Baker - yes
Ms. Turner - yes
Mr. Gardner - yes
Ms. Veenker - yes

TENTATIVE AGREEMENT BETWEEN NIHD AND AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES (AFSCME) RN UNIT

Chair Kilpatrick called attention to the Tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) RN Unit.

It was motioned by Melissa Best-Baker to approve the Tentative Agreement between NIHD and American Federation of State, County, and Municipal Employees (AFSCME) RN Unit, seconded by Jean Turner, and the motion passed 5-0.

DISTRICT BOARD RESOLUTION 23-03

Chair Kilpatrick read aloud District Board Resolution 23-03, a resolution of the governing Board of the Northern Inyo Healthcare District providing for adoption of a tentative agreement between the Northern Inyo Healthcare District and District Council 57, American Federation of State, County, and Municipal Employees (AFSCME), AFL-CIO Registered Nurse Unit. It was motioned by Jody Veenker to approve District Board Resolution 23-03, seconded by Melissa Best-Baker, and the motion passed 5-0 via roll call vote.

Chair Kilpatrick - yes
Ms. Best-Baker - yes
Ms. Turner - yes
Mr. Gardner - yes
Ms. Veenker - yes

ADJOURNMENT

Adjournment at 5:38 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

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

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Date: 3/1/2023
To: Board of Directors
From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Ongoing projects include:

- Multiple physician credentialing in preparation for our Telestroke/Teleneurology service with Sevaro
- Staying up to date with new regulations that affect the Medical Staff and Advanced Practice Providers
- Continuing to take the lead with Physician Recruitment

Physician Recruitment update

- Psychiatric Nurse Practitioner: In partnership with Dr. Murat Akalin, a psychiatrist in San Luis Obispo, we have welcomed Sue Park, Psych NP. Sue will be seeing new patients 18 years and older with any psychiatric diagnosis
- We are recruiting for a pediatrician to join our team and we are using an outside agency for assistance.

Pharmacy Department update

The Pharmacy remodel continues at a steady pace. At this point, framing has begun and the walls/rooms are starting to take shape. Overall, we remain on schedule with the construction.

The Telepharmacy after-hours service has been implemented and is going well. This service is providing our pharmacists with much needed respite during the nighttime hours. Our hospital based clinical teams have had good feedback with the remote service. We will continue to monitor for medication irregularities (as we routinely do) and will continue to seek feedback from our clinical teams.

Quality Department update

Our Quality department has been very active with a large focus on our Quality Incentive Program (QIP). QIP will encompass 12-14 quality projects throughout the District. The Quality department will support each of these projects with data and resources but the bulk of the work will be done by our clinical teams throughout the District. These project will span multiple years and the goal is for improved access and clinical outcomes for all of our patients. We are really excited to be working on all of these projects and will report outcomes to the Board in the coming year.

Dietary Department

Our Registered Dietitians (RD) continue to work diligently for our patients. In the past month, we have had a focus on the RD's partnership with the kitchen staff. As you are aware, many patients have specific dietary restrictions or recommendations while in the hospital. The type of diet is ordered by the attending physician and prepared by our kitchen staff. The kitchen staff is also responsible for any consistency or texture changes that are needed including chopping meat, adding gravy to make things easier to swallow, or pureeing food. Our RD's oversee this process to ensure our patients are getting the correct food. Both our RD's and kitchen staff continue to do a wonderful job.

Rehab Department

Our Rehab Department has been doing a lot of provider and community education over the past few months. Most recently, Adam Maxwell, Physical Therapist teamed up with Dr. Chris Rowan, cardiology to present information about Exercise and Cardiovascular Health for our last Healthy Lifestyles Talk. (Link: https://www.youtube.com/watch?v=wbskLRqS3wg&list=PLspBgFva6dGVDGL1soOWGTlkwPPcFkWEz&index=15) We continue to recruit for a Speech Therapist and recently posted for a Physical Therapy Assistant.

Infection Prevention

Covid 19

We continue to run the RHC "Car Clinic" for acute illness needs, testing for Covid, RSV and influenza. We are still providing "test to treat" Paxlovid as indicated for acute Covid cases.

Infection Prevention

CDPH Hospital Acquired Infection (HAI) team provided us with a voluntary audit in February. Findings were minimal and helpful for our processes. Our Infection Prevention team including Robin Christensen and Andrea Conley are doing an amazing job to keeping up with all of the reporting requirements and are local experts in the area of Infection Prevention.

Community Health Needs Assessment (CHNA)

In response to our CHNA in 2022 outlining our community's desire for more access to services, we have started several projects including EConsults, Psychiatric services and coming this spring, Telestroke. With all of these projects, we are thinking creatively about how to bring services to our area, sometimes in unconventional ways. EConsults are messages that are sent from your provider to a specialist (that you, as a patient never see) and clinical recommendations are received by your primary provider from the specialist. Behavioral health services are more robust in our area now with the addition of a psychiatric nurse practitioner. As noted earlier in my report, this Psych NP will be seeing adults 18 years or older who have any psychiatric diagnosis. Lastly, we know that time sensitive diagnosis like stroke are a challenge to diagnose and treat so we will be partnering with a Telestroke/Teleneurology company called Sevaro to assist us. We will have 24/7 access to a stroke neurologist who will be able to see our patients via video technology and will provide our local physicians with real time recommendations.

Farewell

This will be my last CMO Board report. I have been at Northern Inyo Healthcare District since 2014, initially working in Drs. Kamei and Hathaway's office, then as a hospitalist. Through the years, I have

served as the Hospitalist Director and Chief of Staff. In 2020, I assumed the role of the Chief Medical Officer. I have loved my time here. I have learned more from everyone here than I have given. NIHD is a special place that will always have a special place in my heart. For now, I need to be closer to my family so my husband and I will be moving out of the area. I will be leaving you in very capable hands with Dr. Stefan Schunk assuming my role on an interim basis from April to August, then Dr. Adam Hawkins taking over in August 2023 as the permanent CMO. I will miss you all!

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

Date: March 4, 2023

Title: **Compliance Department Report**

Synopsis: The Compliance Department Quarterly Report updates the Board on the work of the Compliance Department. It provides information on audits, alleged breaches, contract work, and projects. All information in the report is summarized, however, any additional details will be provided to the Board of Directors upon request.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

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

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Annual Compliance Report –Calendar year 2022
March 15, 2023

Comprehensive Compliance Program review summary:

1. **Audits** - A wide variety of audits in the Compliance Program review for privacy concerns, language access issues, and fraud, waste, and abuse.
2. **Security Risk Assessment** - District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment for 2022 has been completed by Compliance and IT Security.
3. **SAFER** - Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) has been completed. Cooperative process between Quality, IT, Informatics, and Compliance.
4. **Compliance Workplan** - The Compliance Workplan is updated annually, and as needed, to adjust the focus of certain audits, in alignment with the Office of Inspector General (of the Department of Health and Human Services) and our local Medicare Administrative Contractor (MAC), Noridian priorities.
5. **Conflicts of Interest** – This important component of the Compliance Program ensures that no parties use or conduct District business for personal financial gain.
6. **Privacy Investigations –** Privacy investigations can arise due to complaints, access audits, HIMS audits, and anonymous reporting.
7. **Other Investigations –** Other compliance related investigations are conducted to avoid regulatory non-compliance, investigate regulatory compliance, and respond to regulatory agency inquiries and investigations.
8. **Compliance Committees –** This section provides a brief overview of the work of the Compliance committees and sub-committees.
9. **Issues and Inquiries** – The compliance team researches numerous questions, concerns and regulatory issues for other NIHD team members to take a proactive approach.
10. **CPRA Requests** – The Compliance Officer is responsible for intake and review of public records requests, and research, investigation, redaction and fulfillment of those requests.

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11. **Policy Management Software** – The Compliance Team currently manages the software, user configuration, policy tracking for approvals and education and support for District leadership.
12. **Contract Document Storage Software** – The Compliance Team currently manually manages contracts.
13. **Unusual Occurrence Reports** – The Compliance Team currently processes and tracks all unusual occurrence reports for the District and provides the quality data to leadership and teams for monitoring and trending, and follow-up to performance improvement projects.

1. Audits

A. Employee Access Audits - The Compliance Department Analyst, Conor Vaughan, completes audits for access of patient information systems to ensure employees access records only on a work-related, need-to-know, and minimum necessary basis.
   i. Cerner semi-automated auditing software tracks all workforce interactions and provides a summary dashboard for the compliance team. The dashboard provides "flags" for unusual activity. The following is Q4 CY22 activity
      a. New Employee Audits: 45
         I. Flags: 0
         II. Flags resulting in policy violations: 0
      b. For Cause Audits: 7
         I. Flags: 2
         II. Flags resulting in policy violations: 2
      c. In "own" chart flags: 12
         I. Flags resulting in policy violations: 12
            i. Provided education and training: 12
            ii. Repeat violations: 0
      d. Same Last Name Search Flags: 320
         I. Resulted in follow up with employee: 8
         II. Flags resulting in disciplinary action: 1

B. Business Associates Agreements (BAA) audit
   i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health

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information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor meets the strict governmental regulations regarding how to handle, transmit, and store protected information to protect NIHD and NIHD patient information.

ii. NIHD currently has approximately 200 BAAs.
    a. 2 are currently in negotiation

C. Contract and Agreement reviews/audit
    i. Contracts and agreements are in the following status for Q4 CY 22:
        a. ~73 contracts were reviewed and executed
        b. ~19 contracts are in the review process
        c. ~10 are awaiting fully executed copies
        d. ~13 are on hold
        e. ~25 existing contracts are also in the review process
        f. ~3 contract terminations are in progress

D. Third Party Electronic Health System Access
    i. Policy has been approved.
    ii. A Smartsheet has been developed to streamline workflow, and has been successfully tested.
    iii. This is a major development and improvement to District processes for access to the EHR by outside vendors, parties, and treatment partners.

E. HIMs (Health Information Management) scanning audit
    i. To be conducted by HIMS and summary reports will be sent to Compliance

F. Email security audit/reviews
    i. Reviewed at least once a month
    ii. Review email security systems for violations of data loss prevention rules
        a. Typically results in reminder emails to use email encryption sent to members of workforce.
        b. Occasionally results in full investigations of potential privacy violations.

G. Language Access Services Audit
    i. Compliance is waiting for Cerner to develop a report to allow selection of English as a Second Language (ESL) patients.
    ii. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.

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H. 340B program audits
   i. Annual 340B audit is underway by SpendMend (formerly TurnKey)
   ii. DHCS (CA Department of Health Care Services) Self Audit – completed. Awaiting final determinations

I. Narcotic Administration/Reconciliation Audit
   i. Working in conjunction with Pharmacy to review narcotic administration.
   ii. One "for-cause" audit completed (January 2023)

J. Vendor Diversity Audit – NIHD has approximately 1370 vendors.
   i. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI, formerly OSHPD) to develop and administer a program to collect hospital supplier diversity reports, including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
   ii. NIHD has 3 certified diverse vendors in the vendor master record
      a. 0% spend for CY 2021 with diverse vendors
      b. CY 2022 report will be submitted to HCAI before the 07/01/2023 deadline.
      c. Diversity reports are now required annually in California. As of this time, there is no requirement to have a percentage of spend with diverse vendors; however, there is discussion of requiring plans for California organizations and businesses to develop plans to increase vendor diversity.

K. Provider Verifications
   i. More than 215 providers were verified and were checked for state and federal exclusions in year 2022
   ii. No exclusions were found for verified providers.
   iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

L. Claim/Charge Audits
   i. Cataract Surgeries – completed
   ii. Department of Transportation Physicals – completed
   iii. Low Dose Lung CT – completed

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iv. Colonoscopies – in progress

2. **HIPAA Security Risk Assessment (SRA)** – Completed November 2022 – see attached
   A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG
   B. Penetration Testing is scheduled with IT (Information Technology) Security.
   C. Internal pre-penetration testing is underway by NIHD security.
3. **Office of National Coordinator of Health Information Technology SAFER Audit** ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) has been completed. see attached
4. **Compliance Work Plan** – Updated October 2022, see attached
5. **Conflicts of Interest**
   A. The Compliance department emailed the NIHD workforce the 2022 Conflicts of Interest (COI) form.
      i. Compliance is processing COI forms received and will notify the Business Compliance Team when ready to schedule a meeting to review the forms.
   B. No COI forms submitted to the compliance department noted any knowledge or concern for the following:
      i. Business transactions with an aim for personal gain.
      ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
      iii. Use of NIHD resources for purposes other than NIHD business, NIHD sponsored business activities, or activities allowed by policy.
      iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
      v. Use of NIHD money, goods, or services to influence government employees, or for special consideration or political contribution.
      vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.
6. **Privacy Investigations**
   A. Privacy investigations/potential breaches between January 1, 2023 – February 28, 2023 – total 5
      i. Reported to CDPH/OCR – 1
         a. One breach were substantiated with no deficiencies
      ii. Investigations still active in the Compliance Department – 3

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a. One reported breach is still in discovery phase. Audits are still being conducted to determine exact volume of breaches. Appears to be under 75 patients affected by one process issue.

iii. Investigations closed by the Compliance Department with no reporting required - 3

B. Privacy investigations/potential breaches between January 1, 2022 – December 31, 2022 – total 53, see attached
   i. Reported to CDPH/OCR – 6
      a. Two breaches were substantiated with no deficiencies
      b. Four breaches in submitted/in progress status with CDPH
   ii. Investigations still active in the Compliance Department - 0
   iii. Investigations closed by the Compliance Department with no reporting required - 38
C. Privacy investigations from 2021
   i. Reported to CDPH/OCR 2021– 4
      a. Two potential breaches are in submitted status with CDPH
D. Privacy investigations from 2020 (outstanding with regulatory agency)
   i. Reported to CDPH/OCR 2020
      a. Eight (8) potential breaches have no CDPH determination at this time.
E. Privacy investigations from 2019 (outstanding with regulatory agency)
   i. Reported to CDPH/OCR 2019
      a. One (1) potential breach has no CDPH determination at this time.

7. Investigations

A. Compliance has conducted or assisted with three (3) investigations/reviews that were not related to privacy/breach allegations thus far in 2023.
   a. California Occupational Safety and Health (January 2023)
      I. One complaint alleged regarding training on location of Personal Protective Equipment (PPE) and providing time to don PPE
B. Compliance conducted or assisted with 37 investigations/reviews that were not related to privacy/breach allegations in 2022.
   i. Regulatory agency requests (examples below, not an inclusive list)
      a. Department of Health Care Services (DHCS)
      b. California Department Public Health (CDPH)
      c. California Occupational Safety and Health

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ii. Workplace Violence/Safety/Security issues
iii. Third party payer grievances or reviews
iv. Workforce compliance and ethics violations
v. Contractual obligation disputes
vi. Fraud, waste, and abuse concerns
vii. Narcotics Reconciliation/Potential Diversion Cases

8. Compliance Committees

A. Compliance and Business Ethics Committee (CBEC**)**
   i. Tabled review of Compliance Program for Q4 CY 2022 meeting
   ii. Next meeting will be scheduled in March 2023

B. Billing and Coding Compliance Committee (BCCC) reports to the CBEC committee.
   i. This group reviews billing/coding issues, chargemaster changes, and policies that affect billing/coding/accounting. This subcommittee is chaired by the Compliance Officer and meets bi-weekly.
   ii. The chair of this meeting will transition to the Billing Office throughout 2023.

C. Business Compliance Team (BCT) reports to the CBEC Committee.
   i. This group reviews all Conflict of Interest questionnaires with potential conflicts to determine the appropriate and consistent method to address the conflict. This subcommittee is chaired by the Compliance Officer and meets on an ad hoc basis.

D. Forms Committee
   i. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. There are standardized templates, designated fonts, official translations, and mandatory non-discrimination and language access information.
   ii. All forms and public information documents used at the District for patient care, regulatory requirements, orders, down-time documentation, standardized workflows, and process improvement are submitted to the Forms Committee. Once approved they are maintained in a location on the NIHD Intranet (a quick link named “Approved Forms”) for access by NIHD workforce.
   iii. The team will begin requesting postings and signage to be approved through the Forms Committee, as there is problem with “signage fatigue,” inconsistency, failure to meet Affordable Care Act Section 1557 standards,

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failure to use consistent District branding, and failure to obtain appropriate translations.

iv. We have added Barbara Laughon to this committee to ensure her review and approval of all signage and postings, other than those posters legally required by employment law.

v. More than 150 forms and documents have been developed or revised from January 1, 2022 through December 31, 2022

E. Non-Clinical Consistency Oversight Committee (NCOC)

i. This Committee mirrors the Clinical Consistency Oversight Committee, however is the approval process for non-clinical policies, such as finance or compliance.

ii. The Compliance Officer currently chairs this meeting but it will transition to the COO.

9. Issues and Inquiries

A. Compliance has researched several hundred issues for various District workforce members and leadership in 2022. They include COVID-19 mandates and changes, COVID-19 exceptions and exemptions, minor privacy regulations, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, Federal Motor Carrier Safety Administration regulations, adoption processes, confidentiality issues, release of information and information blocking regulations, physician departures, regulatory updates, and many other areas of interest and concern.

B. Compliance has worked with NIHD workforce, local law enforcement agencies, and the District Attorney to address multiple areas of partnership, in 2022.

i. Education/training to NIHD and Law Enforcement Agencies regarding mandatory and permissive release of information.

ii. Subpoena service process for subpoenas related to NIHD work-related activities.

iii. Law enforcement presence on campus in non-emergent situations.

iv. Sexual Assault Response Team (SART) regulations and information

10. CPRA (California Public Records Act) Requests

A. Compliance has received four (4) CPRA requests in CY 2023.

i. One is still in progress.

B. The Compliance office received nine (9) CPRA requests in CY 2022.

i. All completed.

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11. Optimization, update, and audit of Policy Management software

A. Proper policies and policy management is a large component of an effective Compliance Program.
B. Tracy Aspel, Compliance Policy Management Administrator, continues to work with leadership to facilitate updated policies and leadership growth.
C. Ms. Aspel will continue to support the Compliance Team and NIHD through March of 2023.

12. Optimization, update, and audit of Contract document storage software

A. Updating contracts/agreements status is facilitated by Katie Manuelito, Compliance Analyst.
    i. NIHD currently has no contract-lifecycle management software. This affects compliance, budgeting, department heads, accounting, and finance. Katie Manuelito, Compliance Contract Analyst, currently spends about 30 hours a week tracking, updating, processing, and following-up on contracts.
        a. Failure to terminate contracts properly has cost the District an average of $10k-20k/year.
        b. There is currently no systemic process to notify Leaders to review and renew or terminate contracts on a timely basis to avoid automatic renewal.
        c. A manual review of all contracts must be undertaken during external financial audit to review for all contracts that require reporting under GASB 87 (leases).
        d. Reconciliation for leadership to sign off on invoices generated from contracts is challenging under the current system.
        e. Manual contract management consumes approximately 25-45 hours of compliance team time weekly.
B. Hosts about 2000 contracts (including archived and current contracts/agreements)

13. Unusual Occurrence Reports (UOR)

A. UOR quality report data for January 1, 2022 through December 31, 2022, see attached
    i. Notable trends out of 613 UORs received in CY 2022:
        a. UORs regarding complaints and requests to review billing and care are the highest volume,
        b. Safety and security issues are trending up.

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c. Specimen issues are trending down following implementation of a new training and competency plan implemented in the phlebotomy area.
d. 34 UORs have resulted in systemic changes in the organization thus far in 2022.

ii. NIHD has added tracking for alarm fatigue – examples: disabled alarms, alarms noted to have the volume turned off, ignored alarms

B. The UOR process involves significant work and time from the Compliance team.
i. All UORs in Complytrack are currently received by the Compliance Team.
a. Many patient complaint and concern phone calls are transferred to the Compliance team for intake and assistance.
b. The Compliance team typically provides response letters for the patient complaints, although the CMO assists on specific clinical matters.
ii. UORs are triaged and assigned to appropriate department leaders for review. Emails and phone calls are placed to leaders for urgent UORs.
iii. The Compliance team reviews replies, ensures thorough responses and corrective actions, provides follow up letters to patients, and ensures the executive team is aware of all areas of concern.
iv. The Compliance team follows up with leaders who are having difficulty with timely responses and attempts to assist them with resolution.
v. The Compliance team ensures UORs are closed after thorough review, corrective actions and, in most cases, resolution.

Section 1, SAMPLE UPDATE SRA Basics	
Threats & Vulnerabilities	
Failure to remediate known risk(s)	
Information disclosure (ePHI, proprietary, intellectual, or confidential)	Low
Penalties from contractual non-compliance with third-party vendors	High
Disruption of business processes, information system function, and/or prolonged adversarial presence within information systems	Medium
Data deletion or corruption of records	Medium
Prolonged exposure to hacker, computer criminal, malicious code, or careless insider	Medium
Corrective enforcement from regulatory agencies (e.g. HHS, OCR, FTC, CMS, State or Local jurisdictions)	High
Hardware/equipment malfunction	Low

Section 2, Security Policies
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 2.

Section 3, Security & Workforce
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 3.

Section 4, Security & Data	
Threats & Vulnerabilities	
Inadequate integrity verification of ePHI	
Accidental modification to ePHI	Low
Damage to public reputation via misuse of patient chart data	Medium
Inaccurate information given to patients or providers	Medium
Unauthorized modification to ePHI	Medium

Section 5, Security and the Practice
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 5.

Section 6, Security and Business Associates
Threats & Vulnerabilities

No Threats and Vulnerabilities were selected or rated in Section 6.

Section 7, Contingency Planning

Threats & Vulnerabilities

No Threats and Vulnerabilities were selected or rated in Section 7.

Areas for Review

Section	Question	Your Answer	Education	References
1	Q6. What do you include in your SRA documentation?	Our SRA documentation includes possible threats and vulnerabilities which we assign impact and likelihood ratings to. This allows us to determine severity. We do not include corrective action plans.	Corrective action plans should be developed as needed to mitigate identified security deficiencies according to which threats and vulnerabilities are most severe.	For additional information, see Security Rule 45 CFR §164.308(a)(1)(ii)(A)

Section	Question	Your Answer	Education	References
2	Q1. Do you maintain documentation of policies and procedures regarding risk assessment, risk management and information security activities?	Yes, we have some documentation for our information security and risk management activities, but not all of our policies and procedures are documented.	You should document policies and procedures to ensure you consistently make informed decisions on the effective monitoring, identification, and mitigation of risks to ePHI.	For additional information, see Security Rule 45 CFR §164.316(a)

Section	Question	Your Answer	Education	References
2	Q5. How does documentation for your risk management and security procedures compare to your actual business practices?	Our risk management and security documentation somewhat accurately reflects our business practices.	Risk management and security documentation should accurately reflect business practices. Ensure that your security documentation represents your actual security practices.	For additional information, see Security Rule 45 CFR §164.316(b)(1)(i) & (ii)

Section	Question	Your Answer	Education	References
3	Q1. Who within your practice is responsible for developing and implementing information security policies and procedures?	The role of security officer is described in our policy documentation, but the person who occupies that role is not named.	You should have a qualified and capable person appointed to the responsibility of security officer. Having a central point of contact helps ensure that information security practices are coordinated, consistent, and that the organization can be held accountable.	For additional information, see Security Rule 45 CFR §164.308(a)(2)

Section	Question	Your Answer	Education	References
3	Q7. How are roles and job duties defined as pertained to accessing ePHI?	We have written job titles, but no written roles or responsibilities for workforce members with access to ePHI.	Consider implementing procedures for the authorization and/or supervision of workforce members who work with ePHI or in locations where it might be accessed. If such procedures are determined to not be reasonable and appropriate, document the reason why and what is being done to compensate for these lack of procedures.	For additional information, see Security Rule 45 CFR §164.308(a)(3)(ii)(A)

Section	Question	Your Answer	Education	References
4	Q6. Do you ensure all of your workforce members have appropriate access to ePHI?	Yes. We have written procedures to ensure workforce members' access privileges are minimum necessary but these are not always based on their roles.	You should implement and document procedures to ensure workforce members have access privileges based on their role and no higher than necessary to perform their duties. These procedures and access privileges should be appropriately approved and communicated.	For additional information, see Security Rule 45 CFR §164.308(a)(3)(i)

Section	Question	Your Answer	Education	References
4	Q21. How do you determine the means by which ePHI is accessed?	Applications which access ePHI are identified, evaluated, approved, and inventoried, but we do not manage which devices can access these applications (e.g. workforce members# personal devices accessing a cloud-based EHR without first identifying and approving the device)	Unsecured points could compromise data accessed through an otherwise secure application. Consider implementing a device management process to ensure security standards are in place for all points accessing ePHI.	For additional information, see Security Rule 45 CFR §164.312(d)

Section	Question	Your Answer	Education	References
4	Q22. Do you protect ePHI from unauthorized modification or destruction?	Yes. We have some procedures to protect the integrity of our ePHI but these may not be totally comprehensive.	Implement policies and procedures to protect ePHI from unauthorized modification or destruction, such as user activity monitoring or data validation tools.	For additional information, see Security Rule 45 CFR §164.312(c)(1)

Section	Question	Your Answer	Education	References
4	Q25. Have you implemented mechanisms to record activity on information systems which create or use ePHI ?	Yes. Activity on systems which create or use ePHI is recorded and examined through hardware, software or procedural mechanisms. However, this process is not formally documented in our procedures.	Mechanisms in place to record and examine activity on information systems which contain or use ePHI should be documented in your security documentation.	For additional information, see Security Rule 45 CFR §164.312(b)

Section	Question	Your Answer	Education	References
5	Q1. Do you manage access to and use of your facility or facilities [i.e. that house information systems and ePHI]?	Yes. Authorization of access to and use of our facilities is verbally communicated, but we do not have written procedures.	Consider implementing documented procedures to govern access to facilities.	For additional information, see Security Rule 45 CFR §164.310(a)(1)

Section	Question	Your Answer	Education	References
5	Q8. Do you have an authorized user who approves access levels within information systems and locations that use ePHI?	Yes. We have a verbally communicated process for determining access to information systems, locations, and ePHI.	Consider assigning an authorized user to approve access levels with information systems and locations that contain and use ePHI. If this is determined to not be reasonable and appropriate, document the reason why and implement a compensating control.	For additional information, see Security Rule 45 CFR §164.308(a)(3)(ii)(A)

Section	Question	Your Answer	Education	References
5	Q22. Do you ensure access to ePHI is terminated when employment or other arrangements with the workforce member ends?	Yes. We have a verbal process to ensure access to ePHI is changed or terminated as needed, but no written procedures.	Changes to access to ePHI should be documented in the event of device recovery, deactivation of user access, and changes in access levels or privileges. Policy documentation should include details on how the process is completed.	For additional information, see Security Rule 45 CFR §164.308(a)(3)(ii)(C)

Section	Question	Your Answer	Education	References
5	Q23. Do you have procedures for terminating or changing third-party access when the contract, business associate agreement, or other arrangement with the third party ends or is changed?	No	Ensure that access to ePHI by third parties is terminated or changed appropriately when your contractual relationship with them s or changes, respectively.	For additional information, see Security Rule 45 CFR §164.308(a)(3)(ii)(C)

Section	Question	Your Answer	Education	References
7	Q4. How do you ensure that your contingency plan is effective and updated appropriately?	We periodically review the plan's contents but do not perform any tests or exercises of the plan#s effectiveness.	Consider periodically testing the contingency plan for effectiveness. Maintain documentation of contingency plan testing and revisions in your policies and procedures.	For additional information, see Security Rule 45 CFR §164.308(a)(7)(ii)(D)

Section	Question	Your Answer	Education	References
7	Q9. How does your practice prevent, detect, and respond to security incidents?	We have a security incident response plan documented in our policies and procedures.	Consider testing the security incident response plan periodically using a documented process. The incident plan should cover broad categories of incidents to prepare for. Testing the incident plan is an effective means of preparation and training.	For additional information, see Security Rule 45 CFR §164.308(a)(6)(i)

Section	Question	Your Answer	Education	References
7	Q12. Has your practice evaluated and determined which systems and ePHI are necessary for maintaining business-as-usual in the event of an emergency?	No, we have not implemented a process for identifying and assessing criticality of information systems.	Consider evaluating all hardware and software systems, including those of business associates, to determine criticality of the systems and ePHI that would be accessed. Document this process and include all mission-critical systems in your contingency plan.	For additional information, see Security Rule 45 CFR §164.308(a)(7)(i)

Section	Question	Your Answer	Education	References
7	Q15. Do you have a plan for backing up and restoring critical data?	Yes, we have a plan for creating retrievable, exact copies of critical data and how to restore that data. We do not have a process for testing and revising this plan.	Consider conducting periodic tests of backup recovery procedures	For additional information, see Security Rule 45 CFR §164.308(a)(7)(ii)(A),§164.308(a)(7)(ii)(B), and §164.308(a)(7)(ii)(E)

Self-Assessment

High Priority Practices

General Instructions for the SAFER Self-Assessment Guides

The SAFER Guides are designed to help healthcare organizations conduct self-assessments to optimize the safety and safe use of electronic health records (EHRs) in the following areas.

- High Priority Practices
- Organizational Responsibilities
- Contingency Planning
- System Configuration
- System Interfaces
- Patient Identification
- Computerized Provider Order Entry with Decision Support
- Test Results Reporting and Follow-Up
- Clinician Communication

Each of the nine SAFER Guides begins with a Checklist of recommended practices. The downloadable SAFER Guides provide fillable circles that can be used to indicate the extent to which each recommended practice has been implemented. Following the Checklist, a Practice Worksheet gives a rationale for and examples of how to implement each recommended practice, as well as likely sources of input into assessment of each practice, and fillable fields to record team members and follow-up action. In addition to the downloadable version, the content of each SAFER Guide, with interactive references and supporting materials, can also be viewed on ONC's website at www.healthit.gov/SAFERGuide.

The SAFER Guides are based on the best evidence available at this time (2016), including a literature review, expert opinion, and field testing at a wide range of healthcare organizations, from small ambulatory practices to large health systems. The recommended practices in the SAFER Guides are intended to be useful for all EHR users. However, every organization faces unique circumstances and will implement a particular practice differently. As a result, some of the specific examples in the SAFER Guides for recommended practices may not be applicable to every organization.

The SAFER Guides are designed in part to help deal with safety concerns created by the continuously changing landscape that healthcare organizations face. Therefore, changes in technology, practice standards, regulations and policy should be taken into account when using the SAFER Guides. Periodic self-assessments using the SAFER Guides may also help organizations identify areas in which it is particularly important to address the implications of change for the safety and safe use of EHRs. Ultimately, the goal is to improve the overall safety of our health care system.

The SAFER Guides are not intended to be used for legal compliance purposes, and implementation of a recommended practice does not guarantee compliance with HIPAA, the HIPAA Security Rule, Medicare or Medicaid Conditions of Participation, or any other laws or regulations. The SAFER Guides are for informational purposes only and are not intended to be an exhaustive or definitive source. They do not constitute legal advice. Users of the SAFER Guides are encouraged to consult with their own legal counsel regarding compliance with Medicare or Medicaid program requirements, HIPAA, and any other laws.

For additional, general information on Medicare and Medicaid program requirements, please visit the Centers for Medicare & Medicaid Services website at www.cms.gov. For more information on HIPAA, please visit the HHS Office for Civil Rights website at www.hhs.gov/ocr.

Self-Assessment

High Priority Practices

Introduction

The *High Priority Practices SAFER Guide* identifies "high risk" and "high priority" recommended safety practices intended to optimize the safety and safe use of EHRs. It broadly addresses the EHR safety concerns discussed in greater detail in the other eight SAFER Guides. Assembling a multi-disciplinary safety team is recommended to complete this guide, as a team will be best equipped to identify which EHR-related safety practices should be addressed first and which of the other SAFER Guides to turn to next.

The potential benefits of EHRs may not be fully maximized unless the people responsible for their implementation, maintenance, and use are prepared for and manage the new challenges and risks they create.[1, 2, 3, 4, 5, 6] These new risks are both "social" (involving people, leadership, workflow, and policies) and "technical" (involving EHR hardware and software and system-to-system interfaces, configurations, upgrades, and maintenance). This guide is designed to help the people responsible for EHR safety in each specific complex "sociotechnical" healthcare organization focus on the most important safety challenges and risks introduced by EHRs.

Completing the self-assessment in the High Priority Practices SAFER Guide requires the engagement of people both within and outside the organization (e.g., EHR technology developers, diagnostic services providers). Because this guide is designed to help organizations prioritize EHR-related safety concerns, clinician leadership in the organization should be engaged to assess whether and how any particular recommended practice affects the organization's ability to deliver safe, high quality care.

Collaboration between clinicians and staff members while completing the self-assessment in this guide will enable an accurate snapshot of the organization's EHR status in terms of safety. Even more importantly, collaboration should lead to a consensus about the organization's future path to optimize EHR-related safety and quality: setting priorities among the recommended practices not yet addressed, ensuring a plan is in place to maintain recommended practices already in place, dedicating the required resources to make necessary improvements, and working together to mitigate the highest priority safety risks introduced by the EHR.

The *Checklist* is structured as a quick way to enter and print your self-assessment. Your selections on the checklist will automatically update the related section of the corresponding *Recommended Practice Worksheet*.

The *Domain* associated with the *Recommended Practice(s)* appears at the top of the column.

The *Recommended Practice(s)* for the topic appear below the associated *Domain*.

Recommended Practices for Domain 1 — Safe Health IT		Implementation Status: Fully in all areas	Partially in some areas	Not implemented	
1.1 The EHR supports and uses standardized protocols for exchanging data with other systems.	Worksheet 1.1	○	○	○	reset
1.2 Established and up-to-date versions of operating systems, virus and malware protection software, application software, and interface protocols are used.	Worksheet 1.2	○	○	○	reset
1.3 System-to-system interfaces support the standard clinical vocabularies used by the connected applications.	Worksheet 1.3	○	○	○	reset
1.4 System-to-system interfaces are properly configured and tested to ensure that both coded and free-text data elements are transmitted without loss of or changes to information content.	Worksheet 1.4	○	○	○	reset
1.5 The intensity and the extent of interface testing is consistent with its complexity and with the importance of the accuracy, timeliness, and reliability of the data that traverses the interface.	Worksheet 1.5	○	○	○	reset
1.6 At the time of any major system change or upgrade that affects an interface, the organization implements procedures to evaluate whether users (clinicians or administrators) on both sides of the interface correctly understand and use information that moves over the interface.	Worksheet 1.6	○	○	○	reset
1.7 Changes to hardware or software on either side of the interface are tested before and monitored after go-live.	Worksheet 1.7	○	○	○	reset
1.8 There is a hardware and software environment for interface testing that is physically separate from the live environment.	Worksheet 1.8	○	○	○	reset
1.9 Policies and procedures describe how to stop and restart the exchange of data across the interface in an orderly manner.	Worksheet 1.9	○	○	○	reset
1.10 Security procedures, including role-based access, are established for managing and monitoring key designated aspects of interfaces and data exchange.	Worksheet 1.10	○	○	○	reset

Select the level of implementation achieved by your organization for each *Recommended Practice*.

Your *Implementation Status* will be reflected on the *Recommended Practice Worksheet* in this PDF.

To the right of each *Recommended Practice* is a link to the *Recommended Practice Worksheet* in the PDF.

The Worksheet provides guidance on implementing the Practice.

*Recommended Practices for **Domain 1 — Safe Health IT***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
1.1	Data and application configurations are backed up and hardware systems are redundant.	*Worksheet 1.1*	●	○	○	reset
1.2	EHR downtime and reactivation policies and procedures are complete, available, and reviewed regularly.	*Worksheet 1.2*	○	●	○	reset
1.3	Allergies, problem list entries, and diagnostic test results, including interpretations of those results, such as “normal” and “high,” are entered/stored using standard, coded data elements in the EHR.	*Worksheet 1.3*	●	○	○	reset
1.4	Evidence-based order sets and charting templates are available for common clinical conditions, procedures, and services.	*Worksheet 1.4*	●	○	○	reset
1.5	Interactive clinical decision support (CDS) features and functions (e.g., interruptive warnings, passive suggestions, info buttons) are available and functioning.	*Worksheet 1.5*	○	○	○	reset
1.6	Hardware and software modifications and system-system interfaces are tested (pre- and post-go-live) to ensure that data are not lost or incorrectly entered, displayed, or transmitted within or between EHR system components.	*Worksheet 1.6*	●	○	○	reset
1.7	Clinical knowledge, rules, and logic embedded in the EHR are reviewed and addressed regularly and whenever changes are made in related systems.	*Worksheet 1.7*	●	○	○	reset
1.8	Policies and procedures ensure accurate patient identification at each step in the clinical workflow.	*Worksheet 1.8*	●	○	○	reset

*Recommended Practices for **Domain 2 — Using Health IT Safely***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
2.1	Information required to accurately identify the patient is clearly displayed on screens and printouts.	*Worksheet 2.1*	●	○	○	reset
2.2	The human-computer interface is easy to use and designed to ensure that required information is visible, readable, and understandable.	*Worksheet 2.2*	●	○	○	reset

*Recommended Practices for **Domain 2 — Using Health IT Safely***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
2.3	The status of orders can be tracked in the system.	*Worksheet 2.3*	◉	○	○	reset
2.4	Clinicians are able to override computer-generated clinical interventions when they deem it necessary.	*Worksheet 2.4*	◉	○	○	reset
2.5	The EHR is used for ordering medications, diagnostic tests, and procedures.	*Worksheet 2.5*	◉	○	○	reset
2.6	Knowledgeable people are available to train, test, and provide continuous support for clinical EHR users.	*Worksheet 2.6*	◉	○	○	reset
2.7	Pre-defined orders have been established for common medications and diagnostic (laboratory/radiology) testing.	*Worksheet 2.7*	◉	○	○	reset

*Recommended Practices for **Domain 3 — Monitoring Safety***

			Implementation Status			
			Fully in all areas	Partially in some areas	Not implemented	
3.1	Key EHR safety metrics related to the practice/ organization are monitored.	*Worksheet 3.1*	○	○	○	reset
3.2	EHR-related patient safety hazards are reported to all responsible parties, and steps are taken to address them.	*Worksheet 3.2*	○	○	○	reset
3.3	Activities to optimize the safety and safe use of EHRs include clinician engagement.	*Worksheet 3.3*	○	○	○	reset

Each *Recommended Practice Worksheet* provides guidance on implementing a specific *Recommended Practice*, and allows you to enter and print information about your self-assessment.

The *Rationale* section provides guidance about "why" the safety activities are needed.

Enter any notes about your self-assessment.

Enter any follow-up activities required.

Enter the name of the person responsible for the follow-up activities.

The *Suggested Sources of Input* section indicates categories of personnel who can provide information to help evaluate your level of implementation.

The *Examples* section lists potentially useful practices or scenarios to inform your assessment and implementation of the specific *Recommended Practice*.

Recommended Practice

1.1 Data and application configurations are backed up and hardware systems are redundant.[7, 8, 9, 10]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Hardware and software failures are inevitable. Without redundant backup hardware, delays in restoring system operation can affect business continuity. Without data backups, key clinical and administrative information can be lost.

Assessment Notes

PD/BH -Cerner has cloud backup, all other District systems have on/off site back ups w/redundancy hardware for critical infrastructure. Systems are tested during upgraded and routinely

Follow-up Actions

None

Person Responsible for Follow-up Action

BH/PD

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- If using a remotely hosted EHR (e.g., cloud-based solution), insist that your EHR provider back up data with tape, Internet, redundant drives, or any means necessary to allow full recovery from incidents.[11]
- Mission-critical hardware systems (e.g., database servers, network routers, connections to the Internet) are duplicated.[12]
- Data are encrypted and backed up frequently, and transferred to an off-site storage location at least weekly.[13, 14, 15]
- System backups are tested (e.g., restored to the test environment) on a monthly basis.

See the Contingency Planning Guide for related recommended practices.

Recommended Practice

1.2 EHR downtime and reactivation policies and procedures are complete, available, and reviewed regularly.[16, 17, 18]
Checklist

Implementation Status

Partially in some areas

Rationale for Practice or Risk Assessment

Failure to prepare for the inevitability of EHR downtimes greatly increases the potential for errors in patient care during these difficult times.

Assessment Notes

Process in place for down time. No policy yet.
No issues identified when we had a 4 hour planned downtime.
Used the 7/24 application provided by Cerner.
When planned communication goes out to all staff

Follow-up Actions

Robin to complete policy

Person Responsible for Follow-up Action

Robin Christensen, Bryan Harper, Patty Dickson - need to review collaboratively to ensure system online order is established for proper security.

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Policies describe:[19]
  - When a "downtime" should be called, including when the EHR is functionally unavailable (e.g., very slow response time)
  - Who will be in charge during the downtime
  - How everyone will be notified
  - Who is responsible for entering data collected during the downtime
  - How orders for medication, labs, imaging, and procedures will be executed and recorded
- Hospital personnel are trained and tested annually in these procedures.[20, 21, 22]
- The organization regularly conducts tabletop downtime and reactivation simulations or "drills."[19]

See the Contingency Planning Guide for related recommended practices.

Recommended Practice

1.3 Allergies, problem list entries, and diagnostic test results, including interpretations of those results, such as "normal" and "high," are entered/stored using standard, coded data elements in the EHR.[23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Free text data cannot be used by clinical decision support (CDS) logic[34] to check for data entry errors or notify clinicians about important new information.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Examples of Potentially Useful Practices/Scenarios

- RxNorm is used for coding medications and NDF-RT for medication classes.
- SNOMED-CT is used for coding allergens, reactions, and severity.
- SNOMED-CT, ICD-10, or ICD-9 is used for coding clinical problems and diagnoses.
- LOINC and SNOMED-CT are used for coding clinical laboratory results.
- Abnormal laboratory results are coded as such.

See the Computerized Provider Order Entry with Decision Support Guide and the Test Results Reporting and Follow-Up Guide for related recommended practices.

Assessment Notes

RxNorm is used for coding medications and NDF-RT for medication classes.
SNOMED-CT is used for coding allergens, reactions, and severity.
SNOMED-CT, ICD-10, or ICD-9 is used for coding clinical problems and diagnoses.
LOINC and SNOMED-CT are used for coding clinical laboratory results.
Abnormal laboratory results are coded as low (L)-blue, high (H)-orange, critical (!)-red.

Follow-up Actions

None

Person Responsible for Follow-up Action

NIHD Leadership

reset page

Recommended Practice

1.4 Evidence-based order sets and charting templates are available for common clinical conditions, procedures, and services.[23, 35]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Requiring clinicians to enter individual orders for routine clinical practices increases risk of overlooking one or more items. Allowing individual clinicians to create order sets runs the risk of institutionalizing poor practice.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Clinical content is developed or modified based on evidence through consensus by experts relying, where available, on nationally recognized, consensus-based clinical decision support (CDS) recommendations.
  See AHRQ's Clinical Decision Support Initiative.[36]
- Institute for Safe Medication Practices (ISMP) order set guidelines[37] are used to create order sets.
- Order sets exist for the ten most common clinical conditions (e.g., management of chest pain), diagnoses, procedures (e.g., insulin administration and monitoring), and clinical services (e.g., admission to labor and delivery).

See the Computerized Provider Order Entry with Decision Support Guide for related recommended practices.

Assessment Notes

Ordersets are approved through committees and can use individual orders

Institute for Safe Medication Practices (ISMP) order set guidelines are used to create order sets-reviewed at Pharmacy and Therapeutics Committe.

Clinical content is developed or modified based on evidence through consensus by experts relying, where available, on nationally recognized, consensus-based clinical decision support (CDS) recommendations.

Follow-up Actions

Confirm departments who are included

Person Responsible for Follow-up Action

Informatics

reset page

Recommended Practice

1.5 Interactive clinical decision support (CDS) features and functions (e.g., interruptive warnings, passive suggestions, info buttons) are available and functioning.[38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Interactive CDS interventions help reduce the risks associated with ordering inappropriate, contraindicated, and non-therapeutic doses (i.e., under or overdoses) and provide just-in-time clinical knowledge to clinicians.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

Dr. Engblade and Jeff Kneip and ED MD

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Each practice identifies a certain number of highly specific, high priority CDS features and functions and monitors their availability and use.
- Appropriate CDS features and functions include:
  - Alerts for abnormal laboratory test results[5]
  - Tiered drug-drug interaction checks[39]
  - Drug-allergy interaction checks[50, 51]
  - "Reverse allergy" checking occurs when a new allergen is entered for a patient
  - Drug-food interaction support for instances in which the organization controls the patient's food choices
  - Drug-condition interaction checks (e.g., Accutane or tetracycline prescribed for a pregnant woman)
  - Drug-patient age interaction checks (e.g., medications contraindicated in the elderly)
  - Drug dosing support for maximum (dose, daily, and lifetime), minimum, renal,[52] weight-based, and age-appropriateness[53]

See the Computerized Provider Order Entry with Decision Support Guide for related recommended practices.

Recommended Practice

1.6 Hardware and software modifications and system-system interfaces are tested (pre- and post-go-live) to ensure that data are not lost or incorrectly entered, displayed, or transmitted within or between EHR system components.[54, 55, 56, 57, 58, 59, 60]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Failure to test new or modified hardware and software functions along with system-system interfaces, both pre- and post-go-live, increases the risk of inadvertent errors and patient harm. Routine changes can result in unexpected side-effects leading to incomplete or unreliable functionality.

Assessment Notes

all systems/interfaces are tested in a test environment if available, and using a "zztest" patient in the live environment if required. All changes/updates and modifications are scheduled through the diverse change committee meetings held weekly to ensure all potential impacts are reviewed and discussed.

Follow-up Actions

None

Person Responsible for Follow-up Action

Bryan Harper-ITS
Patty Dickson-Compliance

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Hardware and software should be tested both pre- and post-go-live. Include tests using clearly named “test” patients (e.g., ZZtest345 with patient ID 999999999) in the “live” environment.
- High priority clinical processes should be simulated using real clinicians.
- Use the Leapfrog Group’s “Evaluation Tool for Computerized Physician Order Entry” or some similar automated tool to assess point-of-care CDS intervention completeness and reliability on a regular basis.[54]
- Applications and system-system interfaces are tested to ensure that data are neither lost nor incorrectly entered, displayed, or transmitted.
- Interfaces (e.g., HL-7) capable of sending, receiving, acknowledging, and canceling orders and results exist and are tested between ADT-Laboratory, -Pharmacy, and -Radiology; and CPOE-Pharmacy, -Laboratory, and -Radiology.
- Error logs are regularly inspected and errors are fixed.

See the System Configuration Guide, the System Interfaces Guide, and the Test Results Reporting and Follow-Up Guide for related recommended practices.

Recommended Practice

1.7 Clinical knowledge, rules, and logic embedded in the EHR are reviewed and addressed regularly and whenever changes are made in related systems.[43, 61, 62, 63, 64, 65]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Medical knowledge is constantly evolving. Failure to review and update clinical content can result in outdated practices continuing long after they should be discontinued or updated.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Clinical content (e.g., order sets, default values, charting templates, patient education materials, health maintenance reminders) are reviewed at least bi-annually or as needed (e.g., following user feedback, changes in clinical practice standards, manufacturer alert) against recent evidence and best practices.

See the Computerized Provider Order Entry with Decision Support Guide for related recommended practices.

Assessment Notes

Ordersets are approved at appropriate medical staff committees.
Education is embedded in Cerner (Elsevier).

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Recommended Practice

1.8 Policies and procedures ensure accurate patient identification at each step in the clinical workflow.
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Wrong patient charting is one of the more common safety problems in EHRs and can result in both data integrity and data confidentiality issues when protected health information (PHI) is disclosed in the wrong chart and is missing from the right chart. Accurate and consistent patient identification is essential for safety in an EHR-enabled healthcare system.

Assessment Notes

Double identifier (Name/DOB)
Same name alert

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Clinicians are trained to use all available patient information to facilitate positive patient identification, including: last name, first name, date of birth, gender, medical record number, in-patient location or home address in the ambulatory setting, recent photograph (if available), and responsible physician (if available).[66]
- The EHR developer implements a master patient index that employs a probabilistic matching algorithm that uses patient's first and last names; date of birth; gender; and zip code, telephone number, or social security number.[67]
- The system generates an alert when a user attempts to create a record for a new patient or looks up an existing patient by name and there are other patients in the database with the same first and last names as that patient.[66]
- Before allowing the user to change the current patient and display data for another patient, the system asks the user whether all entered, but unsaved, data should be saved and signed, saved to a temporary location, or discarded.[68]

See the Patient Identification Guide for related recommended practices.

Recommended Practice

2.1 Information required to accurately identify the patient is clearly displayed on screens and printouts.[66, 68, 69]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

If clinicians cannot clearly identify the patient whose chart they are working on, they are at increased risk of making EHR entries in the wrong record or relying on information on the wrong patient, resulting in patient care and treatment errors, which are among the most common types of errors in the modern EHR-enabled healthcare system.

Assessment Notes

Use double identifier
Color identifiers when multiple charts are open.
Patient photos

Follow-up Actions

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Information required for patient identification includes:
  - Last name
  - First name
  - Date of birth, with calculated age
  - Gender
  - Medical record number
  - In-patient location, or home address in the ambulatory setting
  - Recent photograph (recommended)
  - Responsible physician (e.g., attending, admitting)
- The duplicate patient identification rate (i.e., the percentage of EHR records that refer to the same unique individual as another EHR record) is monitored.[70, 71, 72, 73]

See the Computerized Provider Order Entry with Decision Support Guide and the Patient Identification Guide for related recommended practices.

Recommended Practice

2.2 The human-computer interface is easy to use and designed to ensure that required information is visible, readable, and understandable.[69, 74, 75, 76, 77]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Clinicians are constantly under time pressure. User interfaces that are difficult to see, comprehend, and use significantly increase the risk of error and patient harm.

Suggested Sources of Input

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Visible: columns are wide enough to view critical data.[66, 75]
- Readable: appropriate font sizes and contrast are used.
- Understandable: the most recent orders and results are clearly marked.[69]
- Consistent: similar functions have similar labels; different functions have different labels.[78]
- When possible, items that are related, or have similar functions, are grouped and displayed together, rather than alphabetically (e.g., grouping similar menu items).[78]
- System response time is adequate (e.g., mean under 3 seconds, max under 10 seconds).
- User input data fields are large enough to enter required information, and selection options are clearly defined and easy to select.

See the System Configuration Guide for related recommended practices.

Assessment Notes

Visible: columns are wide enough to view critical data.

Readable: appropriate font sizes and contrast are used.

Understandable: the most recent orders and results are clearly marked.

Consistent: similar functions have similar labels; different functions have different labels

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Recommended Practice

2.3 The status of orders can be tracked in the system.[23, 79, 80, 81]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Errors often occur when users assume that orders entered into the computer will be done as specified. To facilitate closed loop communication and tracking of tasks and orders, the EHR should provide users with information regarding task and order status.

Assessment Notes

Clear indication of orders. ie: ordered, completed, canceled, future

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- The EHR has mechanisms in place **and** the organization has procedures in place to ensure that users are notified of key actions or inactions relating to their orders, such as when ordered medications get discontinued (manually or automatically), when antibiotic renewals are not processed, and when orders placed at later times of the day will not be acted on until the next day.[82, 83]
- Users are able to track the status of orders (e.g., specimen collected, specimen received, resulted).[84, 85, 86, 87, 88, 89, 90, 91]
- There is clear distinction (e.g., different font or color) between newly entered and copied data.[75, 92]

See the Computerized Provider Order Entry with Decision Support Guide and the Test Results Reporting and Folllow-Up Guide for related recommended practices.

Recommended Practice

2.4 Clinicians are able to override computer-generated clinical interventions when they deem it necessary.[93, 94]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Computers cannot practice medicine. Disallowing clinician overrides of computer-generated interventions precludes safe interventions when needed by clinicians with accurate data and greater medical knowledge.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Hard stop alerts (i.e., the user must take an action before proceeding) are used only for the most egregious potential errors. Hard stop alert overrides are closely monitored and reviewed often.[93]
- The alert override rate (i.e., the number of point-of-care alerts that clinicians override divided by the total number of point-of-care alerts generated) is monitored, and alerts with high override rates are reviewed.[44]

See the Computerized Provider Order Entry with Decision Support Guide for related recommended practices.

Assessment Notes

Hard-stop alerts and overrides

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Recommended Practice

2.5 The EHR is used for ordering medications, diagnostic tests, and procedures.[23]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Partial EHR use means that clinicians must look in two separate places to find the most recent orders, which increases the potential to miss or delay filling critical orders. Hybrid systems, part electronic and part paper, are particularly hazardous.[95]

Assessment Notes

All in one system.
Pharmacy able to run a report for CPOE utility

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Diagnostic services

Health IT support staff

Pharmacy

Examples of Potentially Useful Practices/Scenarios

- The CPOE rate (i.e., the number of orders electronically entered by clinicians divided by the total number of orders entered) is monitored.
- The percentage of verbal or paper orders that are entered by ancillary personnel is less than 10 percent.[96]
- Free text and "miscellaneous" orders are discouraged by providing appropriate supports.[97]
- Policies and procedures are in place that clearly identify and manage hazards associated with ordering that continues to occur outside of the EHR.
- Recommendations from The Joint Commission are followed when submitting orders to RNs by text messaging. This is acceptable as long as the texting platform has:[98]
  - A secure sign-on process
  - Encrypted messaging
  - Delivery and read receipts
  - Date and time stamps
  - Customized message retention time frames
  - A specified contact list of individuals authorized to receive and record orders

See the Computerized Provider Order Entry with Decision Support Guide and the Test Results Reporting and Folllow-Up Guide for related recommended practices.

Recommended Practice

2.6 Knowledgeable people are available to train, test, and provide continuous support for clinical EHR users.[99]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Clinicians cannot use EHRs safely if they have not been trained and do not have access to assistance when needed. EHRs are complex tools. To maximize patient safety, clinicians must not be expected to "learn the basics on the job."

Assessment Notes

All clinicians are given EHR training.
Clinical Informatics available for support.
Cerner Learning Journeys to complete.
Job aids available.

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- All clinicians receive training appropriate to their expected use of the EHR. An assessment is made of the need for such specialized training, beyond system-wide, generic training.[83]
- Trainers have advanced EHR and/or informatics training and knowledge of the clinical workflow for the unit/practice they will be assisting.
- Trainers are available before and after go-live, and provide on-going support for users during EHR optimization.[99]
- All clinicians are trained and tested on basic EHR and CPOE operations before being issued login credentials.
- The clinician training rate (i.e., the number of clinicians trained to use the EHR who have passed a basic competency test divided by the total number of clinicians with EHR user privileges) is monitored.
- When any category of clinician users of EHRs requests training, especially when they also indicate that they are not adequately trained to safely do their jobs, such training is promptly provided. The organization has processes to identify training opportunities that would optimize the safe use of EHRs.

See the Organizational Responsibilities Guide for related recommended practices.

Recommended Practice

2.7 Pre-defined orders have been established for common medications and diagnostic (laboratory/radiology) testing.[100]
Checklist

Implementation Status

Fully in all areas

Rationale for Practice or Risk Assessment

Unnecessary clinical practice variation should be minimized. Forcing clinicians to enter specific values (e.g., for medications) that are then matched to a list of allowable values, or to select from a set of possible values, increases variability and can result in errors.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- Complete medication order sentences exist for the most commonly ordered medications, laboratory tests, and radiology studies.[101]

See the Computerized Provider Order Entry with Decision Support Guide for related recommended practices.

Assessment Notes

Complete medication order sentences exist for the most commonly ordered medications, laboratory tests, and radiology studies.

Follow-up Actions

None

Person Responsible for Follow-up Action

reset page

Recommended Practice

3.1 Key EHR safety metrics related to the practice/organization are monitored.[102]
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Measurement and monitoring of key performance indicators are essential for improvements in safety.

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration
EHR developer
Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- See multiple examples of measurements related to health IT safety in the National Quality Forum report "Identification and Prioritization of Health IT Patient Safety Measures."[70]
- **EHR uptime rate**
  Minutes the EHR was available to clinicians divided by the number of minutes in the reporting period.[102, 103]
- **System response time**
  Mean time to display a recent CBC result on a test patient, measured every minute of every day in the reporting period.[104]
- **Serious EHR-related adverse events**
  A list of reported EHR-related adverse events, whether they resulted in patient harm, including any reported breaches of patient confidentiality.
- **Potential wrong patient error rate**
  Requests to “change” orders that result in cancellation of the first order and the creation of an order for the same item on a different patient by the same user.[70]

See the Organizational Responsibilities Guide and System Configuration Guide for related recommended practices.

Assessment Notes

Employee accesses, hardware adverse events, etc are monitored by IT security and Compliance Departments. All patient safety metrics related to practice are monitored by quality or informatics

Follow-up Actions

Person Responsible for Follow-up Action

Hardware/access set up/audits - BH/PD
Application/EHR safety metrics are monitored by quality and informatics

reset page

Recommended Practice

3.2 EHR-related patient safety hazards are reported to all responsible parties, and steps are taken to address them.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Ensuring that EHR-related patient safety hazards are systematically identified, reported, and addressed is essential to improving the safety of EHRs.

Assessment Notes

When Compliance and ITS are notified of EHR related safety issues, it is reported to the appropriate regulatory or accreditation bodies. Issues are addressed through collaborative meetings with quality, informatics, IT and compliance teams.

Follow-up Actions

Person Responsible for Follow-up Action

Bryan Harper-ITS
Patty Dickson-Compliance
Quality, Informatics.

reset page

Suggested Sources of Input

Clinicians, support staff, and/or clinical administration

EHR developer

Health IT support staff

Examples of Potentially Useful Practices/Scenarios

- The organization clearly identifies, through policies and procedures, how to address reports of EHR safety hazards.
- The organization ensures that reports of hazards and adverse events are reported, as appropriate, to EHR developers as well as senior leadership and boards.
- The organization has a relationship with a patient safety organization (PSO), and ensures that individuals with appropriate health information technology expertise and experience in investigating and addressing EHR-related patient safety incidents are involved.
- The total number of EHR-related software errors (i.e., bugs) reported is monitored.
- The serious EHR error fix rate (i.e., the number of errors with the potential for causing direct patient harm that were fixed within one month divided by the total number of errors that were reported) is monitored.

See the Organizational Responsibilities Guide for related recommended practices.

Recommended Practice

3.3 Activities to optimize the safety and safe use of EHRs include clinician engagement.
Checklist

Implementation Status

Off

Rationale for Practice or Risk Assessment

Unless clinicians are included in decisions that affect their use of the EHR, they may not understand or accept changes, which increases risks. Clinicians should be engaged in identifying opportunities for the EHR to support safe and effective clinical use.

Assessment Notes

Follow-up Actions

Person Responsible for Follow-up Action

Medical Staff Office, Quality, CMO

reset page

Suggested Sources of Input

- Clinicians, support staff, and/or clinical administration
- Diagnostic services
- EHR developer
- Health IT support staff
- Pharmacy

Examples of Potentially Useful Practices/Scenarios

- In large organizations, representatives from the following groups are involved in decision making about EHR safety: clinicians, administrators, patients, IT/informatics, board of directors and CEO, and quality and legal staff.[105,106]

See the Organizational Responsibilities Guide for related recommended practices.

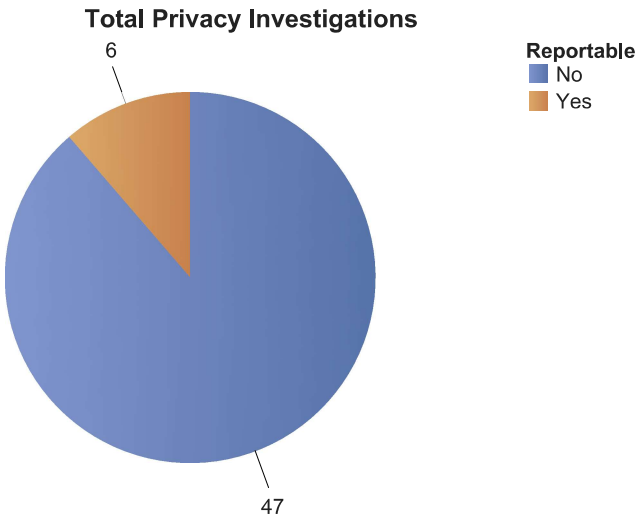
Compliance Work Plan – October 2022

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Review ongoing in 2022
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	ACHD/District Legal. Compliance can perform additional if requested.
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Completed May 2022.
4.	District Policy and Procedure management		Tracy Aspel continues to provide per diem support to leadership and has worked on many "heavy lift" policies for different leaders in the District.
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		87% Compliance with Relias training as 10/1/2022
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		Scheduled for 11/2022
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		In Progress – reviewed by 278 members of workforce
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.		Will be submitted to CBEC
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		Billing and Collections staff now performed by outside agencies, and NIHD campus support

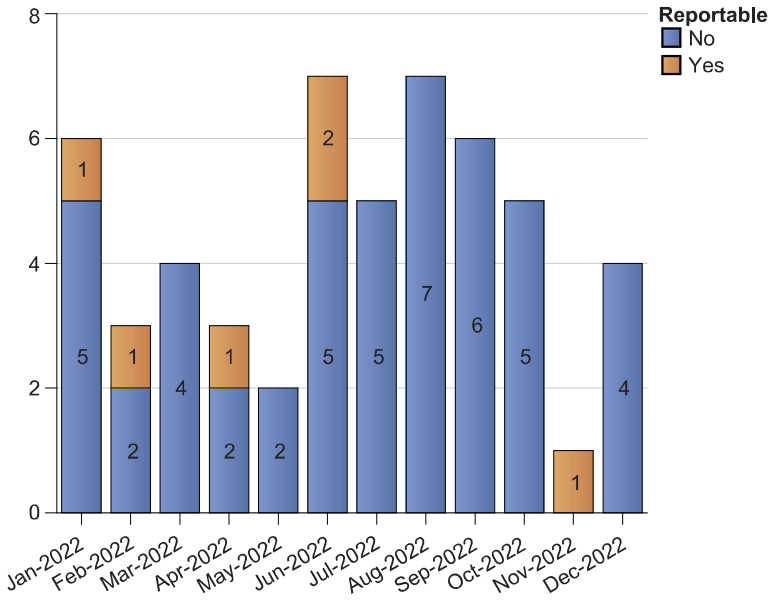
9.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		Role-based access. 3rd party EHR access policy in development
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.	Completed at Orientation and annually.	Completed at orientation – current through 10/1/2022. False Claims Act Policy assigned annually.
Compliance Communication			
11.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Q3CY22 in Q3 Board Report.
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Complytrack	UOR report developed 2021. TJC cited NIHD for non-compliant patient response. Corrective action plan developed.
13.	Document test and review of Compliance Hotline.		Completed 09/2022
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Verified 7/2022
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (OIG) List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new providers. Medical Staff Office (MSO) verifies all medical staff and credentialed providers. Accounting verifies all vendors.	Current through 10/1/2022
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Need to schedule time with HR and develop review process.
17.	Audits		
	a. Arrangements with physician (database)		Physician contract reviews in

			conjunction with CMO – ongoing 10/2022
	b. EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 10/1/2022
	c. Financial Audits	FY 2022	Eide Bailly Audit in progress
	d. Payment patterns		Review of denials, payment patterns, coding occurs in Revenue Cycle Admin Team (RCAT) meetings and other revenue cycle meetings. Updates to Billing and Coding Compliance Committee as needed.
	e. Bad debt/ credit balances, AR days		Reviewed billing processes, provider enrollments, continuous monitoring by CFO
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Scheduled security risk assessment November 2022 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due November 2022
	b. Periodic update to Security Risk Assessment		Update following penetration testing in December 2022
	c. Monthly employee access audits		Cerner provides semi-automatic continuous monitoring, reducing the need for a completely manual auditing process.
19.	Audit required signage		Scheduled 02/2023
20.	Audit HIMS (Health Information Management) scanned document accuracy		Scheduled for Q4 2022
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		Review OIG Compliance Guidance with Compliance and

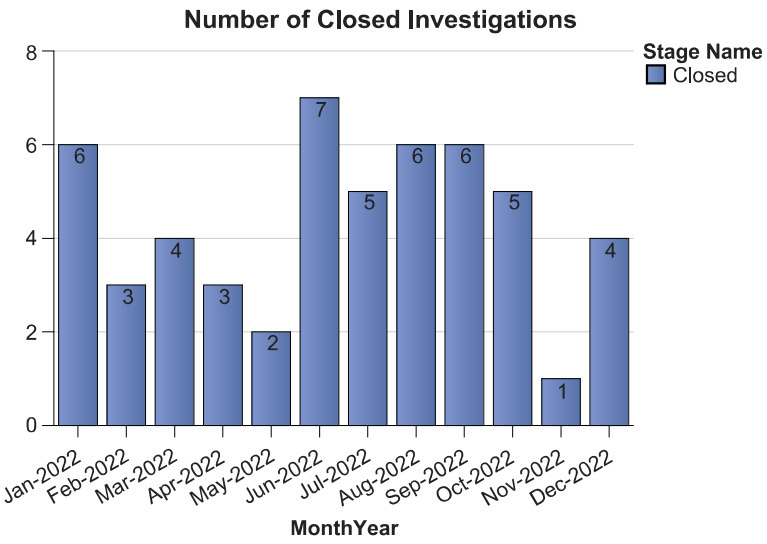
			Business Ethics Committee in 2022
22.	Implement automated access monitoring/auditing software		Semi-automated auditing in progress with manual follow up on all flags
23.	Review CMS Conditions of Participation		2022 TJC Survey and response being compiled by Quality and Survey readiness team.
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		ongoing
25.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Revenue Cycle has meeting weekly to track billing, overpayments and denials management.
26.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Board Report for Calendar year through quarter 3
	a. Provide trend feedback to leadership to allow for data driven decision-making		Quarterly
	I. Overall UOR process		Quarterly 2022
	II. Workplace Violence		Quarterly 2022
	III. Falls Committee		Quarterly 2022
	IV. Nursing Professional Practice Council		October 2022
27.	Pioneer Home Health and Hospice of the Owens Valley Contract(s) review		In Progress 10-2022
28.	Patient complaints		Currently working to determine most effective efficient workflow between Quality, Compliance, and Risk. Documented and tracked in Unusual Occurrence Reporting system
30.	Breach Investigations	On-going	On-going – see Compliance reports


Total Privacy Investigations
6
47
Reportable
No
Yes

Privacy Investigations by Month/Year

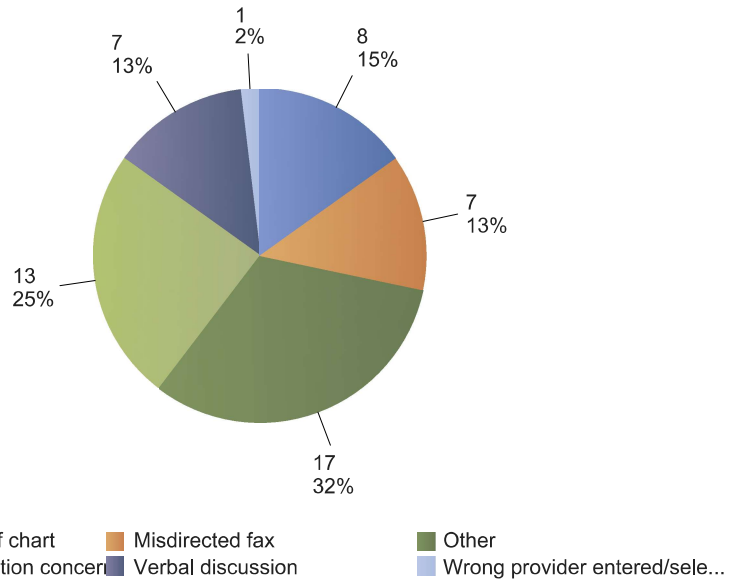


	No	Yes	Total
Jan-2022	5	1	**6**
Feb-2022	2	1	**3**
Mar-2022	4		**4**
Apr-2022	2	1	**3**
May-2022	2		**2**
Jun-2022	5	2	**7**
Jul-2022	5		**5**
Aug-2022	7		**7**
Sep-2022	6		**6**
Oct-2022	5		**5**
Nov-2022		1	**1**
Dec-2022	4		**4**
Total	**47**	**6**	**53**

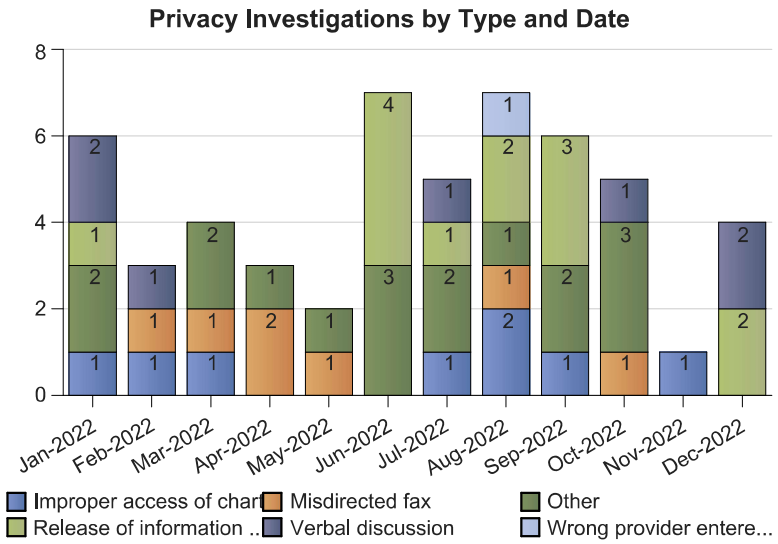


	Closed	Total
Sep-2022	6	**6**
Oct-2022	5	**5**
Nov-2022	1	**1**
May-2022	2	**2**
Mar-2022	4	**4**
Jun-2022	7	**7**
Jul-2022	5	**5**
Jan-2022	6	**6**
Feb-2022	3	**3**
Dec-2022	4	**4**
Aug-2022	6	**6**
Apr-2022	3	**3**
Total	**52**	**52**
Total	**52**	**52**

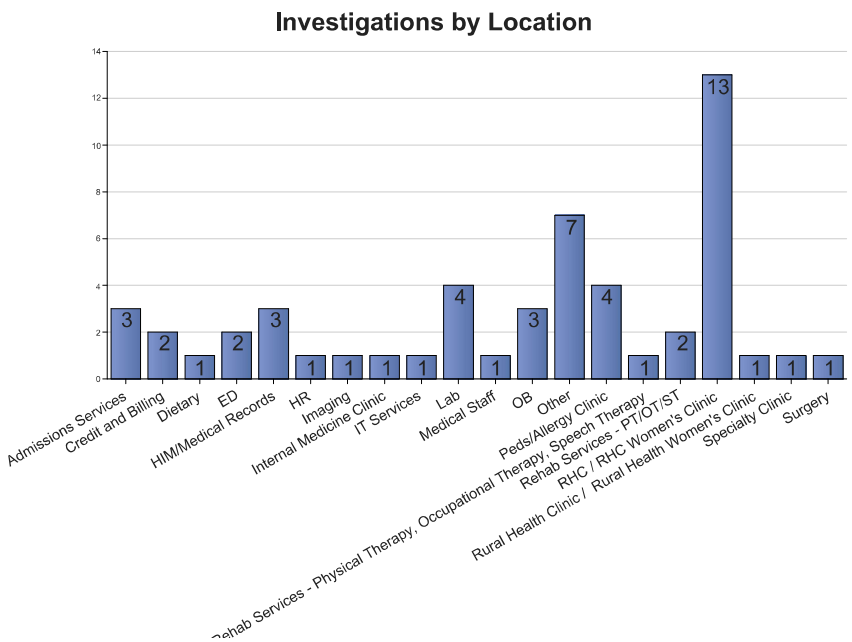
Privacy Investigations by Violation Type



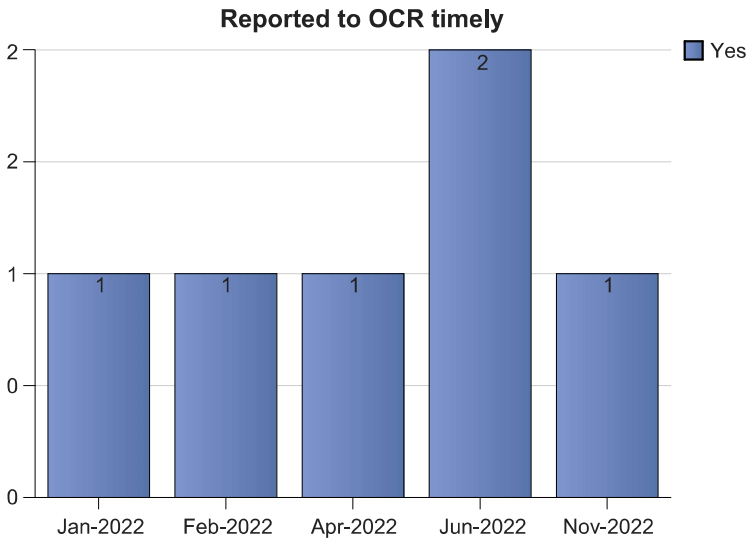
Improper access of chart	8
Misdirected fax	7
Other	17
Release of information concern	13
Verbal discussion	7
Wrong provider entered/selected	1
Total	**53**



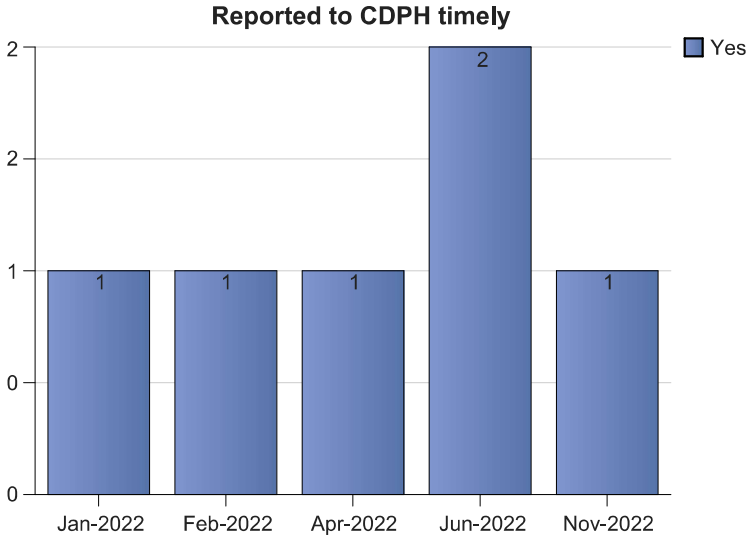
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Total
Improper access of chart	1	1	1				1	2	1		1		**8**
Misdirected fax		1	1	2	1			1		1			**7**
Other	2		2	1	1	3	2	1	2	3			**17**
Release of information concern	1					4	1	2	3			2	**13**
Verbal discussion	2	1					1			1		2	**7**
Wrong provider entered/selected								1					**1**
Total	**6**	**3**	**4**	**3**	**2**	**7**	**5**	**7**	**6**	**5**	**1**	**4**	**53**



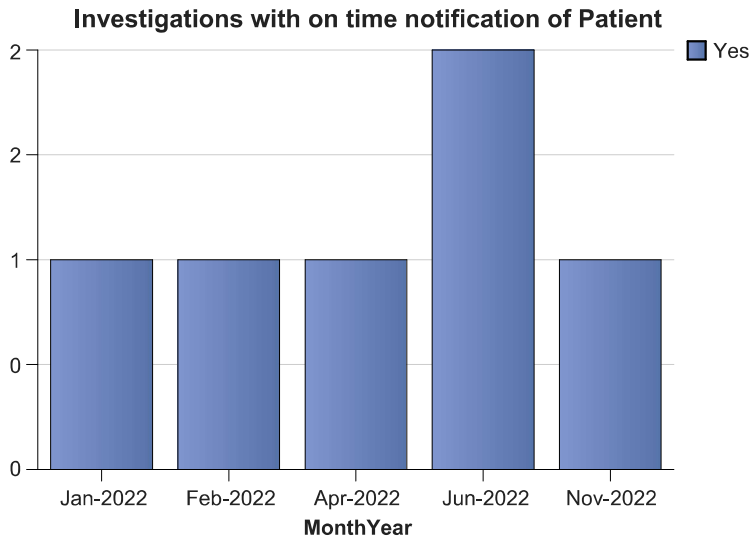
Admissions Services	3
Credit and Billing	2
Dietary	1
ED	2
HIM/Medical Records	3
HR	1
Imaging	1
Internal Medicine Clinic	1
IT Services	1
Lab	4
Medical Staff	1
OB	3
Other	7
Peds/Allergy Clinic	4
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1
Rehab Services - PT/OT/ST	2
RHC / RHC Women's Clinic	13
Rural Health Clinic / Rural Health Women's Clinic	1
Specialty Clinic	1
Surgery	1
Total	**53**



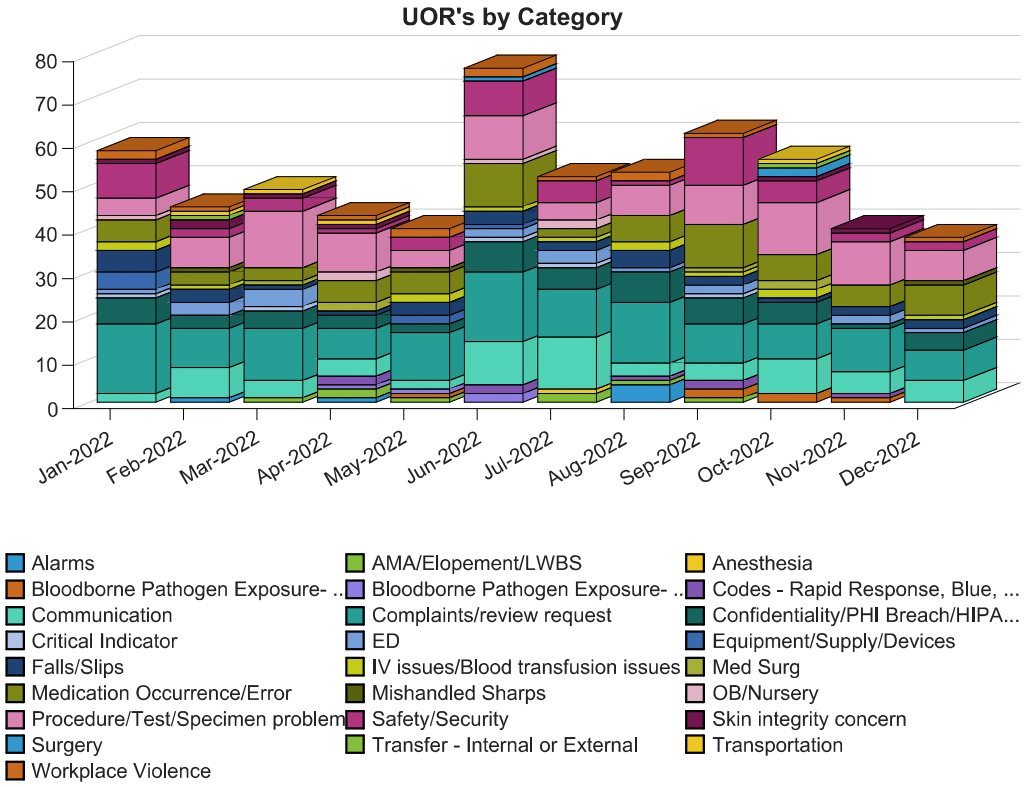
	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Nov-2022	1	**1**
Total	**6**	**6**



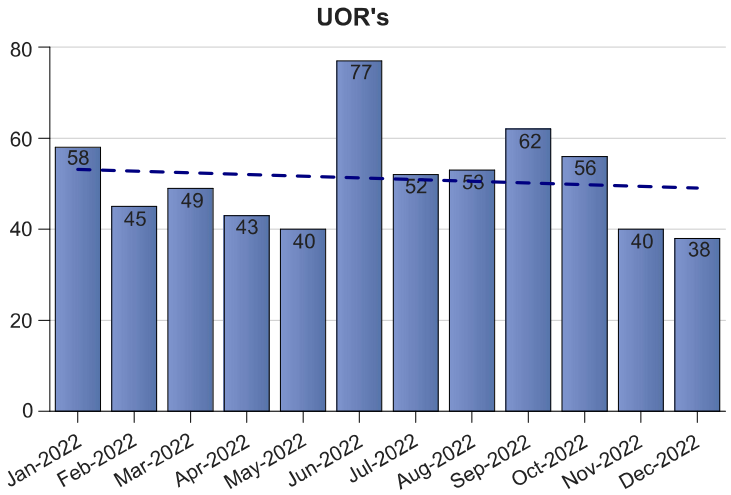
	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Nov-2022	1	**1**
Total	**6**	**6**



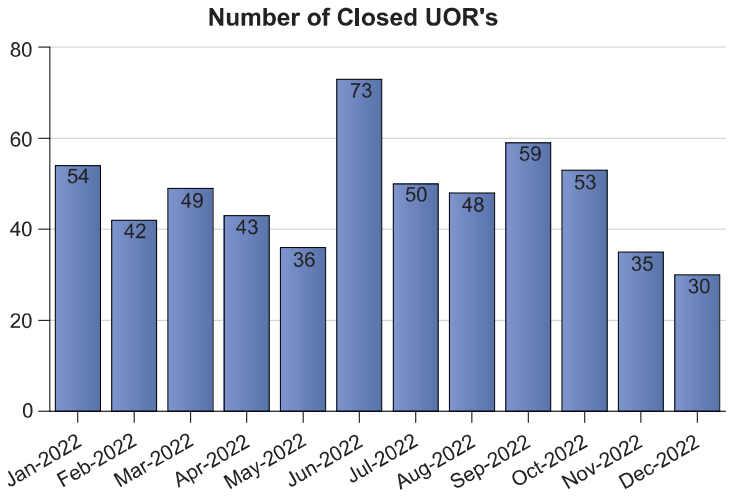
	Yes	Total
Jan-2022	1	**1**
Feb-2022	1	**1**
Apr-2022	1	**1**
Jun-2022	2	**2**
Nov-2022	1	**1**
Total	**6**	**6**


UOR's by Category
80
70
60
50
40
30
20
10
0
Jan-2022
Feb-2022
Mar-2022
Apr-2022
May-2022
Jun-2022
Jul-2022
Aug-2022
Sep-2022
Oct-2022
Nov-2022
Dec-2022
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

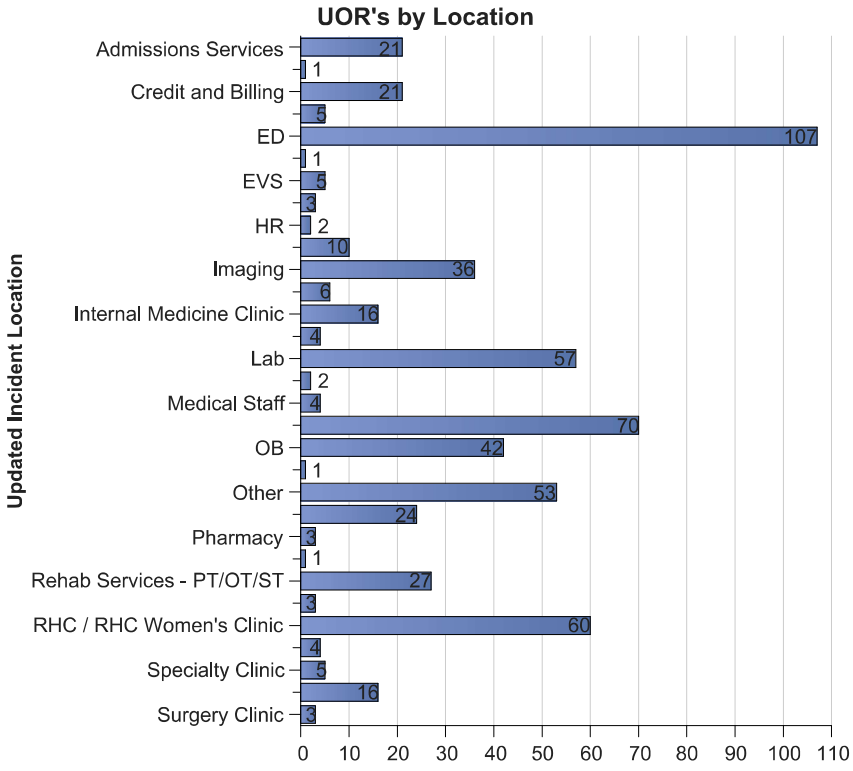
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Total
Alarms		1		1				4					**6**
AMA/Elopement/LWBS			1	2	1		2	1	1				**8**
Anesthesia							1						**1**
Bloodborne Pathogen Exposure- Sharps Injury					1				2	2	1		**6**
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1	1	2							**4**
Codes - Rapid Response, Blue, Deescalation				2		2		1	2		1		**8**
Communication	2	7	4	4	2	10	12	3	4	8	5	5	**66**
Complaints/review request	16	9	12	7	11	16	11	14	9	8	10	7	**130**
Confidentiality/PHI Breach/HIPAA violation	6	3	4	3	2	7	5	7	6	5	1	4	**53**
Critical Indicator	1		1			1	1		1				**5**
ED	1	3	4			2	3	1	2		2	1	**19**
Equipment/Supply/Devices	4				2	1							**7**
Falls/Slips	5	3	1	1	3	3	2	4	2	1	2	2	**29**
IV issues/Blood transfusion issues	2	1			2	1	1	2	1	2		1	**13**
Med Surg			1	2					1	2			**6**
Medication Occurrence/Error	5	3	3	5	5	10	2	6	10	6	5	7	**67**
Mishandled Sharps		1			1							1	**3**
OB/Nursery	1			2		1	2						**6**
Procedure/Test/Specimen problem	4	7	13	9	4	10	4	7	9	12	10	7	**96**
Safety/Security	8	2	3	1	3	8	5	1	11	5	2	2	**51**
Skin integrity concern	1	2	1	1						1	1		**7**
Surgery						1				2			**3**
Transfer - Internal or External		1								1			**2**
Transportation		1	1	1						1			**4**
Workplace Violence	2	1		1	2	2	1	2	1			1	**13**
Total	**58**	**45**	**49**	**43**	**40**	**77**	**52**	**53**	**62**	**56**	**40**	**38**	**613**



Jan-2022	58
Feb-2022	45
Mar-2022	49
Apr-2022	43
May-2022	40
Jun-2022	77
Jul-2022	52
Aug-2022	53
Sep-2022	62
Oct-2022	56
Nov-2022	40
Dec-2022	38
Total	**613**



	Closed
Jan-2022	54
Feb-2022	42
Mar-2022	49
Apr-2022	43
May-2022	36
Jun-2022	73
Jul-2022	50
Aug-2022	48
Sep-2022	59
Oct-2022	53
Nov-2022	35
Dec-2022	30
Total	**572**



Admissions Services	21
Compliance	1
Credit and Billing	21
Dietary	5
ED	107
Employee Health	1
EVS	5
HIM/Medical Records	3
HR	2
ICU	10
Imaging	36
Infusion	6
Internal Medicine Clinic	16
IT Services	4
Lab	57
Med Surg Unit	2
Medical Staff	4
Medical Surgical Unit	70
OB	42
Ortho Clinic	1
Other	53
Peds/Allergy Clinic	24
Pharmacy	3
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1
Rehab Services - PT/OT/ST	27
Respiratory/Cardiopulmonary	3
RHC / RHC Women's Clinic	60
Rural Health Clinic / Rural Health Women's Clinic	4
Specialty Clinic	5

Surgery	16
Surgery Clinic	3
Total	**613**

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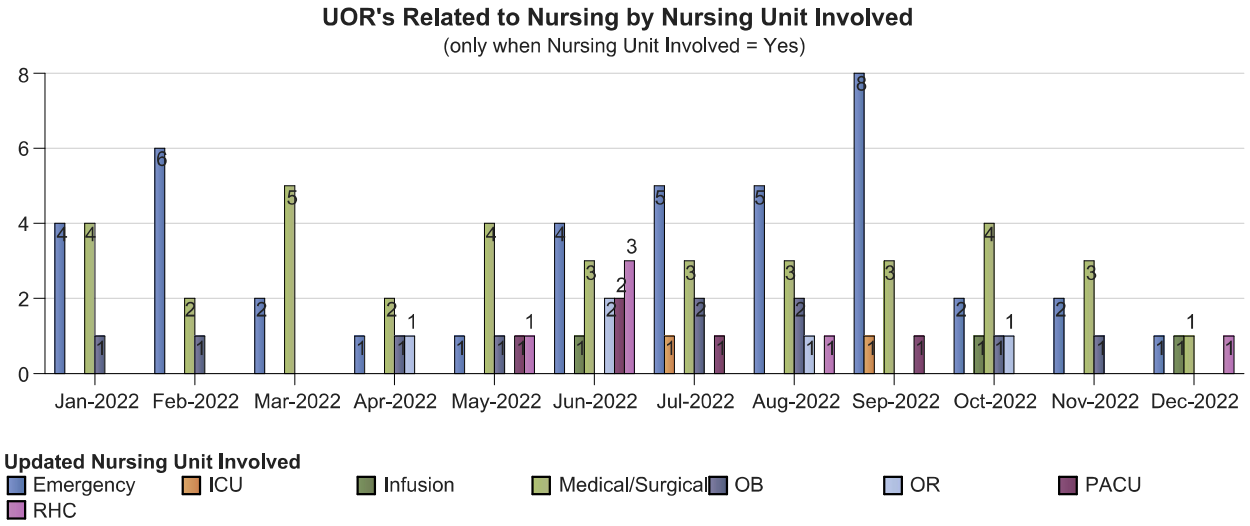
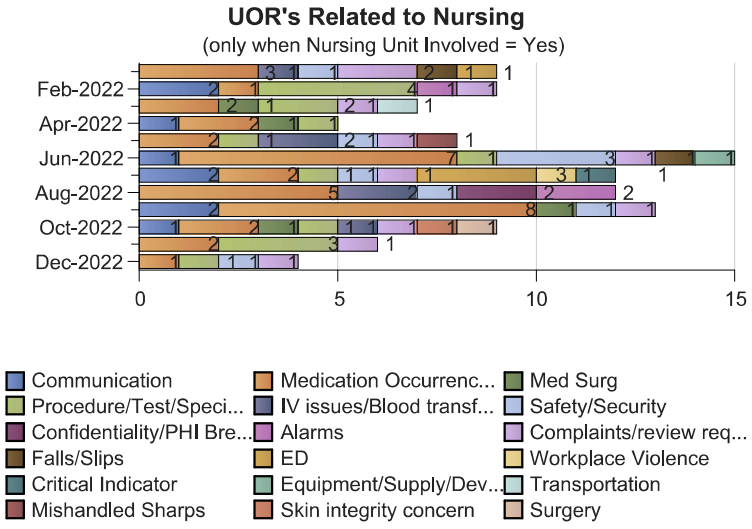
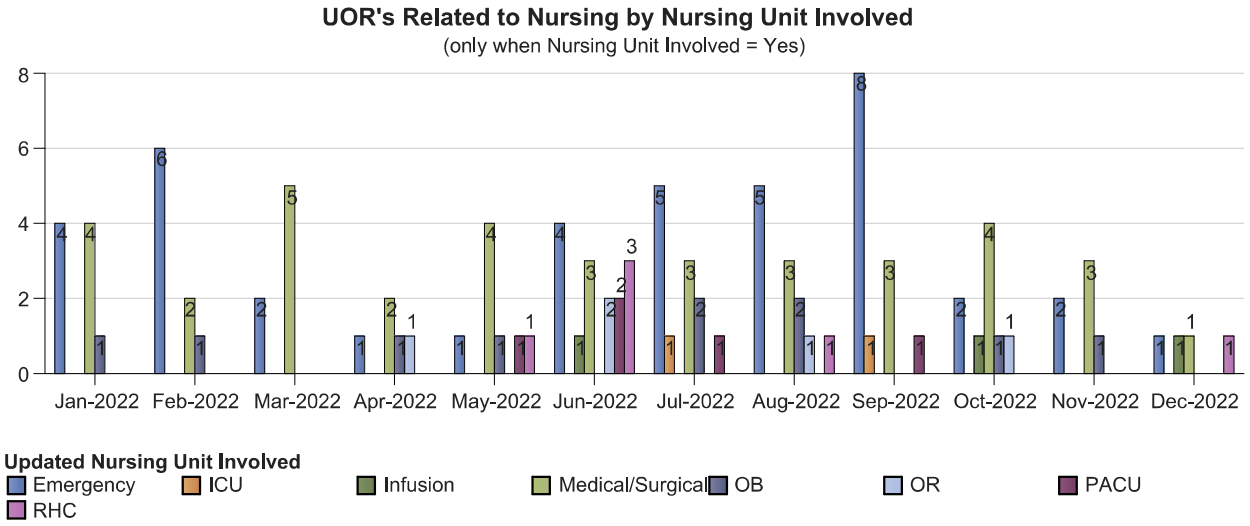
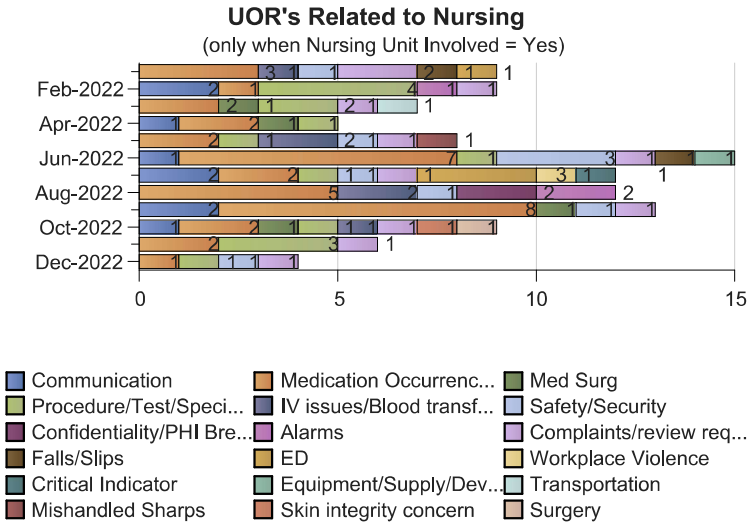


	Yes
Emergency	41
ICU	2
Infusion	3
Medical/Surgical	37
OB	10
OR	5
PACU	5
RHC	6
Total	**109**

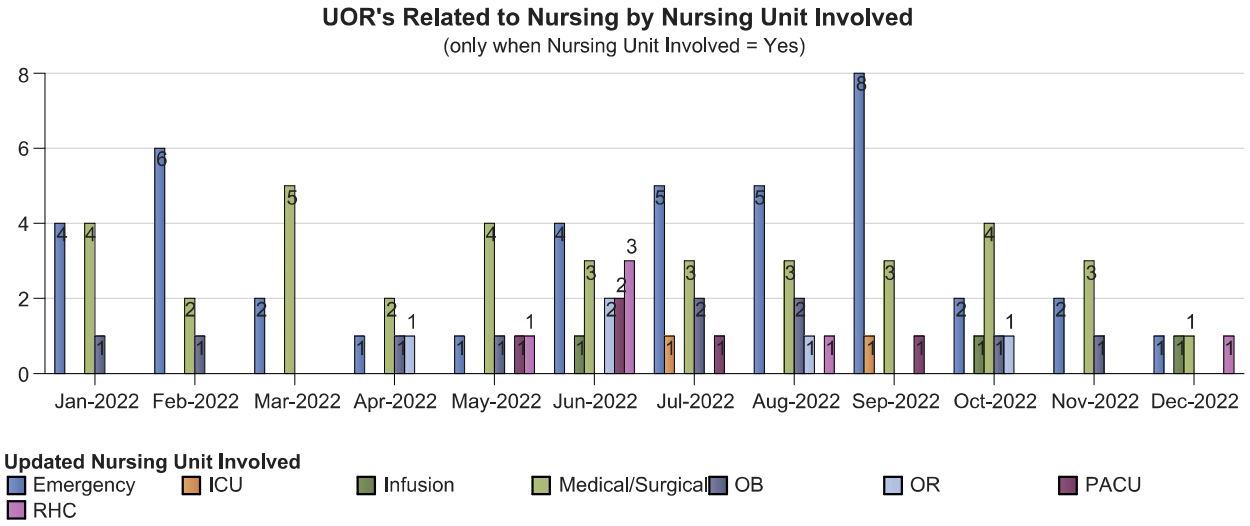


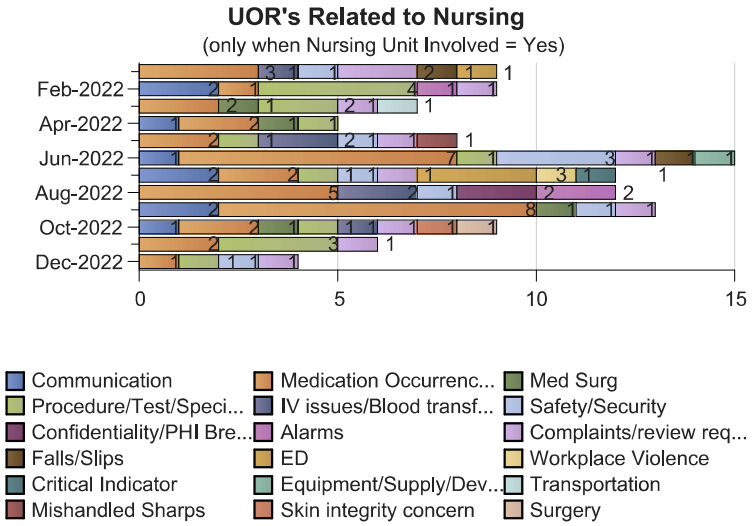
	Jan-2022	Feb-2022	Mar-2022	Apr-2022
Communication		2		1
Medication Occurrence/Error	3	1	2	2
Med Surg			1	1
Procedure/Test/ Specimen problem		4	2	1
IV issues/Blood transfusion issues	1			
Safety/Security	1			
Confidentiality/PHI Breach/HIPAA violation				
Alarms		1		
Complaints/review request	2	1	1	



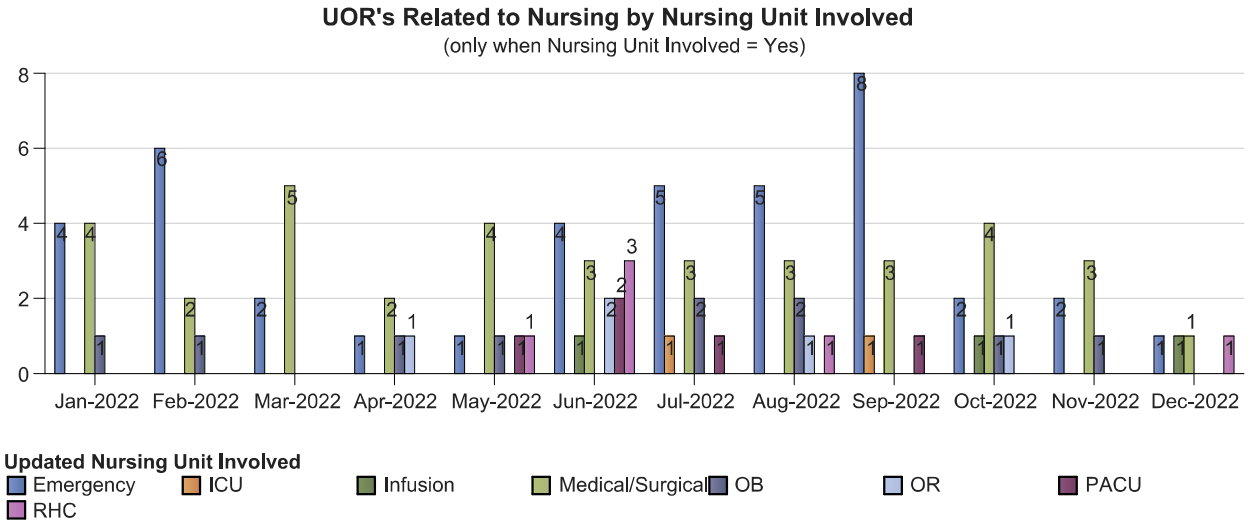


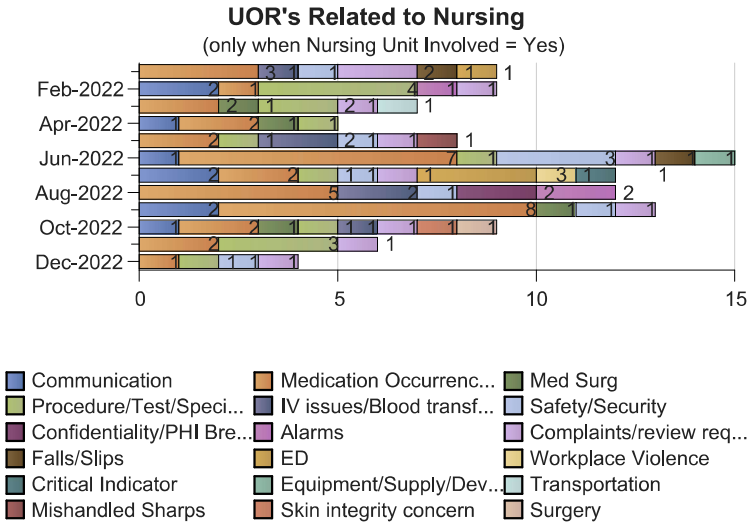
	May-2022	Jun-2022	Jul-2022	Aug-2022
Communication		1	2	
Medication Occurrence/Error	2	7	2	5
Med Surg				
Procedure/Test/ Specimen problem	1	1	1	
IV issues/Blood transfusion issues	2			2
Safety/Security	1	3	1	1
Confidentiality/PHI Breach/HIPAA violation				2
Alarms				2
Complaints/review request	1	1	1	



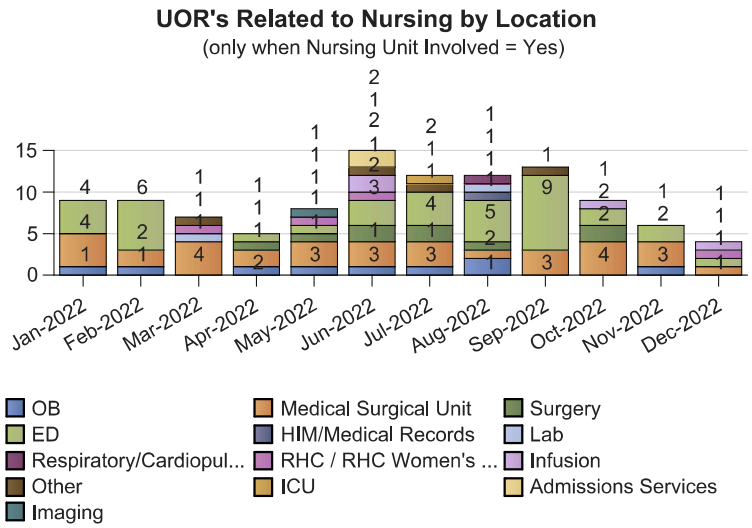


	Sep-2022	Oct-2022	Nov-2022	Dec-2022
Communication	2	1		
Medication Occurrence/Error	8	2	2	1
Med Surg	1	1		
Procedure/Test/ Specimen problem		1	3	1
IV issues/Blood transfusion issues		1		
Safety/Security	1			1
Confidentiality/PHI Breach/HIPAA violation				
Alarms				
Complaints/review request	1	1	1	1



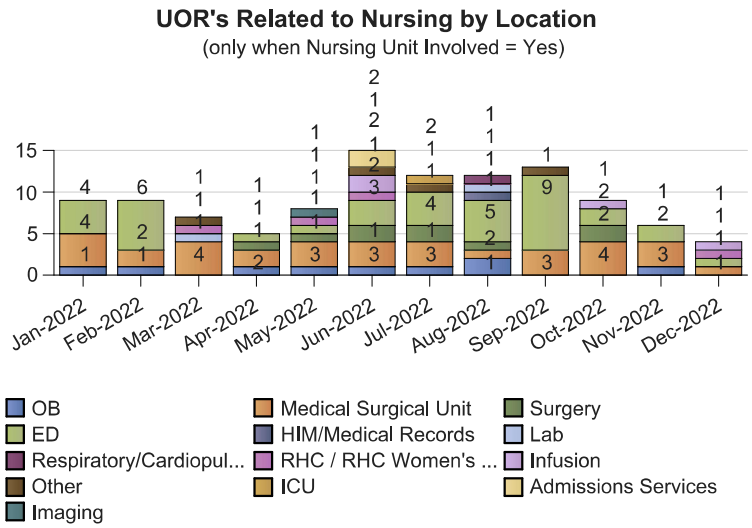


	Total
Communication	9
Medication Occurrence/Error	37
Med Surg	4
Procedure/Test/ Specimen problem	15
IV issues/Blood transfusion issues	6
Safety/Security	9
Confidentiality/PHI Breach/HIPAA violation	2
Alarms	3
Complaints/review request	11



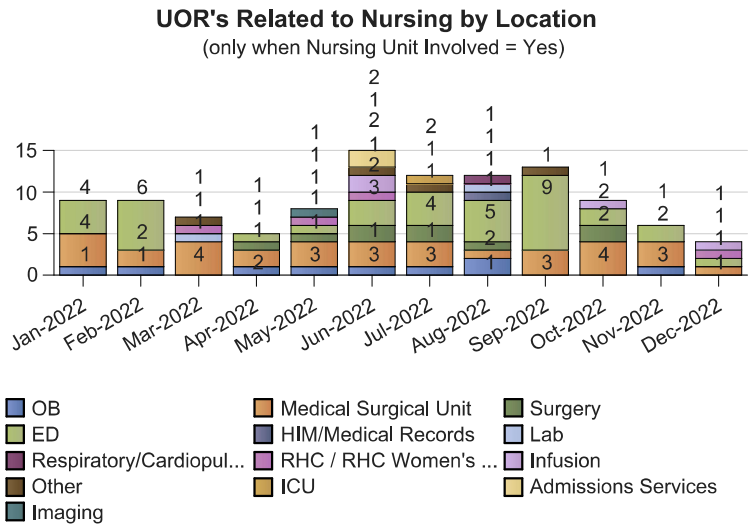
	Jan-2022	Feb-2022	Mar-2022	Apr-2022
Falls/Slips	1			
ED	1			
Workplace Violence				
Critical Indicator				
Equipment/ Supply/Devices				
Transportation			1	
Mishandled Sharps				
Skin integrity concern				
Surgery				
Total	**9**	**9**	**7**	**5**

	Jan-2022	Feb-2022	Mar-2022	Apr-2022
OB	1	1		1
Medical Surgical Unit	4	2	4	2
Surgery				1
ED	4	6		1
HIM/Medical Records				
Lab			1	
Respiratory/ Cardiopulmonary				
RHC / RHC Women's Clinic			1	
Infusion				
Other			1	
ICU				
Admissions				



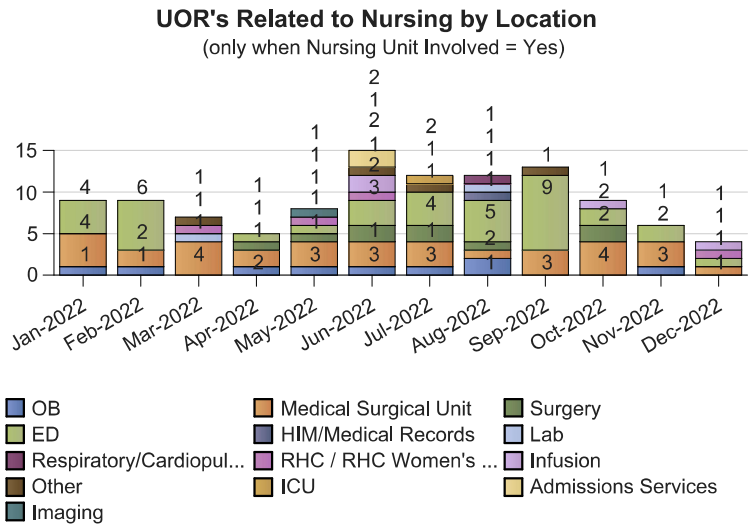
	May-2022	Jun-2022	Jul-2022	Aug-2022
Falls/Slips		1		
ED			3	
Workplace Violence			1	
Critical Indicator			1	
Equipment/ Supply/Devices		1		
Transportation				
Mishandled Sharps	1			
Skin integrity concern				
Surgery				
Total	**8**	**15**	**12**	**12**

	May-2022	Jun-2022	Jul-2022	Aug-2022
OB	1	1	1	2
Medical Surgical Unit	3	3	3	1
Surgery	1	2	2	1
ED	1	3	4	5
HIM/Medical Records				1
Lab				1
Respiratory/ Cardiopulmonary				1
RHC / RHC Women's Clinic	1	1		
Infusion		2		
Other		1	1	
ICU			1	
Admissions		2		



	Sep-2022	Oct-2022	Nov-2022	Dec-2022
Falls/Slips				
ED				
Workplace Violence				
Critical Indicator				
Equipment/ Supply/Devices				
Transportation				
Mishandled Sharps				
Skin integrity concern		1		
Surgery		1		
Total	**13**	**9**	**6**	**4**

	Sep-2022	Oct-2022	Nov-2022	Dec-2022
OB			1	
Medical Surgical Unit	3	4	3	1
Surgery		2		
ED	9	2	2	1
HIM/Medical Records				
Lab				
Respiratory/ Cardiopulmonary				
RHC / RHC Women's Clinic				1
Infusion		1		1
Other	1			
ICU				
Admissions				



	Total
Falls/Slips	2
ED	4
Workplace Violence	1
Critical Indicator	1
Equipment/ Supply/Devices	1
Transportation	1
Mishandled Sharps	1
Skin integrity concern	1
Surgery	1
Total	**109**

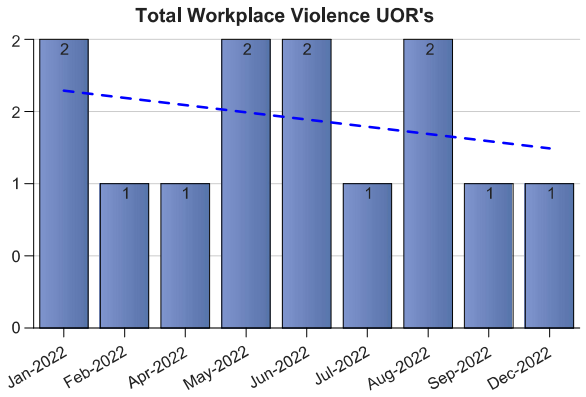
	Total
OB	9
Medical Surgical Unit	33
Surgery	9
ED	38
HIM/Medical Records	1
Lab	2
Respiratory/ Cardiopulmonary	1
RHC / RHC Women's Clinic	4
Infusion	4
Other	4
ICU	1
Admissions	2

	Jan-2022	Feb-2022	Mar-2022	Apr-2022
Services				
Imaging				
Total	**9**	**9**	**7**	**5**

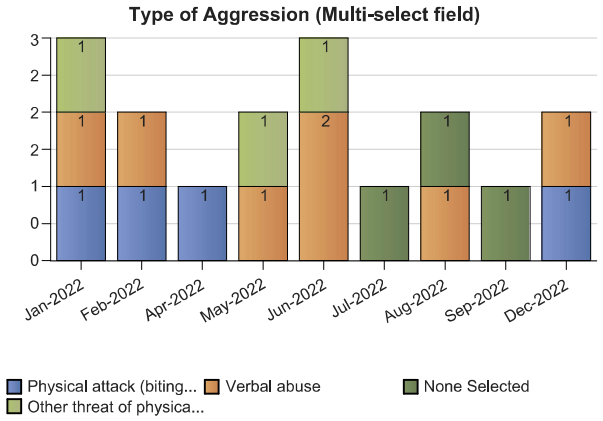
	May-2022	Jun-2022	Jul-2022	Aug-2022
Services				
Imaging	1			
Total	**8**	**15**	**12**	**12**

	Sep-2022	Oct-2022	Nov-2022	Dec-2022
Services				
Imaging				
Total	**13**	**9**	**6**	**4**

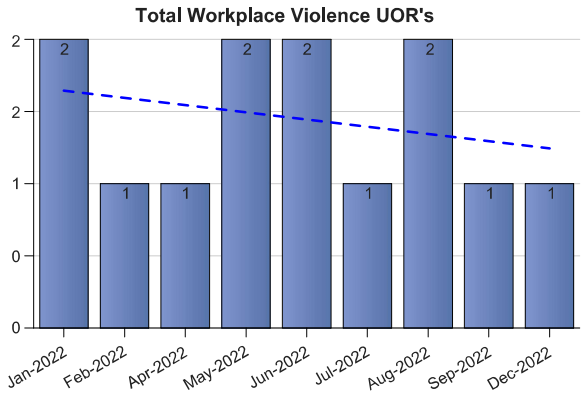
	Total
Services	
Imaging	1
Total	**109**



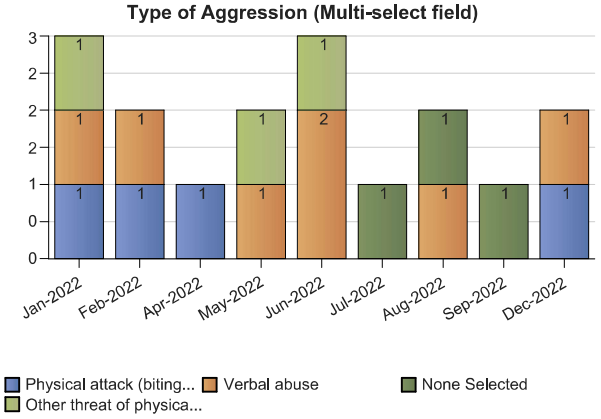
	Jan-2022	Feb-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Workplace Violence	2	1	1	2	2	1
Total	**2**	**1**	**1**	**2**	**2**	**1**



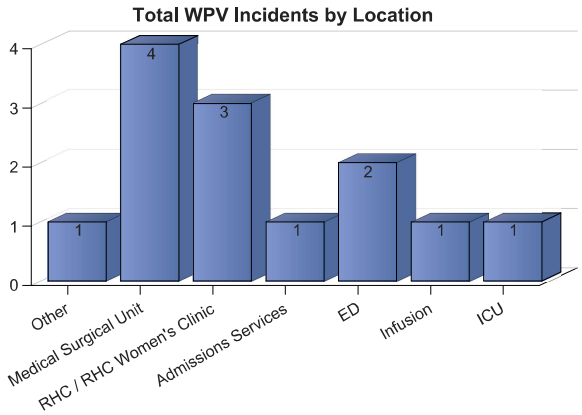
	Jan-2022	Feb-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1	1	1			
Verbal abuse	1	1		1	2	
None Selected						1
Other threat of physical force	1			1	1	
Total	**3**	**2**	**1**	**2**	**3**	**1**



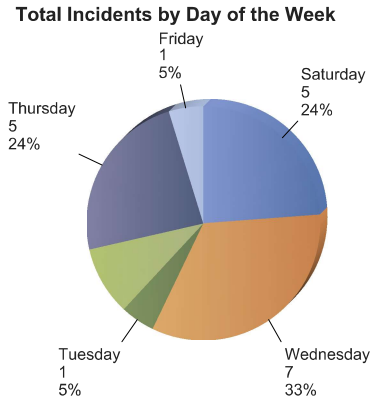
	Aug-2022	Sep-2022	Dec-2022	Total
Workplace Violence	2	1	1	**13**
Total	**2**	**1**	**1**	**13**

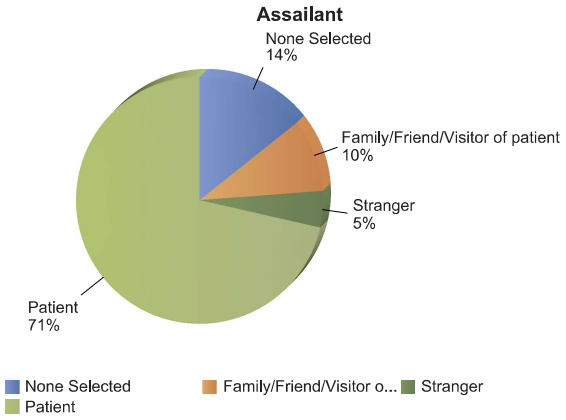


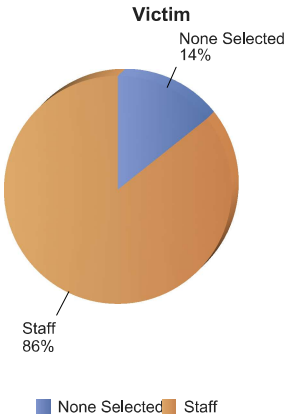
	Aug-2022	Sep-2022	Dec-2022	Total
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)			1	**4**
Verbal abuse	1		1	**7**
None Selected	1	1		**3**
Other threat of physical force				**3**
Total	**2**	**1**	**2**	**17**

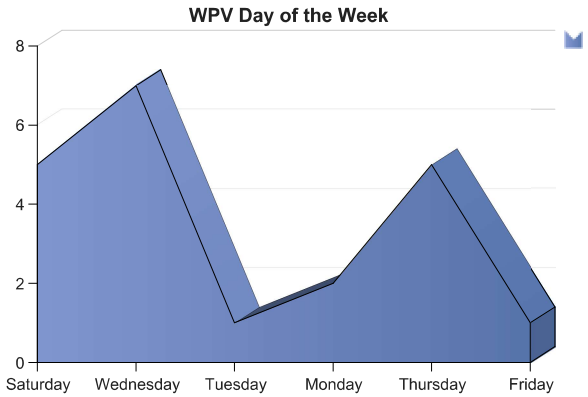


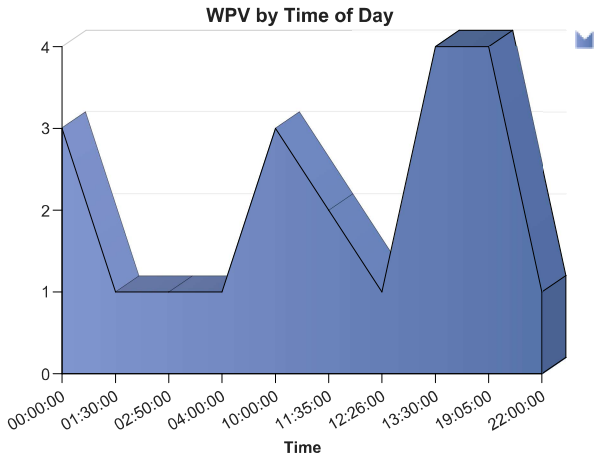
Other	1
Medical Surgical Unit	4
RHC / RHC Women's Clinic	3
Admissions Services	1
ED	2
Infusion	1
ICU	1
Total	**13**

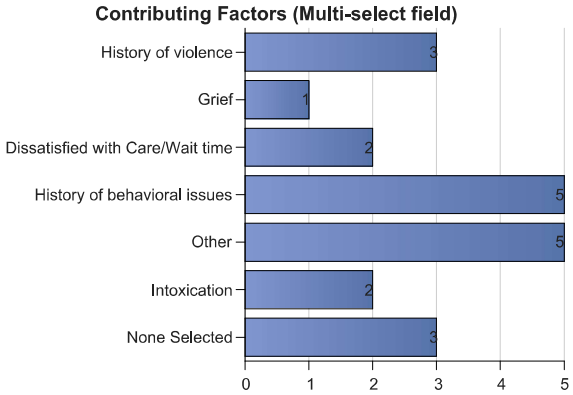






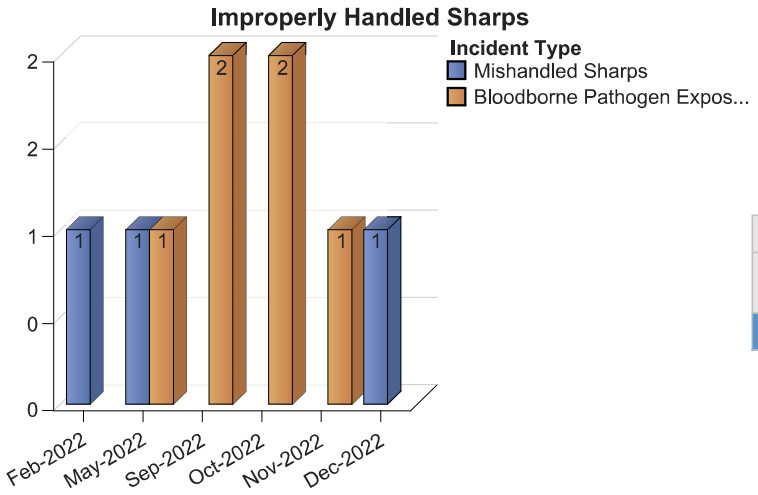




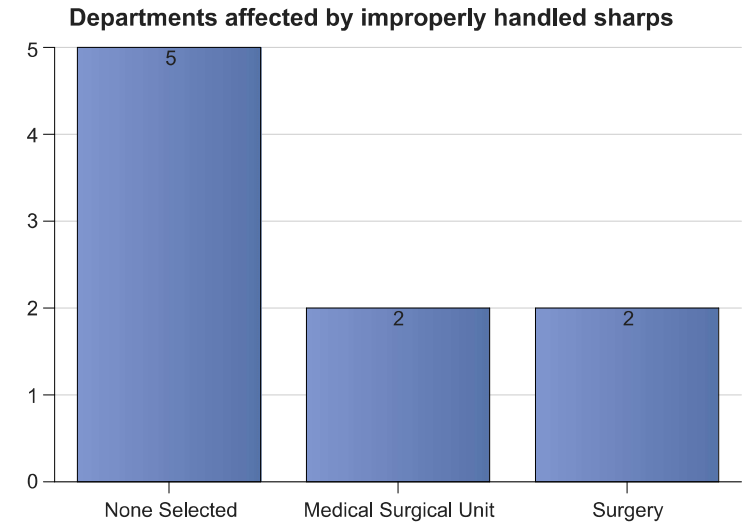


None Selected	3
Dissatisfied with Care/Wait time	1
Grief	1
History of behavioral issues	3
History of violence	2
Intoxication	1
Other	4
Total	**15**

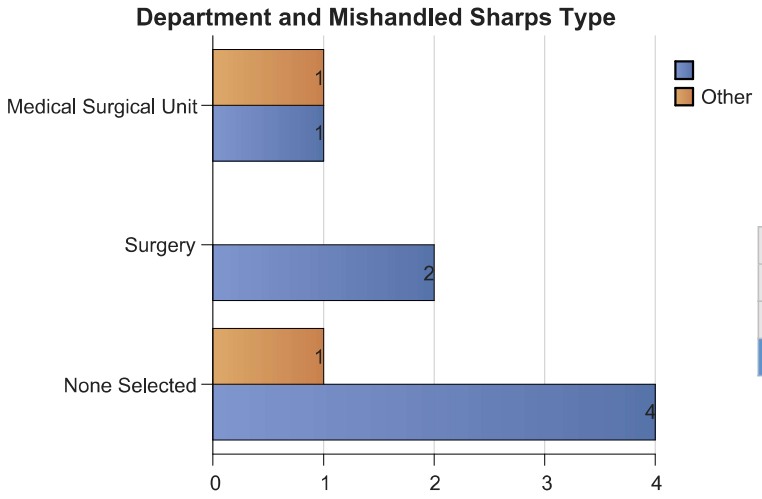
RHC Incidents by Day of the Week - No Data Available



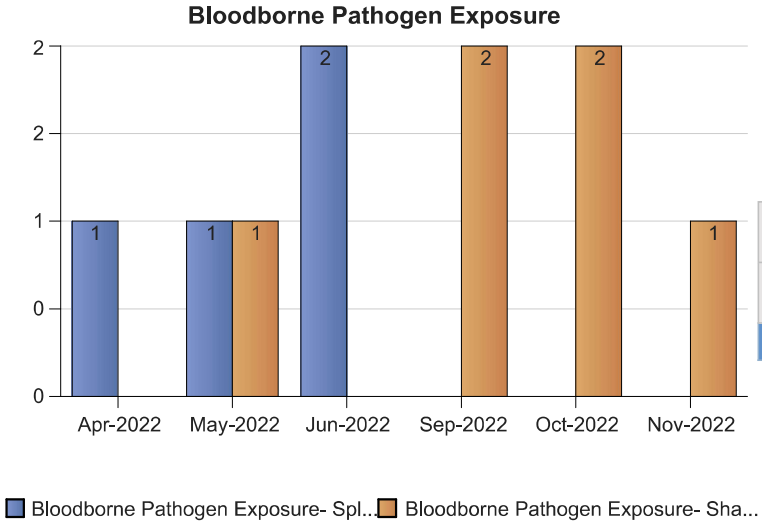
	Feb-2022	May-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Total
Mishandled Sharps	1	1				1	**3**
Bloodborne Pathogen Exposure- Sharps Injury		1	2	2	1		**6**
Total	**1**	**2**	**2**	**2**	**1**	**1**	**9**



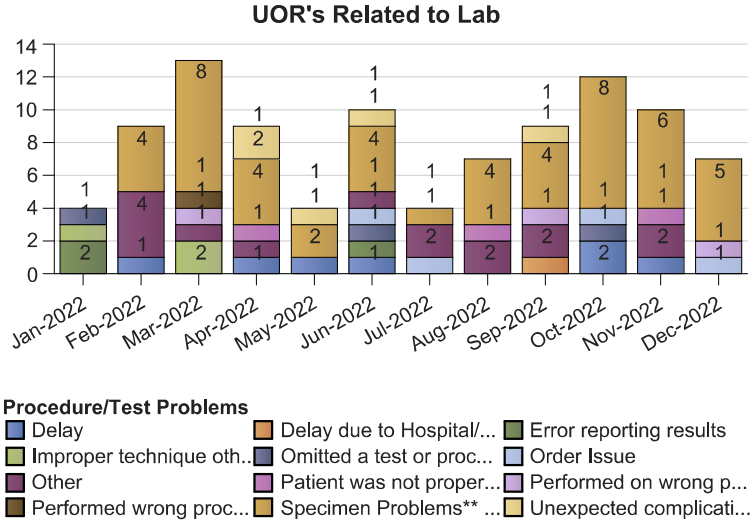
None Selected	5
Surgery	2
Medical Surgical Unit	2
Total	**9**



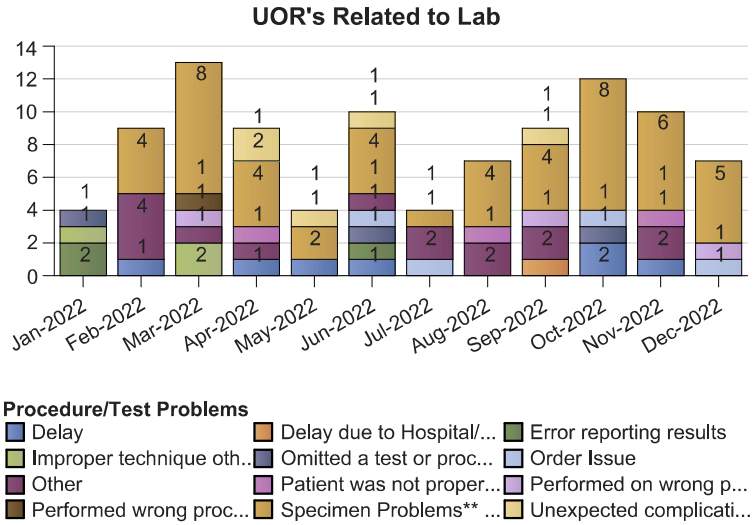
	Mishandled Sharps Type		Total
	None Selected	Other	
None Selected	4	1	**5**
Surgery	2		**2**
Medical Surgical Unit	1	1	**2**
Total	**7**	**2**	**9**



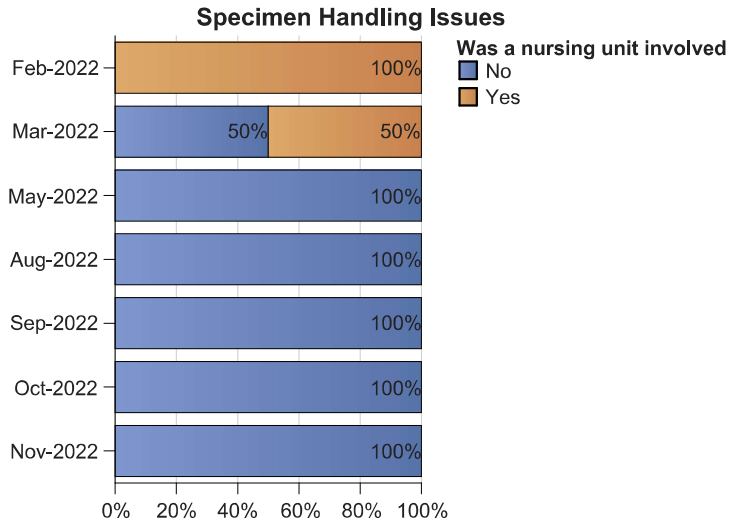
	Apr-2022	May-2022	Jun-2022	Sep-2022	Oct-2022	Nov-2022	Total
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane	1	1	2				**4**
Bloodborne Pathogen Exposure- Sharps Injury		1		2	2	1	**6**
Total	**1**	**2**	**2**	**2**	**2**	**1**	**10**



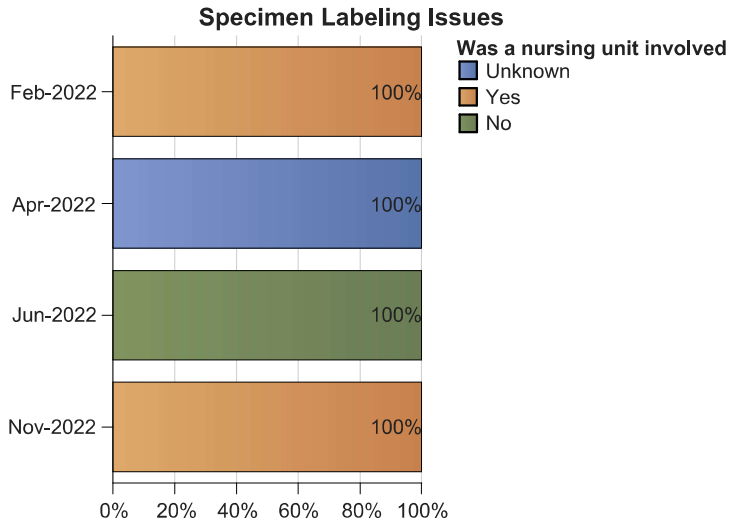
	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022
Delay		1		1	1	1			
Delay due to Hospital/ Radiology systems problems or communication issues									1
Error reporting results	2					1			
Improper technique other than a break in sterile technique	1		2						
Omitted a test or procedure	1					1			
Order Issue						1	1		
Other		4	1	1		1	2	2	2
Patient was not properly prepared for the procedure or test				1				1	
Performed on wrong patient			1						1
Performed wrong procedure			1						
Specimen Problems** LAB ALWAYS SELECT THIS ONE***		4	8	4	2	4	1	4	4
Unexpected complications				2	1	1			1
Total	**4**	**9**	**13**	**9**	**4**	**10**	**4**	**7**	**9**



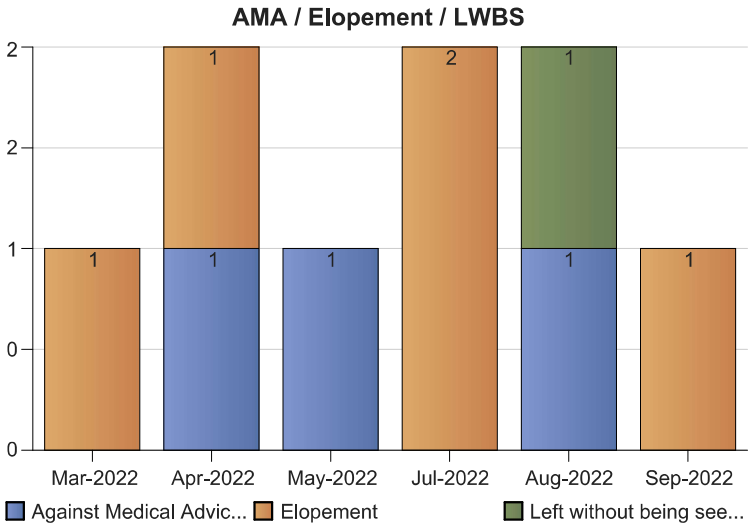
	Oct-2022	Nov-2022	Dec-2022	Total
Delay	2	1		**7**
Delay due to Hospital/ Radiology systems problems or communication issues				**1**
Error reporting results				**3**
Improper technique other than a break in sterile technique				**3**
Omitted a test or procedure	1			**3**
Order Issue	1		1	**4**
Other		2		**15**
Patient was not properly prepared for the procedure or test		1		**3**
Performed on wrong patient			1	**3**
Performed wrong procedure				**1**
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	8	6	5	**50**
Unexpected complications				**5**
Total	**12**	**10**	**7**	**98**



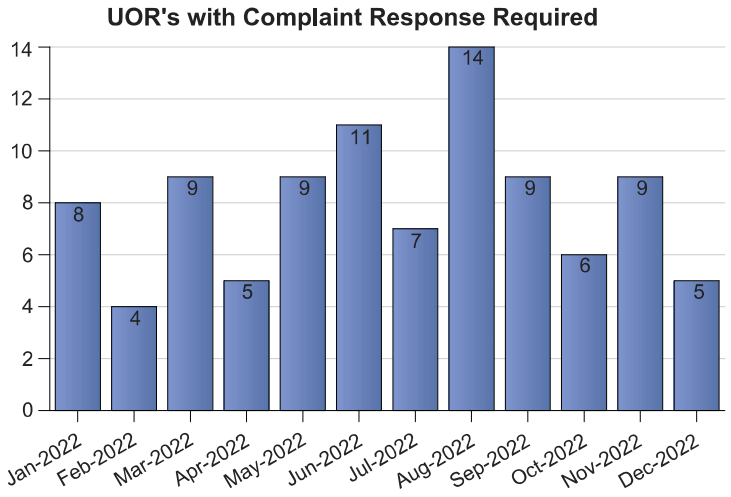
	Feb-2022	Mar-2022	May-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Total
No		1	1	1	2	2	3	**10**
Yes	2	1						**3**
Total	**2**	**2**	**1**	**1**	**2**	**2**	**3**	**13**



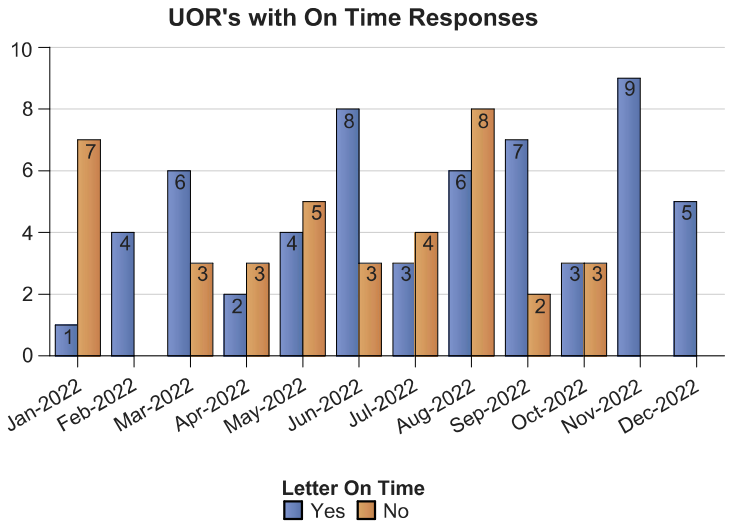
	Feb-2022	Apr-2022	Jun-2022	Nov-2022	Total
Unknown		1			**1**
Yes	4			1	**5**
No			1		**1**
Total	**4**	**1**	**1**	**1**	**7**



	Mar-2022	Apr-2022	May-2022	Jul-2022	Aug-2022	Sep-2022	Total
Against Medical Advice (AMA)		1	1		1		**3**
Elopement	1	1		2		1	**5**
Left without being seen (LWBS)					1		**1**
Total	**1**	**2**	**1**	**2**	**2**	**1**	**9**

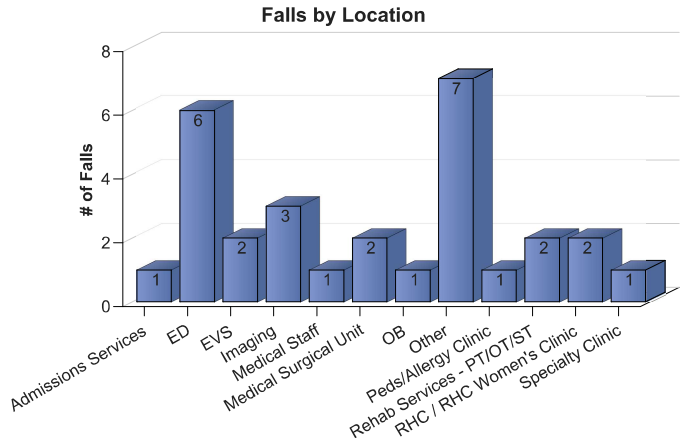


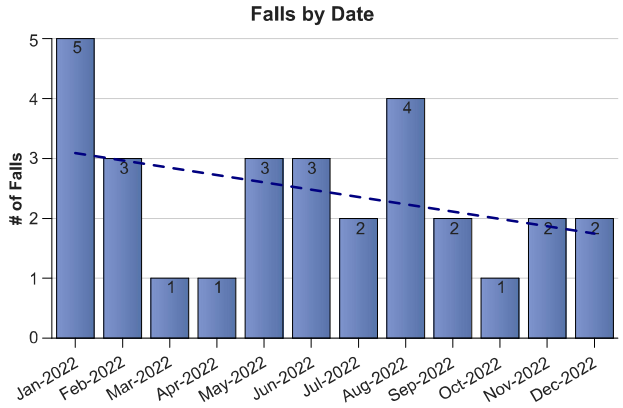
Jan-2022	8
Feb-2022	4
Mar-2022	9
Apr-2022	5
May-2022	9
Jun-2022	11
Jul-2022	7
Aug-2022	14
Sep-2022	9
Oct-2022	6
Nov-2022	9
Dec-2022	5
Total	**96**



	Yes	No	Total
Jan-2022	1	7	**8**
Feb-2022	4		**4**
Mar-2022	6	3	**9**
Apr-2022	2	3	**5**
May-2022	4	5	**9**
Jun-2022	8	3	**11**
Jul-2022	3	4	**7**
Aug-2022	6	8	**14**
Sep-2022	7	2	**9**
Oct-2022	3	3	**6**
Nov-2022	9		**9**
Dec-2022	5		**5**
Total	**58**	**38**	**96**

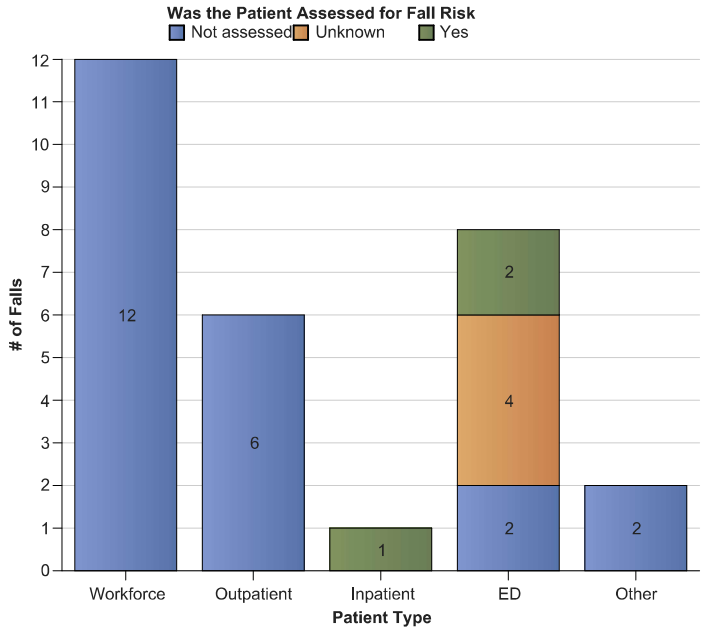
# of Falls	Falls/Slips	Total
Admissions Services	1	**1**
ED	6	**6**
EVS	2	**2**
Imaging	3	**3**
Medical Staff	1	**1**
Medical Surgical Unit	2	**2**
OB	1	**1**
Other	7	**7**
Peds/Allergy Clinic	1	**1**
Rehab Services - PT/OT/ST	2	**2**
RHC / RHC Women's Clinic	2	**2**
Specialty Clinic	1	**1**
Total	**29**	**29**



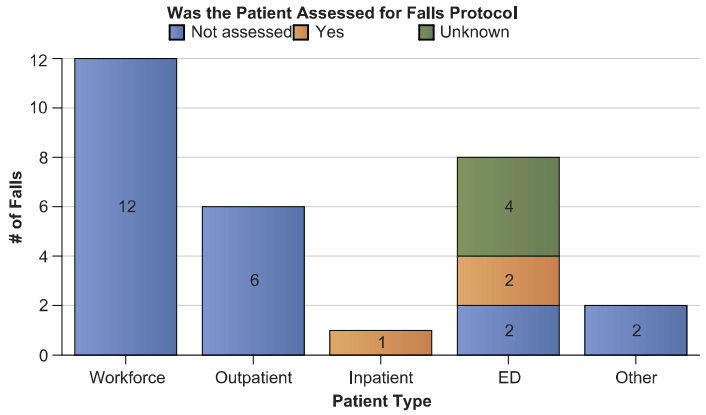


# of Falls	Falls/Slip Problem(s)									Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Ice/weather related	Other	Other Person	
Not Identified	4	4			3	2	1	8	1	**23**
Oriented		4	1	1		1		2		**9**
Total	**4**	**8**	**1**	**1**	**3**	**3**	**1**	**10**	**1**	**32**

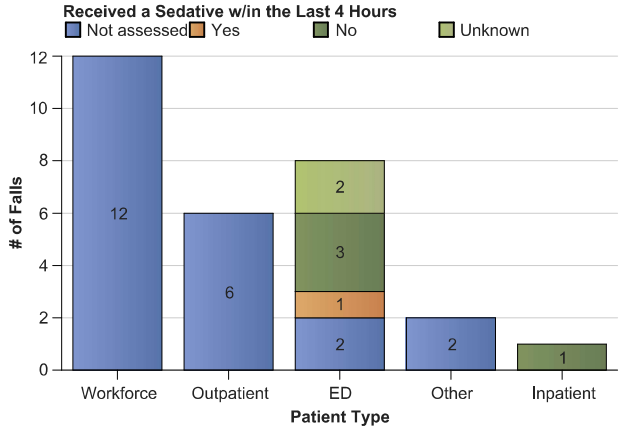
# of Falls	Was there any injury?				
	Not Identified	Unknown	Yes	No	Total
Not Identified	12				**12**
ED	3	2	2	1	**8**
Inpatient	1				**1**
Other	2				**2**
Outpatient	6				**6**
Total	**24**	**2**	**2**	**1**	**29**



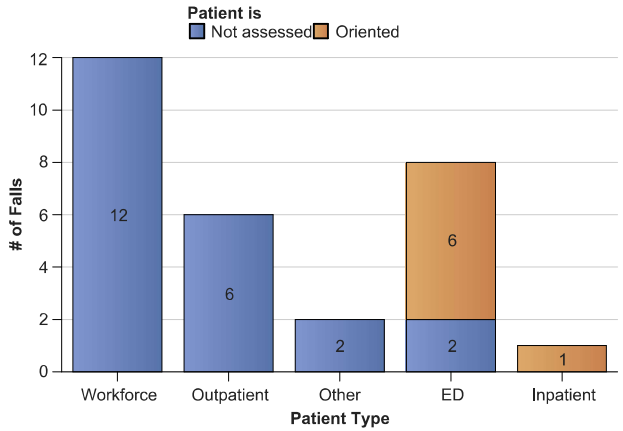
# of Falls	Was the Patient Assessed for Fall Risk			
	Not assessed	Yes	Unknown	Total
Workforce	12			**12**
Outpatient	6			**6**
Inpatient		1		**1**
Other	2			**2**
ED	2	2	4	**8**
Total	**22**	**3**	**4**	**29**



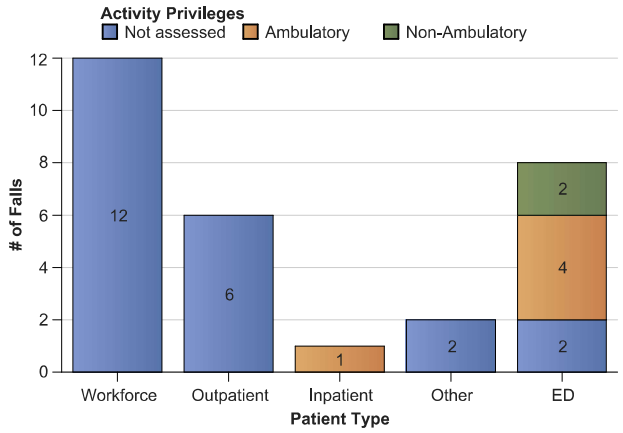
# of Falls	Was the Patient Assessed for Falls Protocol			
	Not assessed	Yes	Unknown	Total
Workforce	12			**12**
Outpatient	6			**6**
Inpatient		1		**1**
Other	2			**2**
ED	2	2	4	**8**
Total	**22**	**3**	**4**	**29**



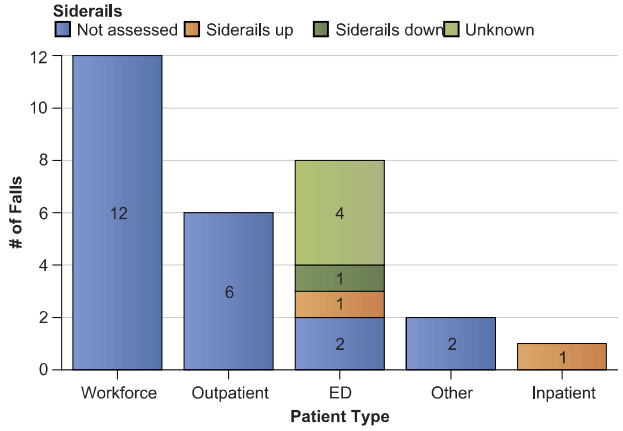
# of Falls	Received a Sedative w/in the Last 4 Hours				
	Not assessed	Unknown	Yes	No	Total
Workforce	12				**12**
Outpatient	6				**6**
Other	2				**2**
ED	2	2	1	3	**8**
Inpatient				1	**1**
Total	**22**	**2**	**1**	**4**	**29**



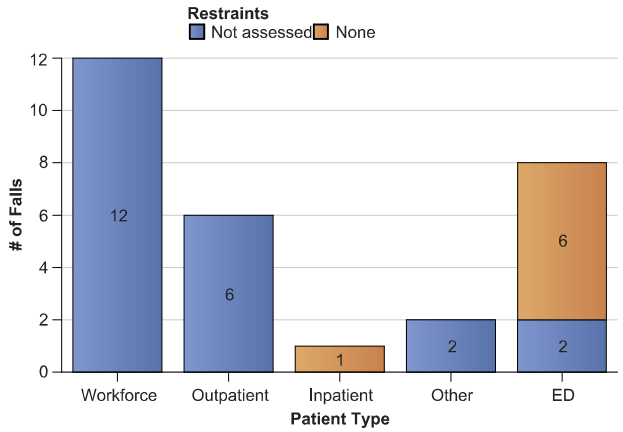
# of Falls	The Patient Is		
	Not assessed	Oriented	Total
Workforce	12		**12**
Outpatient	6		**6**
Other	2		**2**
ED	2	6	**8**
Inpatient		1	**1**
Total	**22**	**7**	**29**



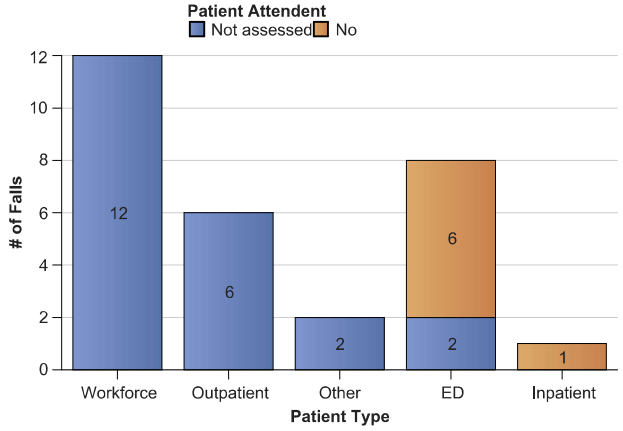
# of Falls	Activity Privileges			
	Not assessed	Ambulatory	Non-Ambulatory	Total
Workforce	12			**12**
ED	2	4	2	**8**
Inpatient		1		**1**
Other	2			**2**
Outpatient	6			**6**
Total	**22**	**5**	**2**	**29**



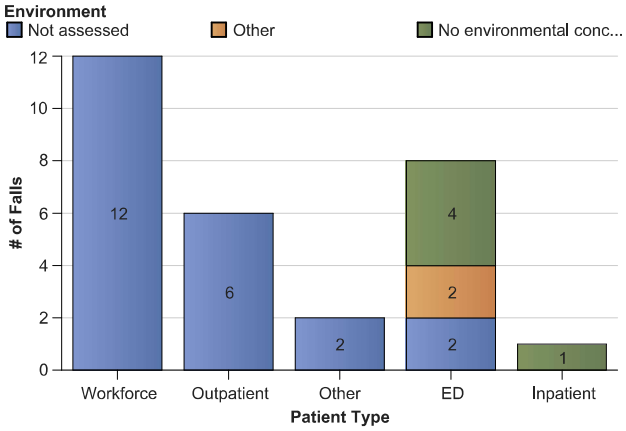
# of Falls	Siderails				
	Not assessed	Unknown	Siderails down	Siderails up	Total
Workforce	12				**12**
Outpatient	6				**6**
Other	2				**2**
ED	2	4	1	1	**8**
Inpatient				1	**1**
Total	**22**	**4**	**1**	**2**	**29**



# of Falls	Restraints		
	Not assessed	None	Total
Workforce	12		12
Outpatient	6		6
Other	2		2
Inpatient		1	1
ED	2	6	8
Total	22	7	29



# of Falls	Patient Attendent		
	Not assessed	No	Total
Workforce	12		12
Outpatient	6		6
Other	2		2
ED	2	6	8
Inpatient		1	1
Total	22	7	29



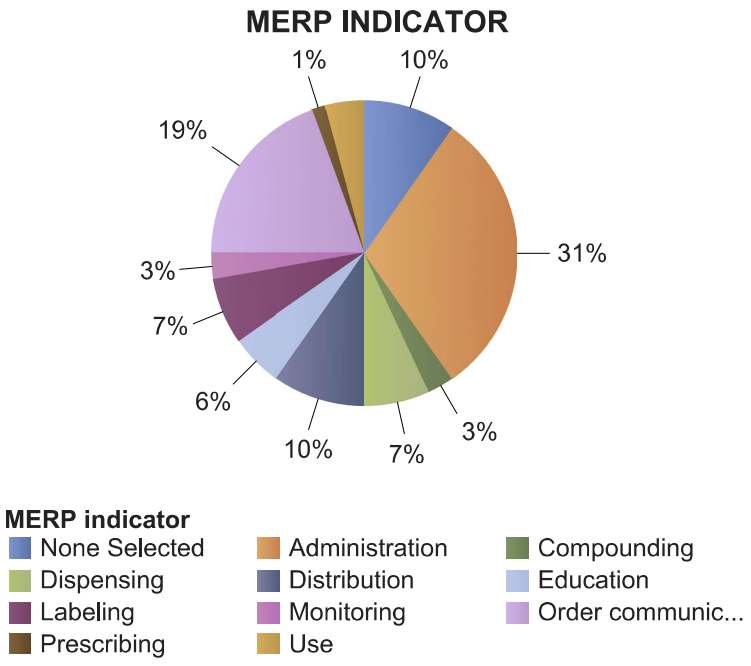
# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	12			**12**
Outpatient	6			**6**
Other	2			**2**
Inpatient		1		**1**
ED	2	4	2	**8**
Total	**22**	**5**	**2**	**29**

# of Falls	Fall Witnessed				Fall Alleged			Assisted to Floor				Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total
Not Identified	12			**12**	12		**12**	12			**12**	12			**12**
ED	4		4	**8**	7	1	**8**	5	2	1	**8**	5	1	2	**8**
Inpatient		1		**1**	1		**1**	1			**1**			1	**1**
Other	2			**2**	2		**2**	2			**2**	2			**2**
Outpatient	6			**6**	6		**6**	6			**6**	6			**6**
Total	**24**	**1**	**4**	**29**	**28**	**1**	**29**	**26**	**2**	**1**	**29**	**25**	**1**	**3**	**29**

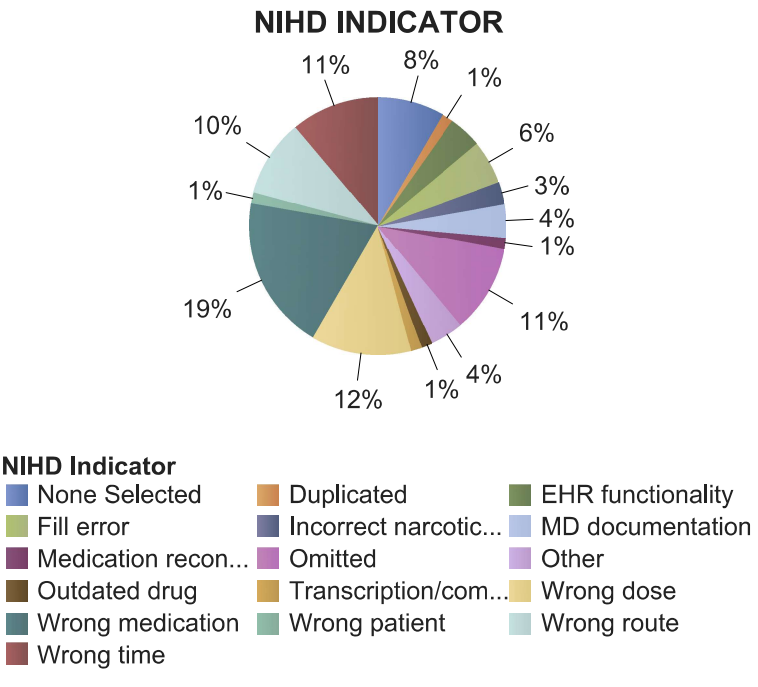
Medication Occurrences are medication issues that did not reach the patient. They were caught prior to administration.

Medication Errors are those issues that did reach the patient.

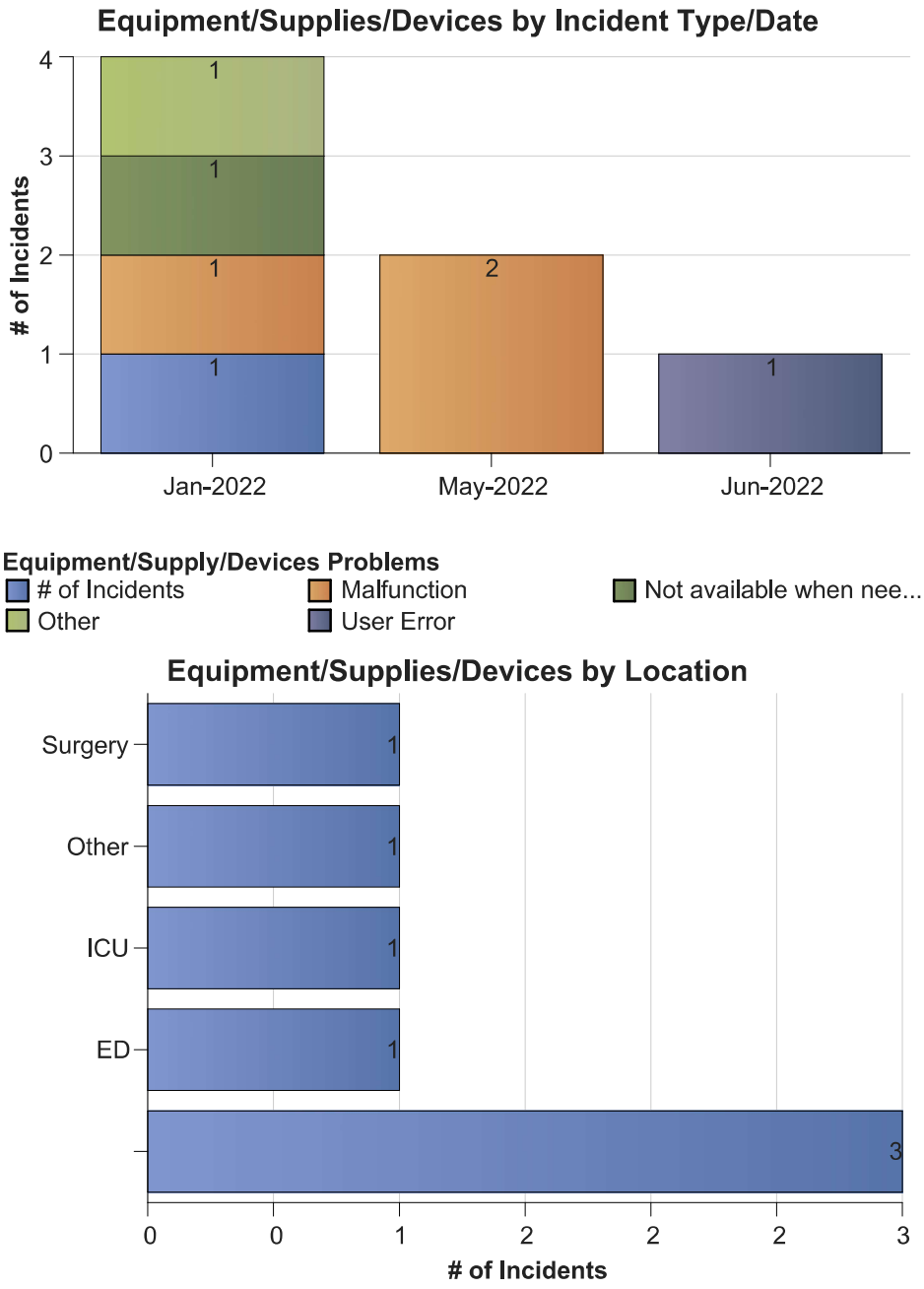
	# of Errors	# of Occurrences	Total
Jan-2022	4	1	**5**
Feb-2022	2	1	**3**
Mar-2022	3		**3**
Apr-2022	4	1	**5**
May-2022	3	2	**5**
Jun-2022	4	6	**10**
Jul-2022	2		**2**
Aug-2022	5	1	**6**
Sep-2022	10		**10**
Oct-2022	6		**6**
Nov-2022	4	1	**5**
Dec-2022	5	2	**7**
Total	**52**	**15**	**67**



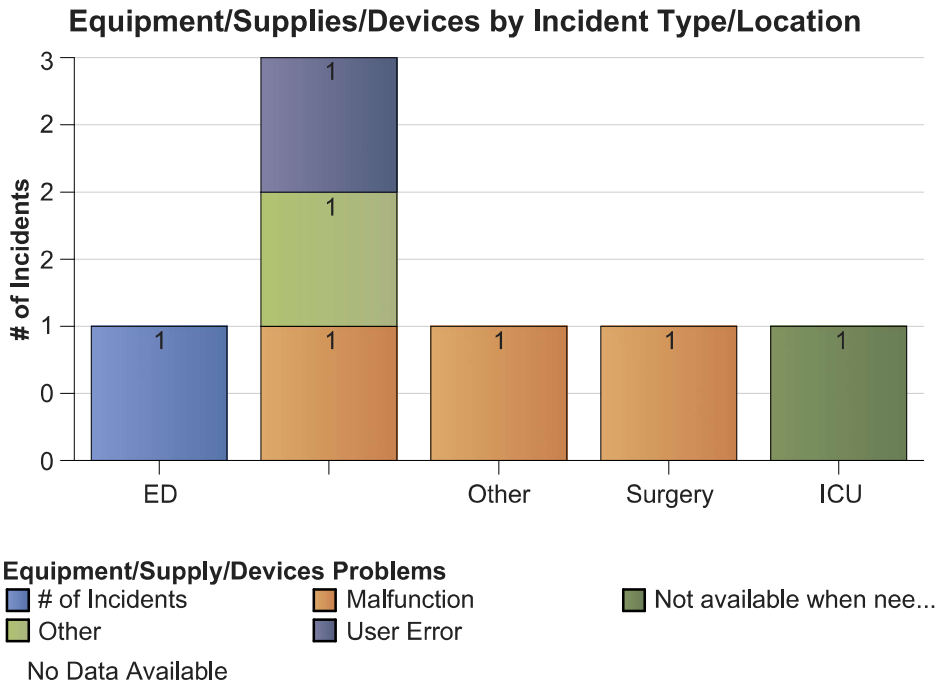
None Selected	7
Administration	22
Compounding	2
Dispensing	5
Distribution	7
Education	4
Labeling	5
Monitoring	2
Order communication	14
Prescribing	1
Use	3
Total	**72**



None Selected	6
Duplicated	1
EHR functionality	3
Fill error	4
Incorrect narcotic count	2
MD documentation	3
Medication reconciliation	1
Omitted	8
Other	3
Outdated drug	1
Transcription/computer entry errror	1
Wrong dose	9
Wrong medication	14
Wrong patient	1
Wrong route	7
Wrong time	8
Total	**72**



No Data Available


Equipment/Supplies/Devices by Incident Type/Location
# of Incidents
3
2
2
1
0
0
1
1
1
1
1
1
1
ED
Other
Surgery
ICU
Equipment/Supply/Devices Problems
# of Incidents
Malfunction
Not available when nee...
Other
User Error
No Data Available

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Use of Hospital Issued Notice of Noncoverage (HINN)		
Owner: Director of Patient Access	Department: Patient Access	
Scope: Case Manager, LCSW, House Supervisor, Patient Access Inpatient Registration		
Date Last Modified: 09/28/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/14/2017	

PURPOSE:

The purpose of this policy is to describe the circumstances in which Northern Inyo Healthcare District (NIHD) must issue the following notices to **Medicare beneficiaries** regarding **inpatient** coverage issues; Hospital Issued Notice of Non coverage (HINN), Hospital Request for Review (HRR) by Quality Improvement Organization (QIO) and Detailed Notice of Discharge. Medicare Beneficiaries include Medicare fee-for service; Medicare Advantage (MA); or other Medicare health plans subject to the MA regulations. The purpose of these beneficiary notices is to enable the beneficiary or representative to better participate in the decisions affecting his or her care and financial liability.

POLICY:

1. Hospitals may issue HINNs to Medicare fee-for service inpatients if they plan to hold the patient financially liable. HINNs may be issued prior to admission, at admission, or at any point during an inpatient stay if it is determined that the care the patient is receiving, or is about to receive, is not covered because it is:
    a. Not medically necessary;
    b. Not delivered in the most appropriate setting; or
    c. Is custodial in nature.

2. Prior to issuing a HINN, hospitals may contact the ordering physician for additional information regarding the patient's case.

3. When the requirements of a Medicare National or local Coverage Determination (NCD or LCD) may or may not have been met, hospitals should proceed with obtaining a HINN in order to allow the Medicare Contractor to adjudicate the claim.

4. Do NOT issue a HINN to patients who are unable to comprehend the HINN, under duress, in a medical emergency, or in any case, where the Emergency Medical Treatment and Active labor Act (EMTALA) applies.

5. When notifying patients of Medicare non-coverage services, hospitals must use the form that best represents the scenario of non-coverage. The hospital must adhere to the general guidelines and the specific guidelines applicable to the form being issued.

6. Services for which HINNs are issued must be billed in accordance with the requirements within this policy.

7. If an inpatient service is determined not to be reasonable and necessary, the patient cannot be held financially liable unless a proper HINN is obtained.

PROCEDURE:

Issuing a HINN Form

1. The hospital must use the HINN that is appropriate to the situation as described above. The hospital must also adhere to the following guidelines for issuing a HINN:
    a. Use exact language as specified in CMS model forms.
    b. Only use CMS model forms.
    c. Deliver in-person to patient representative*.
    d. Ensure comprehension by patient or representative.
    e. Obtain patient or representative signature along with the date and time.
    f. Annotate if patient or representative refuses to sign.
    g. Provide a copy to the patient.
    h. Retain a copy on file in the patient's medical record and provide a copy to the Medicare Contractor or QIO upon request.

    *If the patient's representative is not physically present, the hospital should communicate financial information by telephone and receive the representative's agreement for financial liability. The hospital must maintain documentation regarding communication, understanding and agreement by the patient's representative.

Preadmission/Admission HINN

1. When issuing the HINN prior to the inpatients admission, the hospital must:
    a. Complete and deliver the form as described above;
    b. Inform the patient that they will be liable for all services, except those services eligible for payment under Part B;
    c. Inform the patient they have a right to a QIO review, but they should do so immediately or no later than 3 days post receipt of the HINN.

2. When issuing the HINN at 3pm or earlier on the day of admission, the hospital must:
    a. Complete and deliver the form as described above;
    b. Inform the patient that they will be liable for all services rendered after the receipt of notice, except those services eligible for payment under Part B;
    c. Upon issuance of HINN, inform the patent that they have right to a QIO review, but they should do so immediately or at any point during their stay.

3. When issuing the HINN after 3 pm on the day of admission the hospital must:
    a. Complete the form as described above;
    b. Inform the patient that they will be liable for all services rendered on the day following receipt of notice, except those services eligible for payment under Part B;
    c. Inform the patient they have a right to a QIO review, but they should do so immediately or no later than 3 days post receipt of the HINN.

HINN 10- Notice of Hospital Requested Review (HRR)

1. When the hospital requests a QIO review, it must supply any pertinent information to the QIO by close of business on the first full day immediately following the day of submission. The QIO must:
    a. Notify the hospital of receipt of request and if it has not received pertinent records;
    b. Make determination within 2 days of request; and notify the beneficiary, hospital and physician by telephone and subsequently via written decision;
    c. The hospital should follow-up with the QIO if the above-specified items are not executed by the QIO;
    d. If the QIO concurs with the hospital, the hospital must issue a HINN 12.

HINN 11:

1. When issuing the HINN, the hospital must:
    a. Complete and deliver the form as described above;
    b. Inform the patient that he/she will be liable for all non-covered services.

HINN 12:

1. When the physician concurs that inpatient care is no longer necessary and the patient did not request a QIO review by midnight of the proposed discharge and chose to remain in the Hospital, the hospital must:
    a. Complete and deliver the form as described above; and inform the patient that he/she will be liable for charges incurred as of midnight on the day of the proposed discharge.

REFERENCES:

1. http://www.cms.hhs.gov/Medicare/Coverage/CoverageGenInfo/index.html
2. **https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html**

FORMS found on the intranet>Forms:
HINN – Preadmission Admission Form
HINN 10 Notice of Hospital Requested Review (HRR)
HINN 11 - Noncovered Service(s) during Covered Stay
H**I**NN 12- Medicare Non-Covered Continued Stay Form

RECORD RETENTION AND DESTRUCTION:
The HINN document(s) become a part of the patient's medical records; as such, are maintained by the NIHD Health Information Management Services.

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Use of Hospital Issued Notice of Noncoverage (HINN)*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Verifying and Securing Authorizations		
Owner: Director of Patient Access	Department: Patient Access	
Scope: Patient Access (Inpatient Admissions, Outpatient Registration, Authorization and Referral)		
Date Last Modified: 11/02/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To inform the Northern Inyo Hospital Patient Access staff on the process for verifying and, if necessary, obtaining prior authorization for a scheduled procedure, service or test in order to financially clear patients and ensure reimbursement for the organization.

POLICY:

The Patient Access staff at Northern Inyo Healthcare District will verify whether a prior authorization is necessary for scheduled procedures, services, and tests. They will be diligent in securing the prior authorization either from the ordering provider's office or from the insurance company authorizing the procedure, service or test.

PROCEDURE:

1. **Identifying Payer Requirements**
    a) Whenever possible, staff should initiate the verification of possible need for authorization as soon as possible after receipt of an order for a procedure, service or test by reviewing the payor requirements for pre-authorizations
    b) Staff should verify the patient's eligibility and benefits, and ensure that complete demographic and insurance information is entered for that patient
        1. If critical data elements are missing, contact the ordering physician's office or the patient to obtain the necessary information
2. **Obtaining the prior authorization if one is required by the payor**
    a) If the authorization for the ordered procedure, service or test was not submitted with the order from the ordering provider's office, contact the office and ask them to fax a copy of the authorization to the appropriate hospital fax number

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:

Record retention and destruction occurs within the Health Information Management Services Department at Northern Inyo Healthcare District.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Verifying and Securing Authorizations
2. Admission procedure of Hospice

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Advance Beneficiary Notice (ABN)		
Owner: Director of Patient Access	Department: Patient Access	
Scope: District Wide		
Date Last Modified: 12/01/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/21/2003	

PURPOSE:

To comply with the Medicare requirement of supplying Advance Beneficiary Notice (ABN) when the hospital or physician believes that Medicare probably or certainly will not pay for some or all of items or services.

POLICY:

1. If the patient's provider, or hospital department providing service, expects denial of payment for items or services by Medicare, the patient's provider, or/hospital department providing service must advise the patient before items or services are furnished that the patient may be personally and fully responsible for payment, except when the patient is in a medical emergency or is otherwise under great duress.

2. ABNs will be used only for patients who are Medicare beneficiaries, whether or not they have co-insurance such as Medi-Cal.

3. The ABN must
    a. Be on the CMS approved Form CMS-R-131 (Or Latest Version); https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN
    b. Clearly identify the particular item or service;
    c. State that the patient's provider, or hospital department providing service, believes Medicare is likely (or certain) to deny payment for the particular item or service;
    d. Provide the reason(s) for their belief that payment will be denied for the item or service, in language that gives the patient sufficient information to make an informed consumer decision whether or not to receive the service and pay for it personally.

4. Blanket ABN's will not be utilized.

5. If the hospital service department, or patient's provider expects payment for the items or services to be denied by Medicare, the hospital or patient's provider must advise the patient before items or services are furnished that in their opinion the patient will be personally and fully responsible for payment.

6. The hospital or physician must issue notices each time, and as soon as, they make the assessment that Medicare payment probably (or certainly) will not be made.

7. An ABN will not be given to a patient in any case in which EMTALA applies, until the hospital has met its obligations under EMTALA, which includes completion of a medical screening examination (MSE) to determine the presence or absence of an emergency medical condition, or until an emergency medical condition has been stabilized.

8. The hospital will not bill for a service if it failed to provide an ABN in situations where one is required, unless the hospital can show that they did not know (and could not reasonably have been expected to know) that Medicare would deny payment.

9. In the case that an ABN on which the hospital's or physician's identifying information in the header of the ABN form identifies the hospital or physician that obtained the ABN, rather than the hospital or physician that is billing for the services (e.g., when one laboratory refers a specimen to another laboratory which then bills Medicare for the test; when a physician executes an ABN with his or her own identifying information in the header in conjunction with ordering a laboratory test for which the testing laboratory will submit the claim to Medicare), the ABN form is valid, so long as it was otherwise properly executed.

PROCEDURE:

1. Check on-line resource for ABN requirement via order entry system or separate software.

2. Deliver the ABN to the patient far enough in advance of receiving the service so that the patient can make a rational, informed consumer decision without undue pressure.

    a. As a general rule, ABN delivery should take place before a physical preparation of the patient (e.g., disrobing, placement in or attachment of diagnostic or treatment equipment) begins. This criterion does not constitute a blanket prohibition on giving an ABN to a patient after she/he has entered an examination room or a draw room, and is ready to receive services or items.

    b. Situations may arise during an encounter when a physician sees a need for a previously unforeseen service, expects that Medicare will not pay for it, and wishes to give an ABN. This is permissible, provided that the patient is capable of comprehending the notice, and has a meaningful opportunity to act on it (e.g., the patient is not under general anesthesia).

    c. Where it is foreseeable that the need for service for which Medicare likely would not pay may arise during the course of an encounter, and the patient is either certain or likely not to be capable of receiving notice during the initial service (e.g., the patient will be under anesthesia), it is permissible to give an ABN before any service is initiated. Such an ABN would not violate the general prohibition of routine ABNs.

    d. Also, in a case where a physician draws a test specimen and sends it to a laboratory for testing, and did not give the patient an ABN, the laboratory may contact the patient and give him/her an

ABN without violating this timely delivery rule, so long as testing of the specimen has not begun.

3. Give the ABN to the patient, or the patient's authorized health care decision-making representative, surrogate decision-maker, or public guardian.

4. Fill out all of the following on the ABN;
    a. The patient's name (do not use the authorized representative's name);
    b. Patient encounter number;
    c. The services and reason the hospital or physician believes Medicare will not pay for the service;
    d. Option 1 or Option 2 or Option 3 must be checked personally by the patient (or authorized representative);
    e. Date of signature;
    f. Signature of the patient or authorized representative.

5. Obtain the signed and dated ABN either in person or, where this is not possible, via return mail from the patient or authorized representative acting on the patient's behalf as soon as possible after the ABN has been signed and dated.

6. Retain the original.

7. Scan into the patient's medical record.

8. Give the patient the copy.

REFERENCES:

1. https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

RECORD RETENTION AND DESTRUCTION:

ABN become a part of the patient's medical record.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Advance Beneficiary Notice (ABN)

Supersedes: v.2 Advance Beneficiary Notice