Northern Inyo Healthcare District

Board Meetings

September 20, 2023 Regular Board of Directors Meeting

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

September 20, 2023 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are **limited to three (3) minutes per speaker**, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. Ad Hoc Committee Reports (*Board will provide this information*)
      a. Governance (Jean Turner)
      b. HR (Mary Mae Kilpatrick)
      c. Finance (Melissa Best-Baker)
      d. Compliance (vacant)
   B. Department of Homeland Security CISA Cybersecurity Assessment, Bryan Harper *(Board will receive this information)*

C. Revenue Cycle Report, Gloria Sacco, Revenue Cycle Director *(Board will receive this report)*

D. Chief Executive Officer Report *(Board will receive this report)*

   a. Removal of Surgery Trailer

   b. Urology and Surgery Update

   c. Master Plan

E. Chief Financial Officer Report

   a. Financial & Statistical Reports (*Board will consider the approval of these reports*)

   b. Capital Budget Request (*Board will consider the approval of the Capital Budget Request*)

   c. TAG Update *(Board will receive this report)*

F. Chief Nursing Officer/Chief Operations Officer Report *(Board will receive this report)*

G. Chief of Staff Report, Sierra Bourne MD:

A. Policies (*Board will consider the approval of these Policies and Procedures*)

   1. *Chemical Hygiene Plan for Clinical Laboratory*
   2. *DI – Communication of Mammography Results to the Patient*
   3. *Diagnostic Imaging – Peer Review Policy*
   4. *Infection Prevention Plan*
   5. *Standardized Procedure – Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife*
   6. *Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife*
   7. *Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife*
   8. *Standardized Procedure – Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife*
   9. *Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife*
   10. *Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife*

B. Medical Staff Appointments *(Board will consider the approval of these Medical Staff Appointments)*

   1. *Elizabeth Haun, FNP (family practice) – APP Staff*
   2. *Maria Ramirez, MD (hospitalist) – Courtesy Staff*
   3. *James Tur, MD (hospitalist) – Active Staff*
   4. *Steven Arbogast, DO (teleneurology) – Telemedicine Staff*
   5. *Swati Laroia Coon, DO (teleneurology) – Telemedicine Staff*

6. *Aravind Reddy, MD (teleneurology) – Telemedicine Staff*
7. *Gautam Sachdeva, MD (teleneurology) – Telemedicine Staff*

C. Staff Category Changes *(Board will consider the approval of these Staff Category Changes)*
1. *Joy Engblade, MD (internal medicine) – change from Active Staff to Courtesy Staff*
2. *Monika Mehrens, DO (family medicine) – change from Active Staff to Courtesy Staff*

D. Privilege Forms *(Board will consider the approval of these Privilege Forms)*
1. *Cardiovascular Disease*
2. *Nurse Practitioner*
3. *Physician Assistant*

E. Medical Staff Resignations in Good Standing *(Board will consider the approval of these Medical Staff Resignations in Good Standing)*
1. Alissa Dell, NP (family practice) – effective 7/14/23

F. 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.

4. Approval of minutes of the July 19, 2023 Regular Board Meeting *(Board will consider the approval of these minutes)*
5. Approval of minutes of the August 16, 2023 Regular Board Meeting *(Board will consider the approval of these minutes)*
6. Chief Medical Officer Report *(Board will consider accepting this report)*
7. Department Reports *(Board will consider accepting these reports)*
8. Approval of Policies and Procedures (*Board will consider the approval of these Policies and Procedures)*
    a. *Check Signing*
    b. *Compliance Program for Northern Inyo Healthcare District*
    c. *Employee Complaints and the Grievance Process*
    d. *Nursing Certification*

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

a. Conference with Legal Counsel – Existing Litigation. Government Code 54956.9(d)(1).
   Name of Case: Claim # 23-000653M Pavlovsky
b. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1).
   Title: Interim CEO

4. 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.

Department of Homeland Security
CISA
Cybersecurity Assessment

Remote Penetration Test Out-Brief

— DRAFT —

Northern Inyo Healthcare District

(NINYHCD)

Sep 13, 2023

NOTICE:

The information that follows in this presentation is preliminary and is not fully validated or finalized. Engineers and managers are still in the process of analyzing this information and preparing findings. It is presented in its rough draft state and may be significantly modified prior to the publication of the final report or an official out-brief.

This RPT is not an audit. The services provided only demonstrates what actions an adversary could accomplish within the timeframe of the assessment.

Agenda

Assessment Timeframe & Team

Scope and Limitations

Targets and Status

Goals

Open Source Information Gathering

Findings

Observations

Next Steps

- Questions

Assessment Timeframe & Team

Date	Activity
2023-08-29 to 2023-09-08	External Assessment

Customer Point of Contact (POC)	
Dean Lewis	dean.lewis@nih.org

RPT Fed Lead	
Bob McNeal	robert.mcneal@cisa.dhs.gov

RPT Team
Blake Rash

Scope and Limitations

- External IP Ranges
  - 66 IP addresses across several subnets
    - Third-party site (www.nih.org

- Testing Limitations
  - Short timeframe - overcome by working with NINYHCD staff
  - Testing assumes in-scope systems are a fair representation of all production systems

Goals

Goals

Identify risks within the environment

Provide an actionable report that will increase security posture

Identify specific external attack vectors that can be used to compromise assets

- Determine extent of possible compromise utilizing existing vulnerabilities

Open Source Information Gathering

- 38 emails were scraped from various Internet sources
- 37 scraped emails were identified as existing in previous data breaches (according to HaveIBeenPwned database)
- 37 sets of credentials (emails and passwords) identified in the wild
- 0 sets of credentials were successfully validated

Findings

Finding Severity Classification

Severity	Description
Critical	Critical vulnerabilities pose an immediate and severe risk to the environment because of the ease of exploit and/or potential severe impact. Critical items will be brought to the customer's attention immediately.
High	Intruders may be able to exercise full control on the targeted device such as: - Easily exploitable vulnerabilities that can lead to complete application, system and/or network compromise, such as an intruder having the ability to remotely administer files on a web server - Severe router/firewall/server misconfigurations - Worm, Trojan and/or backdoor detected - Vulnerability exists that has tools readily available on the Internet to take advantage of it - Weak passwords for remote administration and users
Medium	Intruders may be able to exercise some control of the targeted device such as: - Disclosure of unauthorized sensitive customer information or user account information - An intruder can obtain full read access to corporate confidential information - Lack of basic logging and alerting capabilities - Antivirus misconfigurations - Untrusted networks having access to trusted networks
Low	Vulnerabilities discovered and reported as item of interest, but are not normally exploitable. Many low items reported by security tools are not included in this report as they are often informational, unverified, or of minor risk.
Informational	Potential weaknesses within the system that cannot be readily exploited. These findings represent areas that the customer team should be cognizant of, but does not require any immediate action.

Findings Overview

-- PRELIMINARY --

Medium

- Spear Phishing Weaknesses

Low

- Data Disclosure

Informational

- Self-Signed Certificates

Low

Data Disclosure

```
---------------------------------------------------------------------------
+ Target IP:          199.26.184.19
+ Target Hostname:    webmail.nih.org
+ Target Port:        443
---------------------------------------------------------------------------
+ SSL Info:        Subject:  /C=US/ST=California/L=Bishop/O=Northern Inyo Hospital/CN=webmail.nih.org
                   Altnames: webmail.nih.org, webmail.root.nih.org, autodiscover.nih.org, autodiscover
.root.nih.org, ex-mb-01.root.nih.org, ex-mb-02.root.nih.org
                   Ciphers:  ECDHE-RSA-AES128-SHA256
                   Issuer:   /C=US/O=DigiCert Inc/CN=DigiCert Global G2 TLS RSA SHA256 2020 CA1
+ Start Time:         2023-09-12 20:00:36 (GMT0)
---------------------------------------------------------------------------
+ Server: Microsoft-IIS/8.5
+ /: The web server may reveal its internal or real IP in the Location header via a request to with HT
TP/1.0. The value is "10.21.0.202". See: http://cve.mitre.org/cgi-bin/cvename.cgi?name=CVE-2000-0649
+ /Microsoft-Server-ActiveSync: Microsoft Exchange Systems (CAS and OWA) may reveal the internal or re
al IP in the WWW-Authenticate header via a request to /Microsoft-Server-ActiveSync over HTTP/1.0. The
value is "10.21.0.202". See: http://cve.mitre.org/cgi-bin/cvename.cgi?name=CVE-2000-0649
```

Informational

Self-Signed Certificates

```
SCAN RESULTS FOR MSGCTR.NIH.ORG:8010 - 199.26.184.18
--------------------------------------------------

    Certificate #0 ( _EllipticCurvePublicKey )
      SHA1 Fingerprint:                 1e9948d1f6e0bacb95255289292e7ae4361a5854
      Common Name:                      msgctr.nih.org
      Issuer:                           FGVM04TM19002694
      Serial Number:                    198895222161669885742091
      Not Before:                       2022-10-04
      Not After:                        2023-10-17

    Certificate #0 - Trust
      Hostname Validation:              OK - Certificate matches server hostname
      Android CA Store (13.0.0_r9):     FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Apple CA Store (iOS 16, macOS 13) FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Java CA Store (jdk-13.0.2):       FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Mozilla CA Store (2022-12-11):    FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Windows CA Store (2023-02-19):    FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain


SCAN RESULTS FOR WEBMAIL.NIH.ORG:8010 - 199.26.184.19
--------------------------------------------------

    Certificate #0 ( _EllipticCurvePublicKey )
      SHA1 Fingerprint:                 ed8cf537aa5b692b557fecfd8fa647df0b926cca
      Common Name:                      webmail.nih.org
      Issuer:                           FGVM04TM19002694
      Serial Number:                    51677996802764581530030
      Not Before:                       2022-10-04
      Not After:                        2023-10-17

    Certificate #0 - Trust
      Hostname Validation:              OK - Certificate matches server hostname
      Android CA Store (13.0.0_r9):     FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Apple CA Store (iOS 16, macOS 13) FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Java CA Store (jdk-13.0.2):       FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Mozilla CA Store (2022-12-11):    FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
      Windows CA Store (2023-02-19):    FAILED - Certificate is NOT Trusted: self-signed certificate in certificate chain
```

Medium

Spear Phishing Weaknesses

Payload	C2 Protocol	Border Protection	Host Protection
Linked VBScript HTA	DNS	Not Blocked	Blocked
Linked Tikitorch HTA	DNS	Not Blocked	Blocked
Linked Scarecrow	DNS	Not Blocked	Blocked
Linked Encrypted Macro Enabled Word Document	DNS	Not Blocked	Blocked
Linked Encrypted (Velvet Sweatshop) Excel Document	DNS	Not Blocked	Blocked

Medium

Spear Phishing Weaknesses

Payload	C2 Protocol	Border Protection	Host Protection
Linked Powershell HTA	HTTPS	Not Blocked	Blocked
Linked Morph Powershell HTA	HTTPS	Not Blocked	Blocked
Linked Sharpshooter HTA	HTTPS	Not Blocked	Blocked
Linked Sharpshooter HTA with ASMI Bypass	HTTPS	Not Blocked	Blocked
Linked Executable HTA	HTTPS	Not Blocked	Blocked
Linked VBScript HTA	HTTPS	Not Blocked	Blocked
Linked Cactustorch HTA	HTTPS	Not Blocked	Blocked
Linked Tikitorch HTA	HTTPS	Not Blocked	Blocked
Linked Tikitorch HTA (with 3 second delay)	HTTPS	Blocked	Blocked

Medium

Spear Phishing Weaknesses

Payload	C2 Protocol	Border Protection	Host Protection
Linked Scarecrow	HTTPS	Not Blocked	Blocked
Linked Bankai	HTTPS	Not Blocked	Blocked
Linked Executable	HTTPS	Not Blocked	Blocked
Linked Embedded LNK	HTTPS	Not Blocked	Blocked

Medium

Spear Phishing Weaknesses

Payload	C2 Protocol	Border Protection	Host Protection
Linked Macro Enabled Word Document	HTTPS	Blocked	Blocked
Linked Encrypted Macro Enabled Word Document	HTTPS	Not Blocked	Blocked
Linked Encrypted Macro Enabled Word Document (with 3 second delay)	HTTPS	Blocked	Blocked
Linked OLE Embedded Word Document	HTTPS	Not Blocked	Blocked
Linked Encrypted OLE Embedded Word Document	HTTPS	Not Blocked	Blocked
Linked Encrypted (Velvet Sweatshop) Excel Document	HTTPS	Not Blocked	Blocked

Medium

Spear Phishing Weaknesses

Payload	C2 Protocol	Border Protection	Host Protection
Attached VBScript HTA	HTTPS	Blocked	Blocked
Attached Tikitorch HTA	HTTPS	Blocked	Blocked
Attached Executable	HTTPS	Blocked	Blocked
Attached Marco Enabled Word Document	HTTPS	Blocked	Blocked
Attached Encrypted Marco Enabled Word Document	HTTPS	Not Blocked	Blocked
Attached OLE-Embedded Word Document	HTTPS	Blocked	Blocked
Attached Encrypted OLE-Embedded Word Document	HTTPS	Not Blocked	Blocked
Attached Encrypted (Velvet Sweatshop) Excel Document	HTTPS	Blocked	Blocked

Observations

Overall Observations

- Well configured, maintained, and mature external environment

- Multiple network and email security mechanisms
  - Use of anti-virus (Morphisec and Windows Defender) identified and prevented the execution all tested payloads
  - Weekly log monitoring (Morphisec) identified malicious activity and notified NIH personnel
  - Security appliance (Ironport) or service blocked the delivery of all messages containing malicious payloads

Next Steps

- RPT Team
  - Additional Analysis
  - Draft Report to POC

- Dean Lewis
  - Review & validate findings
  - Action Plans to remediate, as appropriate
  - Future work with DHS CISA

Questions?

Revenue Cycle Over View

Northern Inyo Healthcare District

Home | Welcome to CernerWorks! | Patient Accounting - Lights On N | Outcomes Excellence | Chart Con

lightson.cerner.com/clients/INYO_CA/domains/P0786/analytics/revenue-cycle/

Apps | Managed bookmarks | Search Result - JE P... | Home | Internet-Only Manu... | New Provider New... | Weather | National...

Lights On Network® | Northern Inyo Healthcare District CERN_COMH | INYO_CA

Search

Scorecards | Metrics | Calendar | Organization

Thursday, 31-Aug-2023

Summary | A/R Summary | DNFB Summary | Metric Trend

The Revenue Cycle Summary dashboard provides summary information around your top KPIs as well as trend alerting information.

6 Month Environment Summary Trend as of Thursday, 31-Aug-2023

Download Billing Entit

Download Facility Lev

Select Billing Entities

Northern Inyo Healthcar...

	Historical Avg	Feb-2023	Mar-2023	Apr-2023	May-2023	Jun-2023	Jul-2023
Charges	$16,604,921	$14,843,881	$17,793,305	$15,244,082	$18,143,759	$15,655,733	$17,539,017
Payments	($7,753,724)	($6,371,018)	($8,471,266)	($6,735,931)	($8,482,997)	($7,865,339)	($6,760,181)
Adjustments	($8,432,096)	($7,934,499)	($10,396,209)	($6,811,315)	($8,378,016)	($9,922,429)	($9,287,768)
Net Change in A/R	$419,101	$538,363	($1,074,170)	$1,696,836	$1,282,746	($2,132,035)	$1,491,069
Average Daily Revenue	$ 546,352	$539,646	$555,912	$548,533	$559,350	$556,438	$570,189
A/R Balance	$ 50,248,577	$50,685,438	$49,611,267	$50,690,261	$51,973,007	$49,959,302	$51,612,007
A/R Days	92.00	93.92	89.24	92.41	92.92	89.78	90.52
A/R > 90 Days	$ 24,731,839	$26,753,439	$25,286,960	$25,737,608	$26,738,034	$25,752,910	$23,660,417
A/R > 90 Days %	49.20%	52.78%	50.97%	50.77%	51.45%	51.55%	45.84%
DNFB Dollars	$ 5,763,919	$6,802,769	$5,801,455	$6,547,016	$6,349,636	$7,265,735	$7,775,947
DNFB Days	10.54	12.61	10.44	11.94	11.35	13.06	13.64

60 Day Summary

Type here to search

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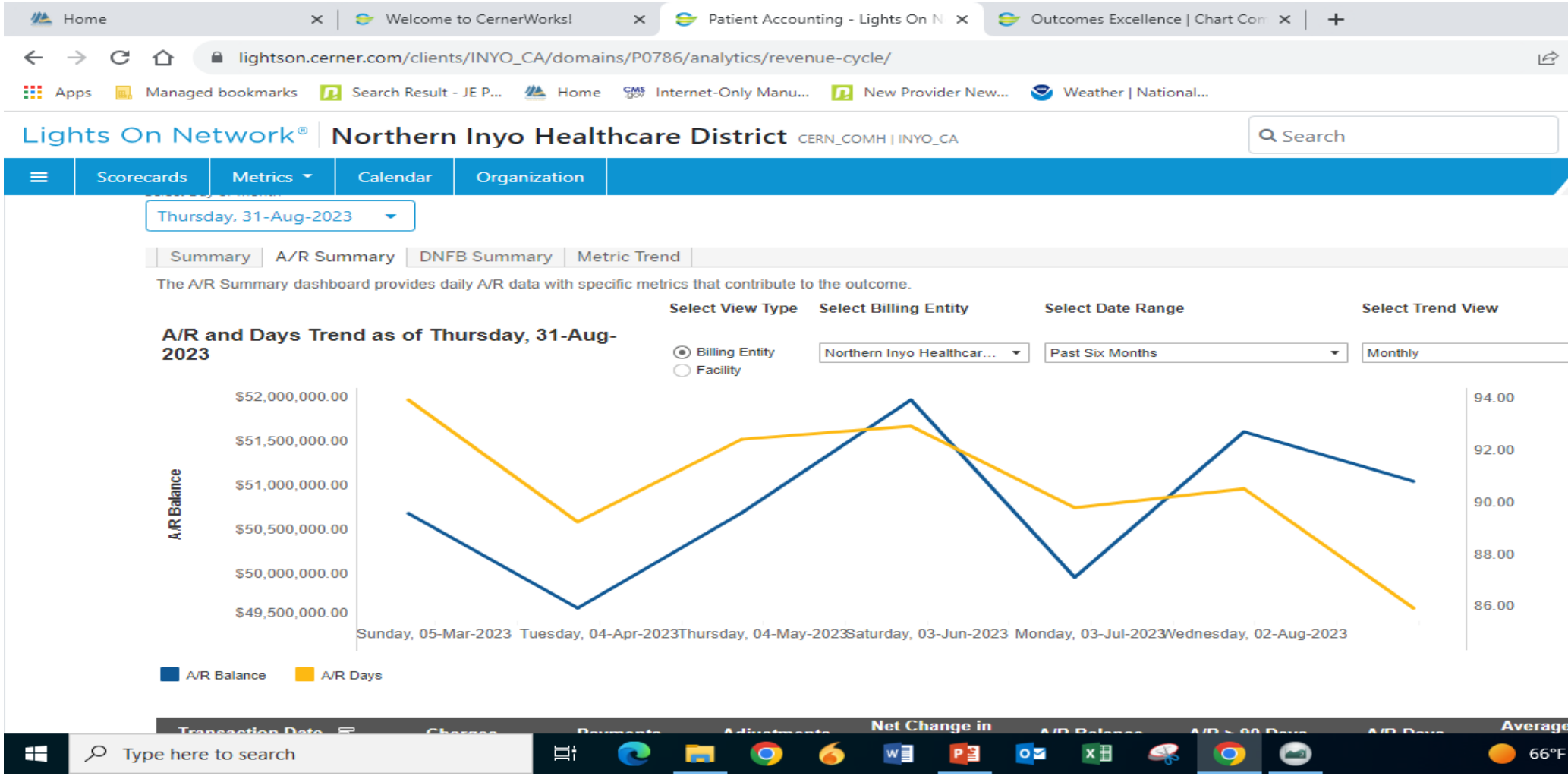
NORTHERN INYO HEALTHCARE DISTRICT



NORTHERN INYO HEALTHCARE DISTRICT

Action Taken To Date

- Determine Uncollectible Receivables (Untimely, contractual)
- Correct Cerner system issues (Update Cerner, correct work flow & educate)
- Self-pay balances placed with MedPlan in May/June (Regulations followed)
- Patients refusing to pay or not setup on payment plans sending to Hauge C million placed. October next large placement)
- Established Denial Avoidance Meetings (First meeting 9/20/23)
- Reduce chart deficiencies (Marnie Davis working with Dr. Hawkins)
- Provider Education & document reviews - Clinic (28 providers – completed & ED (10 providers to start in October)
- Increase daily revenue (charge reconciliation daily by Department)
- Revenue Vendor Audits - OS Healthcare & Novus - Set time line situational Follow up audit in 3 months to monitor progress.

NORTHERN INYO HEALTHCARE DISTRICT

Goals to Achieve

- AR Days (Gross) — Goal 48 Currently as of 8/31/23 86
- DNFB Days — Goal 7 Currently as of 8/31/23 12
- AR over 90 days — Goal 15% Currently as of 8/31/23
- Cash Collection projection — **Prepare in October once all uncollec removed**

NORTHERN INYO HEALTHCARE DISTRICT
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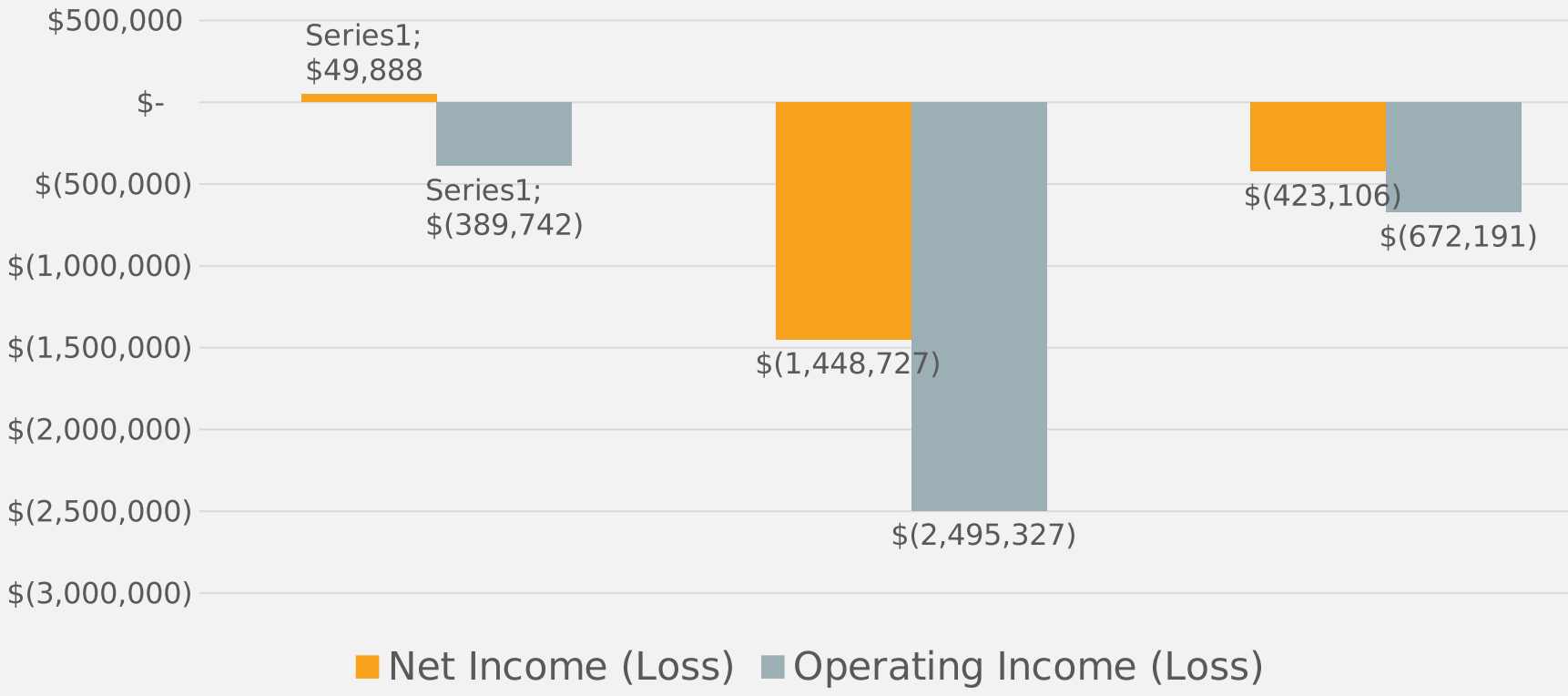
NIHD FINANCIAL UPDATE

July 2023

JULY 2023 FINANCIAL PERFORMANCE



KEY PERFORMANCE INDICATORS

DAYS CASH ON HAND

Metric	FYE 2023 Average	July 2023	% Change
Average Daily Expenses	$314,618	$292,272	-7%
Unrestricted Funds	$25,392,054	$30,155,529	19%
Days Cash on Hand	81	103	28%

WAGE COSTS

Metric	FYE 2023 Average	July 2023	% Change
Total FTEs	424.90	398.04	-6%
Contract Labor Average Hourly Rate	$110.87	$85.09	-23%
Salaries, Wages, Benefits (SWB) per Adjusted Patient Day (APD)	$5,935	$5,807	-2%
Employed Average Hourly Rate	$47.59	$50.17	5.4%

AUDIT UPDATE

- Enjoying the partnership with new firm
- Working through cleanup FYE 2023
- On track to have financial statements by deadline of November 30th

FINANCIAL FOCUS

HEADWINDS

- Accuracy & Timeliness of Financials
  - Coding
  - Accruals
  - Meeting deadlines
- Legal requirements
  - Missed meal and break penalties
  - Potential minimum wage increase

TAILWINDS

- Revenue Cycle Focus
- Other Income Focus
- Contract Labor Rates
- Other Expenses Focus

Northern Inyo Healthcare District
July 2023 – Financial Summary

	CY MONTH	PY MONTH	PY Variance
Net Income (Loss)	(423,106)	49,888	(472,994)
Operating Income (Loss)	(672,191)	(389,742)	(282,449)

Variance from prior year is due to inaccurate accounting practices occuring in prior year which was prior to CFO and Controller's start dates.

IP Gross Revenue	3,306,704	3,986,305	(679,601)
OP Gross Revenue	13,693,264	11,474,649	2,218,615
Clinic Gross Revenue	1,274,341	1,112,050	162,291
Net Patient Revenue	8,730,507	8,690,703	39,804
Cash Net Revenue % of Gross	48%	52%	-5%

IP revenue is down due to less admissions related to a decline in IP surgeries. OP revenue is up due to higher volume in OP surgeries, RHC vists, ER, and diagnostic imaging. 4% of gross charges are self-insured charges (no profit). Payor Mix shift from Blue Cross & Commercial to Government & Self-Pay Payors causing NR decline. Also, new highsight metholody didn't get implemented in PY until September Contributing to YOY variance in CR%. Our own insured employees represents $288k in net revenue. Chargemaster increase will occur in January 2024 for an average of 7% increase.

Admits (excl. Nursery)	64	77	(13)
IP Days	197	246	(49)
IP Days (excl. Nursery)	172	220	(48)
Average Daily Census	6	7	(2)
ALOS	2.7	2.9	(0.2)
Deliveries	14	17	(3)
OP Visits	3,340	3,486	(146)
RHC Visits	2,371	2,249	122
NIA Clinic Visits	1,504	1,493	11
Surgeries IP	12	29	(17)
Surgeries OP	122	105	17
Total Surgeries	134	134	-
Diagnostic Imaging	2,108	1,960	148
Emergency Visits	925	890	35
ED Admits	42	57	(15)
ED Amits % of ED Visits	4.5%	6.4%	-1.9%
Rehab	661	738	(77)
Nursing Visits	266	261	5
Observation Hours	2,051	1,707	344

Admissions down due to a decrease in IP surgeries, deliveries, and ER acuity. RHC increased due to merger with Internal Medicine which occured in late July. Ortho clinic increased by 61 visits. Peds and Allergy increased by 88 visits. Specialty clinic declined

	CY MONTH	PY MONTH	PY Variance

by (28) visits with surgery and virtual care clinics flat compared to prior year. 6% of RHC visits and 15% of clinic visits were self insured visits (no profit). OP surgeries increased due to flip from IP to OP. 6% of OP surgeries were self insured surgeries (no profit). DI services are up due to X-ray and mammo services. 4% of DI services are self insured (no profits) Rehab services are down due to OT and speech (staffing challenges and charges not entered timely - working on project to ensure these occur timely). Volume decline was less than what is reflected her (~30 visits lower than prior year). 7% of rehab services were self insured (no profits).

Payor mix

Blue Cross	17.80%	21.50%	-3.70%
Commercial	2.50%	7.30%	-4.80%
Medicaid	15.20%	34.60%	-19.40%
Medicare	59.90%	35.00%	24.90%
Self-pay	4.60%	1.60%	3.00%
Workers' Comp	0.00%	0.00%	0.00%

DEDUCTIONS

Contract Adjust	(8,174,338)	(6,172,708)	(2,001,630)
Bad Debt	(1,040,036)	(1,834,762)	794,726
Write-off	(330,815)	(378,045)	47,230
Other	-	497,912	(497,912)

Contractuals increased due to payor mix shift to government and change in methodology

CENSUS

Patient Days	197	246	(49)
Adjusted Days	979	1,023	(44)
Employed FTE	365	387	(21)
Contract FTE	33	50	(17)
Total FTE	398	436	(38)
EPOB	2.0	1.7	0.3
Adjusted EPOB	0.4	0.4	(0.1)

Decline in contract FTEs and total FTEs due to RIFF in April 2023 and staffing management. Highwatermark was 459 in August 2022

DENIALS

Denials declined $1.4M from 6 month run rate due to high dollar review meeting implementation

CHARITY

Charity discounts were $11k for July

Northern Inyo Healthcare District
July 2023 – Financial Summary

	CY MONTH	PY MONTH	PY Variance
BAD DEBT			
Bad debt write offs were $2.6M. More accounts are being identified as bad debt as the AR is being reviewed and corrected.			
CASH			
Cash deficit for July was $876k compared to $4M in July 2022			
SALARIES			
Per Adjust Bed Day	$ 2,994	$ 2,478	$ 516
Total Salaries	$ 2,931,229	$ 2,535,292	$ 395,937
Normalized Salaries (incl PTO used)	$ 3,246,211	$ 2,874,071	$ 372,141
Average Hourly Rate	$ 50.17	$ 41.98	$ 8.19
Employed FTEs	365.27	386.52	(21.25)
Second wave of merits averaging 5% were given in July causing increase. Average hourly base rate increase 20% from prior year.			
BENEFITS			
Per Adjust Bed Day	$ 2,142	$ 2,311	$ (169)
Total Benefits	$ 2,097,052	$ 2,364,334	$ (267,282)
Benefits % of Wages	72%	93%	-22%
Pension Expense	$ 611,278	$ 913,367	$ (302,089)
MDV Expense	$ 548,575	$ 688,376	$ (139,801)
Payroll Taxes & WC insurance	$ 346,431	$ 350,059	$ (3,627)
PTO Incurred	$ 314,982	$ 338,779	$ (23,797)
PTO Accrued	$ 275,785	$ 73,753	$ 202,032
Normalized Benefits	$ 1,782,070	$ 2,025,555	$ (243,485)
Normalized Benefits % of Wages	55%	70%	-16%

Benefits at a % of Wages are down due to reduced pension and MDV costs with increase in wages. PTO taken is included in benefits but is truly wages. Normalized salaries and benefits take this into account. DC is $162k in July 2023. New pension matching occurred in August and resulted in a $40k savings per pay period - anticipated $960k annually. However, this is offset with increase wages.

Salaries, Wages & Benefits	$ 5,028,281	$ 4,899,625	$ 128,655
SWB/APD	$ 5,136	$ 4,789	$ 347

Total earnings including benefits increased 3%. Pension offsets took place in August and we anticipate wage increases will be offset by benefit decreases.

PROFESSIONAL FEES			
Per Adjust Bed Day	$ 2,585	$ 2,543	$ 42
Total Physician Fee	$ 1,369,822	$ 1,255,502	$ 114,320
Total Contract Labor	$ 493,990	$ 685,234	$ (191,243)
Total Other Pro-Fees	$ 666,978	$ 661,252	$ 5,726
Total Professional Fees	$ 2,530,790	$ 2,601,988	$ (71,198)
Contract FTEs	32.77	49.84	$ (17)

Physician expense increase due to anesthesia expenses. Contract labor reductions have occurred and is being limited to essential personnel.

PHARMACY			
Per Adjust Bed Day	$ 401	$ 207	$ 195
Total Rx Expense	$ 392,685	$ 211,326	$ 181,358
Prior year was under-accrued due to accountings not completing full month end trend			

	CY MONTH	PY MONTH	PY Variance
accruals			
MEDICAL SUPPLIES			
Per Adjust Bed Day	$ 402	$ 309	$ 93
Total Medical Supplies	$ 393,315	$ 315,752	$ 77,563
Prior year was under-accrued due to accountings not completing full month end trend accruals			
EHR SYSTEM			
Per Adjust Bed Day	$ (136)	$ 106	$ (242)
Total EHR Expense	$ (133,359)	$ 107,979	$ (241,338)
June was over-accrued by $270k which reversed in current month causing credit activity.			
OTHER EXPENSE			
Per Adjust Bed Day	$ 867	$ 612	$ 255
Total Other	$ 848,705	$ 625,688	$ 223,017
Prior year was under-accrued due to accountings not completing full month end trend accruals. Particular increases are food, dues/subscriptions, and utilities			
DEPRECIATION AND AMORTIZATION			
Per Adjust Bed Day	$ 350	$ 311	$ 39
Total Depreciation and Amortization	$ 342,281	$ 318,087	$ 24,194
Total dollar consistent with run-rate.			

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2024

	7/31/2023	7/31/2022	YOY Change
Gross Patient Service Revenue			
Inpatient Patient Revenue	3,306,704	3,986,305	(679,601)
Outpatient Revenue	13,693,264	11,474,649	2,218,615
Clinic Revenue	1,274,341	1,112,050	162,291
Gross Patient Service Revenue	18,274,309	16,573,004	1,701,305
Deductions from Revenue			
Contractual Adjustments	(8,174,338)	(6,172,708)	(2,001,630)
Bad Debt	(1,040,036)	(1,834,762)	794,726
A/R Writeoffs	(330,815)	(378,045)	47,230
Other Deductions from Revenue	-	497,912	(497,912)
Deductions from Revenue	(9,545,189)	(7,887,603)	(1,657,586)
Other Patient Revenue			
Incentive Income	-	-	-
Other Oper Rev - Rehab Thera Serv	1,387	5,303	(3,916)
Medical Office Net Revenue	-	-	-
Other Patient Revenue	1,387	5,303	(3,916)
Net Patient Service Revenue	**8,730,507**	**8,690,703**	**39,804**
CNR%	**48%**	**52%**	**-5%**
Cost of Services - Direct			
Salaries and Wages	2,489,077	2,175,027	314,049
Benefits	1,776,636	2,008,070	(231,433)
Professional Fees	1,793,204	1,381,538	411,667
Contract Labor	366,857	655,016	(288,159)
Pharmacy	392,685	211,326	181,358
Medical Supplies	393,315	315,752	77,563
Hospice Operations	-	-	-
EHR System Expense	(133,359)	107,979	(241,338)
Other Direct Expenses	671,043	546,374	124,669
Total Cost of Services - Direct	7,749,458	7,401,082	348,376
General and Administrative Overhead			
Salaries and Wages	442,153	360,265	81,888
Benefits	320,415	356,264	(35,848)
Professional Fees	243,596	535,217	(291,621)
Contract Labor	127,133	30,218	96,915
Depreciation and Amortization	342,281	318,087	24,194
Other Administative Expenses	177,662	79,314	98,348
Total General and Administrative Overhead	1,653,240	1,679,363	(26,124)
Total Expenses	**9,402,698**	**9,080,446**	**322,252**
Financing Expense	180,370	183,196	(2,826)
Financing Income	228,125	64,203	163,922
Investment Income	60,924	74,115	(13,191)
Miscellaneous Income	140,406	484,508	(344,103)
Net Income (Change is Financial Position)	**(423,106)**	**49,888**	**(472,994)**
Operating Income	(672,191)	(389,742)	(282,449)

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2024

	Prior Year Balances	7/31/2023	7/31/2022	YOY Change
Assets				
Current Assets				
Cash and Liquid Capital	19,390,555	17,067,550	8,260,905	8,806,645
Short Term Investments	10,497,077	10,513,789	24,254,218	(13,740,429)
PMA Partnership	-	-	-	-
Accounts Receivable, Net of Allowance	9,351,360	10,701,794	22,573,731	(11,871,936)
Other Receivables	5,711,717	5,538,617	3,628,324	1,910,294
Inventory	5,159,474	5,120,179	3,116,641	2,003,538
Prepaid Expenses	1,694,180	2,054,965	1,466,831	588,133
Total Current Assets	**51,804,362**	**50,996,894**	**63,300,650**	**(12,303,756)**
Assets Limited as to Use				
Internally Designated for Capital Acquisitions	-	-	-	-
Short Term - Restricted	1,466,355	1,466,418	2,044,212	(577,794)
Limited Use Assets				-
LAIF - DC Pension Board Restricted	798,218	870,163	747,613	122,550
Other Patient Revenue	19,296,858	19,296,858	19,296,858	-
PEPRA - Deferred Outflows	-	-	-	-
PEPRA Pension	-	-	-	-
Total Limited Use Assets	20,095,076	20,167,021	20,044,471	122,550
Revenue Bonds Held by a Trustee	1,078,189	1,072,482	1,105,984	(33,502)
Total Assets Limited as to Use	**22,639,619**	**22,705,921**	**23,194,667**	**(488,746)**
Long Term Assets				
Long Term Investment	2,767,655	2,776,508	2,274,959	501,550
Fixed Assets, Net of Depreciation	77,430,543	77,115,335	76,799,479	315,856
Total Long Term Assets	**80,198,197**	**79,891,843**	**79,074,438**	**817,405**
Total Assets	**154,642,179**	**153,594,658**	**165,569,755**	**(11,975,096)**
Liabilities				
Current Liabilities				
Current Maturities of Long-Term Debt	822,049	825,158	2,575,534	(1,750,376)
Accounts Payable	7,768,116	7,688,430	5,058,837	2,629,593
Accrued Payroll and Related	10,634,804	9,917,379	6,269,082	3,648,297
Accrued Interest and Sales Tax	93,155	170,685	145,639	25,047
Notes Payable	1,633,671	1,633,671	2,133,708	(500,037)
Unearned Revenue	(4,542)	(4,542)	1,160,535	(1,165,076)
Due to 3rd Party Payors	693,247	693,247	693,247	-
Due to Specific Purpose Funds	-	-	-	-
Other Deferred Credits - Pension	2,146,080	2,146,080	2,146,080	-
Total Current Liabilities	**23,786,581**	**23,070,109**	**20,182,661**	**2,887,448**
Long Term Liabilities				
Long Term Debt	33,455,530	33,455,530	33,455,947	(417)
Bond Premium	203,263	200,126	237,771	(37,645)
Accreted Interest	17,123,745	17,218,877	16,820,264	398,613
Other Non-Current Liability - Pension	50,366,473	50,366,473	47,950,740	2,415,733
Total Long Term Liabilities	**101,149,011**	**101,241,006**	**98,464,722**	**2,776,284**
Suspense Liabilities	-	-	-	
Uncategorized Liabilities	649,721	649,721	451,476	198,245
Total Liabilities	**125,585,313**	**124,960,836**	**119,098,859**	**5,861,977**
Fund Balance				
Fund Balance	43,831,306	26,446,580	43,831,306	(17,384,726)
Temporarily Restricted	2,610,286	2,610,349	2,589,701	20,647
Net Income	(17,384,726)	(423,106)	49,888	(472,994)
Total Fund Balance	**29,056,866**	**28,633,823**	**46,470,896**	**(17,837,073)**
Liabilities + Fund Balance	**154,642,179**	**153,594,658**	**165,569,755**	**(11,975,096)**
(Decline)/Gain		(1,047,521)	(1,743,492)	695,971
	-	-	-	-

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2024

Operating Activities			
Receipts from and on behalf of patients (per bank account)	$	7,901,520	
Payments to suppliers, contractors, and employees	$	(9,979,178)	
Other receipts and payments, net	$	53,687	
Net Cash from Operating Activities	**$**	**(2,023,971)**	
Noncapital Financing Activities			
Noncapital contributions (and grants)	$	-	
Property taxes received	$	66,946	
Reduction of CMS advance	$	-	
Other	$	-	
Net Cash from Noncapital Financing Activities	**$**	**66,946**	
Capital and Capital Related Financing Activities			
Principal payments on long-term debt	$	(3,137)	
Interest Paid	$	(180,370)	
Purchase and construction of capital assets	$	(315,856)	
Property Taxes Received	$	161,179	
Net Cash used for Capital and Capital Related Financing Activities	**$**	**(338,184)**	
Investing Activities			
Investment income	$	60,924	
Net Cash from Investing Activities	**$**	**60,924**	
Net Change in Cash and Cash Equivalents	**$**	**(2,234,284)**	
Cash and Cash Equivalents, Beginning of Year	$	32,152,204	As of 06/30/2023
Cash and Cash Equivalents, YTD 2024	**$**	**29,917,920**	
		-	

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2024

Calculation method agrees to SECOND and THIRD SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ (651,231)
+ Depreciation Expense	342,281
+ Interest Expense	180,370
Less GO Property Tax revenue	228,125
Less GO Interest Expense	44,532
2013 and 2021 Indenture)	**$ 144,077**

Other Patient Revenue

Denominator:	
3rd Supplemental Indenture of Trust)	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	905,057
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,704,252
Total **Maximum Annual Debt Service**	**$ 2,722,009**
Ratio: (numerator / denominator)	**0.05**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**FALSE**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 29,917,920
Cash and Investments-non current	2,776,508
Sub-total	32,694,429
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(1,072,482)
Building and Nursing Fund	(1,466,418)
Total Unrestricted Funds	**$ 30,155,529**
Total Operating Expenses	$ 9,402,698
Less Depreciation	342,281
Net Expenses	9,060,417
Average Daily Operating Expense	$ 292,272
Days Cash on Hand	**103**

Key Financial Performance Indicators	Industry Benchmark	Jul-22	Apr-23	May-23	Jun-23	FYE 2023 Average	Jul-23	Variance to Prior Month	Variance to FYE 2023 Average	Variance to Prior Year Month	Variance to Benchmark	Reduction Target	Comment
Volume													
Admits	41	77	59	78	83	68	64	(19)	(4)	(13)	23		Mammoth monthly average in 2022 per HCAI
Adjusted Patient Days	n/a	915	902	1,190	1,105	984	951	(154)	(33)	36	n/a		
Total Surgeries	153	134	117	123	81	120	134	**53**	14	-	(19)		Mammoth monthly average in 2022 per HCAI
ER Visits	659	890	863	815	851	810	661	(190)	(149)	(229)	2		Mammoth monthly average in 2022 per HCAI
RHC and Clinic Visits	n/a	3,742	4,313	4,557	4,381	4,353	3,875	(506)	(478)	133	n/a		
Diagnostic Imaging Services	n/a	1,960	2,002	2,191	2,051	2,020	2,108	57	88	148	n/a		
Rehab Services	n/a	738	809	949	896	762	661	(235)	(101)	(77)	n/a		
AR & Income													
Gross AR	n/a	$ 52,995,998	$ 54,010,319	$ 50,856,137	$ 50,668,396	$ 53,638,580	$ 51,928,721	$ 1,260,325	$ (1,709,858)	$ (1,067,277)	n/a		
AR > 90 Days	$ 7,789,308	$ 22,785,117	$ 25,737,608	$ 26,738,034	$ 25,752,910	$ 23,448,266	$ 23,784,037	$ (1,968,872)	$ 335,771	$ 998,920	$ 15,994,729	(15,994,729)	15% of gross AR is benchmark
AR % > 90 Days	15%	43.0%	47.7%	52.6%	50.8%	43.8%	45.8%	-5.0%	2.0%	2.8%	30.8%		Industry average
Net AR	n/a	$ 22,573,731	$ 14,264,930	$ 9,681,108	$ 9,351,360	$ 17,800,084	$ 10,701,794	$ 1,350,435	$ (7,098,289)	$ (11,871,936)	n/a		
Net AR % of Gross	n/a	42.6%	26.4%	19.0%	18.5%	33.1%	20.6%	2.2%	-12.4%	-22.0%	n/a		
Gross Patient Revenue/Calendar Day	n/a	$ 534,613	$ 530,722	$ 585,271	$ 543,011	$ 546,652	$ 589,494	$ 46,483	$ 42,842	$ 54,881	n/a		
Net Patient Revenue/Calendar Day	n/a	$ 280,345	$ 204,737	$ 269,771	$ 198,702	$ 243,317	$ 281,629	$ 82,927	$ 38,313	$ 1,284	n/a		
Net Patient Revenue/APD	n/a	$ 9,498	$ 6,809	$ 7,028	$ 5,395	$ 7,622	$ 9,180	$ 3,786	$ 1,558	$ (318)	n/a		
Wages													
Wages	n/a	$ 2,874,071	$ 3,970,962	$ 3,154,215	$ 5,954,820	$ 3,281,173	$ 3,246,211	$ (2,708,608)	$ (34,961)	$ 372,141	n/a		
Employed FTEs	n/a	386.52	388.07	364.62	364.62	384.63	365.27	0.65	(19.36)	(21.25)	n/a		
Employed Average Hourly Rate	$ 38.00	$ 41.98	$ 57.76	$ 48.83	$ 92.19	$ 47.59	$ 50.17	$ (42.02)	$ 2.58	$ 8.19	$ 12.17		According to California Hospital Association data
Benefits	n/a	$ 2,025,555	$ 1,746,328	$ 1,819,896	$ 1,610,167	$ 1,907,194	$ 1,782,070	$ 171,902	$ (125,125)	$ (243,485)	n/a		
Benefits % of Wages	30%	70.5%	44.0%	57.7%	27.0%	58.7%	54.9%	27.9%	-3.8%	-15.6%	24.9%	$ (443,680)	Industry average
Contract Labor	n/a	$ 685,234	$ 522,140	$ 821,563	$ 803,281	$ 808,284	$ 493,990	$ (309,291)	$ (314,294)	$ (191,243)	n/a		
Contract Labor FTEs	n/a	49.84	39.68	37.94	39.55	40.27	32.77	(6.78)	(7.50)	(17.07)	n/a		
Total FTEs	n/a	436.36	427.75	402.56	404.17	424.90	398.04	(6.13)	(26.86)	(38.32)	n/a		
Contract Labor Average Hourly Rate	$ 81.04	$ 77.61	$ 74.28	$ 122.24	$ 114.66	$ 110.87	$ 85.09	$ (29.56)	$ (25.77)	$ 7.48	$ 4.05	$ (23,526)	Per zip recruiter as of August 2023 for California, higher range is benchmark
Total Salaries, Wages, & Benefits	n/a	$ 5,584,859	$ 6,239,430	$ 5,795,674	$ 8,368,268	$ 5,996,651	$ 5,522,271	$ (2,845,997)	$ (474,380)	$ (62,588)	n/a		
SWB% of NR	50%	64.3%	101.6%	69.3%	140.4%	79.8%	63.3%	-77.1%	-16.5%	-1.0%	n/a	$ (1,157,018)	Per Becker Healthcare, max should be 50%
SWB/APD	2,903	$ 6,104	$ 6,917	$ 4,870	$ 7,573	$ 5,935	$ 5,807	$ (1,766)	$ (128)	$ (297)	n/a		Industry average
SWB % of total expenses		61.5%	68.7%	63.8%	92.2%	66.0%	58.7%	-33.4%	-7.3%	-2.8%	n/a		
Physician Spend													
Physician Expenses	n/a	$ 1,916,754	$ 2,327,326	$ 2,140,584	$ 2,449,495	$ 2,059,998	$ 2,036,800	$ (412,695)	$ (23,198)	$ 120,046	n/a		
Physician expenses/APD	n/a	$ 2,095	$ 2,580	$ 1,799	$ 2,217	$ 2,124	$ 2,142	$ (75)	$ 18	$ 47	n/a		
Supplies													
Supply Expenses	n/a	$ 527,078	$ 691,965	$ 227,784	$ (985,032)	$ 544,557	$ 786,000	$ 1,771,032	$ 241,443	$ 258,922	n/a		
Supply expenses/APD		$ 576	$ 767	$ 191	$ (891)	$ 579	$ 826	$ 1,718	$ 248	$ 250	n/a		
Other Expenses													
Other Expenses	n/a	$ 1,051,755	$ (178,275)	$ 916,404	$ (752,285)	$ 479,240	$ 1,057,627	$ 1,809,912	$ 578,387	$ 5,872	n/a		
Other Expenses/APD	n/a	$ 1,149	$ (198)	$ 770	$ (681)	$ 505	$ 1,112	$ 1,793	$ 607	$ (37)	n/a		
Margin													
Net Income	n/a	$ 49,888	$ (3,854,455)	$ (915,356)	$ (5,031,592)	$ (1,448,727)	$ (423,106)	$ 4,608,486	$ 1,025,621	$ (472,994)	n/a		
Net Profit Margin	n/a	0.6%	-62.8%	-10.9%	-84.4%	-20.8%	-4.8%	79.6%	16.0%	-5.4%	n/a		
Operating Income	n/a	$ (389,742)	$ (4,318,093)	$ (1,173,331)	$ (5,308,483)	$ (2,495,327)	$ (672,191)	$ 4,636,292	$ 1,823,136	$ (282,449)	n/a		
Operating Margin	n/a	-4.5%	-70.3%	-14.0%	-89.1%	-36.0%	-7.7%	81.4%	28.3%	-3.2%	n/a		
Cash													
Avg Daily Expenses	n/a	$ 282,657	$ 337,324	$ 296,510	$ 364,341	$ 314,618	$ 292,272	$ (72,069)	$ (22,346)	$ 9,615	n/a		
Unrestricted Funds	n/a	$ 30,112,541	$ 22,327,644	$ 25,560,191	$ 28,141,305	$ 25,392,054	$ 30,155,529	$ 2,014,224	$ 4,763,475	$ 42,988	n/a		
Days Cash on Hand	75	107	66	86	77	81	103	26	22	(3)	n/a		Per bond requirement, we need 75 minimum

CAPITAL BUDGET REQUEST			
DESCRIPTION	**PURPOSE**	**ESTIMATE**	**REASON FOR URGENCY**
Backup generator switch gear upgrade	Paralleling control switch gear component level upgrade	$ 78,490.00	Outdated control system, no parts, must be upgraded
Medical air compressor replacement	Parts not availbale for existing unit	$ 56,360.00	Discontinued device parts not available
Nitrous / nitrogen gas manifold replacement	End of life 20+ years old parts not available	$ 28,050.00	Parts not available
Med vacuum compressor	Replacement compressor	$ 12,000.00	
PMA AC unit replacement	All but one unit is end of life not able to keep them running	$ 50,000.00	End of life; parts not available; 30+ years old
Birch St property roof	Worn out	$ 116,000.00	
1967 IT server room AC installation	1967 building AC is not keeping up	$ 10,000.00	Need to install a split unit
DI building HVAC unit replacement	Old units	$ 300,000.00	
Equipment for new pharmacy	Misc equipment - we have been budgeting for this each year	$ 85,000.00	Shelving, omnicell install, hood install, computer, server room racks, switches
AC unit for generator building	Not repairable	$ 10,000.00	
1967 roof replacement		$ 405,000.00	~30,000 sq feet
	Identified	$ 1,150,900.00	
	Break and replace	$ 500,000.00	
		$ 1,650,900.00	

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Chemical Hygiene Plan for Clinical Laboratory		
Owner: Medical Laboratory Services Manager	Department: Laboratory	
Scope: Laboratory Services Department		
Date Last Modified: 05/11/2023	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE

The purpose of the Chemical Hygiene Plan (CHP) is to minimize exposure of laboratory personnel to health and physical hazards presented by hazardous chemicals, and to comply with the requirements of 29 CFR 1910.1450 and the California Code of Regulations, Title 8 Section 5191.

OVERVIEW

The following protocols have been included in this CHP and elsewhere (as indicated) to reduce potential safety and health hazards when working with hazardous chemicals:

a. Limiting use of hazardous chemicals
b. Storing hazardous chemicals correctly
c. Disposing hazardous chemicals correctly
d. Maintaining equipment and instruments (refer to appropriate instrument operator's guides)
e. Wearing correct PPE when working with hazardous chemicals
f. Using correct engineering controls such as fume hoods and shields when working with hazardous chemicals
g. Prohibiting eating, drinking, smoking and applying make-up while working
h. Obtain the Laboratory Director and Laboratory Safety Officer's approval before implementing new procedures that will involve hazardous chemicals needing special engineering controls, workplace practices and PPE.

DEFINITIONS

Hazardous chemical: A chemical for which there is statistically significant evidence, based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed personnel.

Particularly Hazardous Substances: Select carcinogens, reproductive toxins and substances with a high degree of acute toxicity

Permissible exposure level (PEL): The maximum permitted 8-hour time-weighted average concentration of an airborne contaminant. Cal/OSHA lists these limits at www.dir.ca.gov/Title8/5155table_ac1.html

Cutaneous hazards: Substances that affect the dermal layer of the body.

- Signs and Symptoms: Defatting of the skin, rashes, irritation.
- Substances: Ketones, chlorinated compounds.

Eye hazards: Substances that affect the eye or visual capacity.

- Signs and Symptoms: Conjunctivitis, corneal damage.
- Substances: Organic solvents, acids.

Physical hazard: A substance for which there is scientifically valid evidence that it is a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive), or water-reactive.

Carcinogen: A substance is a carcinogen if:

- It has been evaluated by the International Agency for Research on Cancer (IARC) Monographs, Vols 1-34, and found to be a carcinogen or potential carcinogen; or
- It is listed as a carcinogen or potential carcinogen in the Third Annual Report on Carcinogens published by the National Toxicology Program (NTP); or
- It is regulated by OSHA as a carcinogen.

Corrosive: A substance that causes visible destruction of, or irreversible alterations in, living tissue by chemical action at the site of contact. For example, a substance is considered to be corrosive if, when tested on the intact skin of albino rabbits by the method described by the U.S. Department of Transportation in Appendix A to 49 CFR Part 173, it destroys or changes irreversibly the structure of the tissue at the site of contact following an exposure period of four hours. This term does not refer to action on inanimate surfaces.

Reproductive toxins (teratogens): Substances that affect the reproductive capabilities including chromosomal damage (mutations) and effects on fetuses (teratogenesis).

i. Signs and Symptoms: Birth defects, sterility.
ii. Substances: Lead, DBCP.

Irritant: A substance that is not corrosive but that causes a reversible inflammatory effect on living tissue by chemical action at the site of contact. A substance is a skin irritant if, when tested on the intact skin of albino rabbits by the methods of 16 CFR 1500.41 for four hours exposure or by other appropriate techniques, it results in an empirical score of five or more. A substance is an eye irritant if so determined under the procedure listed in 16 CFR 1500.42 or other appropriate techniques.

Toxic: A substance falling within any of the following categories:

1. A substance that has a median lethal dose (LD50) of more than 50 milligrams per kilogram but not more that 500 milligrams per kilogram of body weight when administered orally to albino rats weighing between 200 and 300 grams each.
2. A substance that has a median lethal dose (LD50) of more than 200 milligrams per kilogram but not more than 1,000 milligrams per kilogram of body weight when administered by continuous contact for 24 hours (or less if death occurs within 24 hours) with the bare skin of albino rabbits weighing between two and three kilograms each.
3. A substance that has a median lethal concentration (LC50) in air of more than 200 parts per million but not more than 2,000 parts per million by volume of gas or vapor, or more than two milligrams per liter but not more than 20 milligrams per liter of mist, fume, or dust, when administered by continuous inhalation for one hour (or less if death occurs within one hour) to albino rats weighing between 200 and 300 grams each.

Highly Toxic: A substance falling within any of the following categories:

1. A substance that has a median lethal dose (LD50) of 50 milligrams or less per kilogram of body weight when administered orally to albino rats weighing between 200 and 300 grams each.
2. A substance that has a median lethal dose (LD50) of 200 milligrams or less per kilogram of body weight when administered by continuous contact for 24 hours (or less if death occurs within 24 hours) with the bare skin of albino rabbits weighing between two and three kilograms each.
3. A substance that has a median lethal concentration (LC50) in air of 200 parts per million by volume or less of gas or vapor, or 2 milligrams per liter or less of mist, fume, or dust, when administered by continuous inhalation for one hour (or less if death occurs within one hour) to albino rats weighing between 200 and 300 grams each.

Laboratory Safety Officer (LSO): The Laboratory Director or designee who can provide technical guidance in the development and implementation of the Chemical Hygiene Plan. The Laboratory Director or designee is the Laboratory Safety Officer (LSO). The LSO is responsible for the annual review of the Chemical Hygiene Plan and for providing technical assistance to laboratory workers.

Protective laboratory practices and equipment: Those laboratory procedures, practices and equipment (engineering controls) accepted by laboratory health and safety experts as effective in minimizing the potential for employee exposure to hazardous chemicals.

CHEMICAL HYGEINE PLAN

Particularly Hazardous Chemicals (PHCs) at NIH Clinical Laboratory

1. Northern Inyo Hospital's clinical laboratory does not stock or use particularly hazardous substances ("select carcinogens ", "reproductive toxins" and "substances with a high degree of acute toxicity").
2. Because of this,
    a. specific training for PHC use is not necessary
    b. designated areas and containment devices for PHCs are not necessary
    c. procedures for decontamination and safe removal of PHC waste are not necessary
3. However, laboratory employees are trained in chemical hygiene safe practices for the chemicals that are used and these chemicals are labeled, stored, handled and discarded following OSHA and Cal Osha regulations.
4. If new procedures that involve use of particularly hazardous chemicals are introduced, the above mentioned would be defined and provided. (See "prior approval" section below)

Training

1. Initial training of laboratory personnel includes chemical hygiene safe practices and safety rules. Chemical hygiene safe practice training also occurs when new assignments and procedures are introduced that involve exposure to hazardous chemicals. (See "Prior Approval" section below)
2. Information provided during training includes:
    a. Location of the Chemical Hygiene Plan
    b. Location of SDSs
    c. Correct Personal Protective Equipment
    d. Use of Engineering Controls
    e. Appropriate safe work practices
    f. Chemicals in stock at NIH laboratory and their physical and health hazards
    g. Emergency Procedures and Medical Consultation
3. Training includes observation of work habits
4. The hospital also requires annual viewing of fire safety, electrical safety and MSDS labeling videos

CHEMICAL SAFETY RULES

1. Know the location of emergency showers, eyewashes, first aid kits, emergency exits, spill kits, telephone and fire alarm pull stations
2. Know the location of Safety Data Sheets
    a. PC → LAB(U:) → SAFETY DATA SHEETS
    b. Red binders in laboratory training room
    c. NIHD intranet under "Safety"
    d. Manufacturer
3. Ensure you are familiar with this Chemical Hygiene Plan.
4. Do not drink, eat, smoke or apply cosmetics in the laboratory.
5. Wash hands after working with chemicals, even when gloves have been used.
6. Dress appropriately.
    a. Long hair, neckties, or loose clothing should be tied back or otherwise secured.
    b. No sandals, open-toed or perforated shoes are allowed
    c. Wear a lab coat
7. Wear appropriate eye protection. Wear safety goggles over contacts
8. Wear the appropriate personal protective equipment for the chemicals you are working with.
9. Comply with warning signs and labels.
10. Do not directly smell or taste any chemical.
11. Do not pipette or siphon by mouth.
12. Keep containers closed when not in use.
13. Perform only those experiments or procedures you are authorized to do by the person in charge of the lab.
14. Report all injuries, fires, and accidents to your supervisor immediately.
15. If you have a question about a procedure or the hazards of a chemical, ask your supervisor before performing the procedure.

MANAGEMENT OF CHEMICALS IN THE LABORATORY

Hazardous Chemical Procurement, Distribution, and Inventory

a. Whenever possible use substitutes for hazardous chemicals
b. Use the minimum amount necessary whenever possible
c. Limit purchases of hazardous chemicals to minimal amounts
d. Ensure there are adequate storage cabinets for hazardous chemicals
e. Ensure that SDSs are available before purchase.
a. California Law requires an inventory of hazardous materials. Each laboratory section must complete an inventory and update the inventory annually.

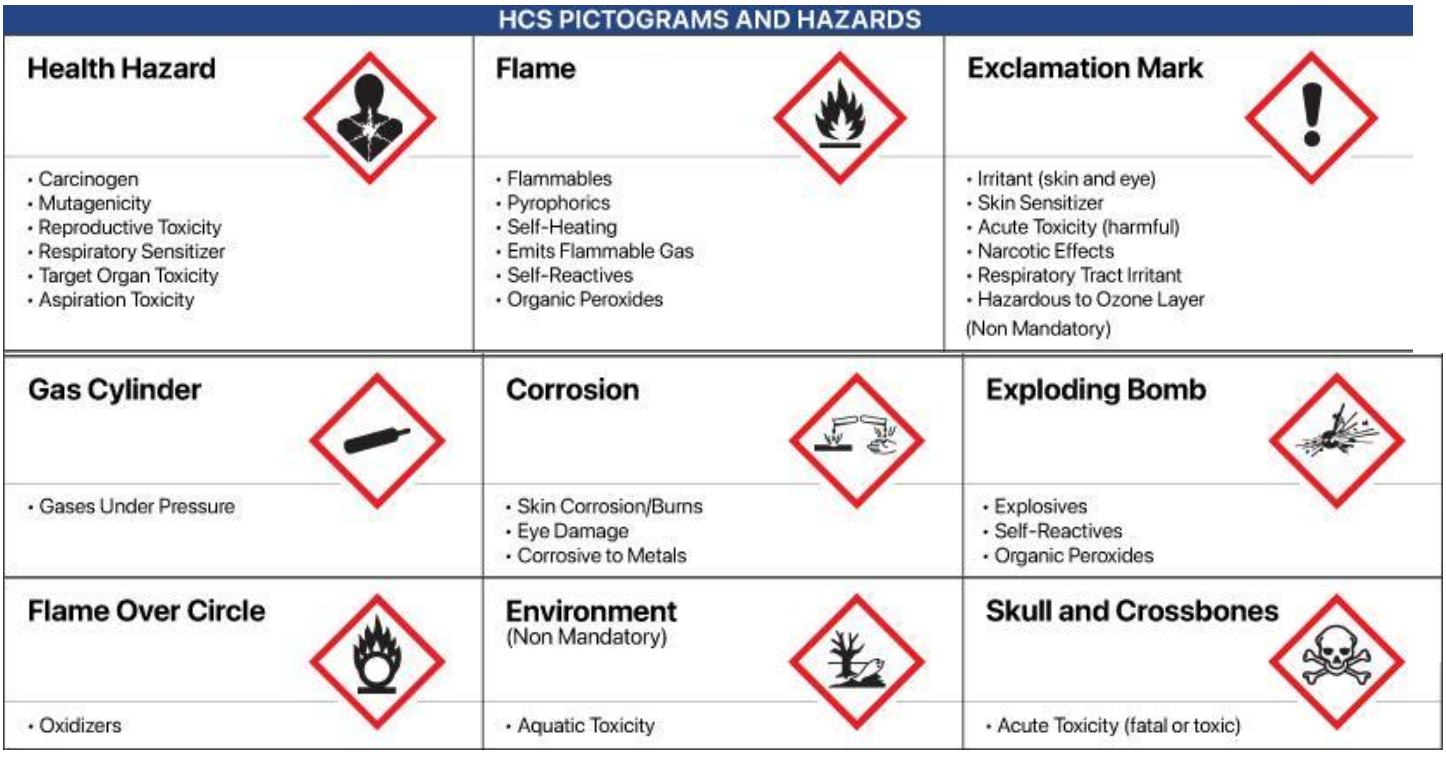
Storage of Hazardous Chemicals in the Laboratory

a. Store hazardous chemicals in cabinets labeled with appropriate Hazard signs
b. Ensure that shelves used for chemical storage are of substantial construction and adequately braced.
c. Arrange containers so that all labels are visible
d. Do not store chemicals on the floor
e. Do not store food in areas where hazardous chemicals are used.
f. Store flammable liquids in flammable liquid safety cabinets and do not store oxidizers, strong acids or water-reactive material with flammable liquids in a manner in which mixing is possible during a catastrophic event such as an earthquake.
g. Do not store chemical under sinks
h. Do not store corrosives in areas where plumbing, equipment or shelving could be damaged by corrosive effects

i. Store hydrochloric acid securely capped.
j. Store organic acids with organics, not with inorganic acids.

Labeling

a. Label all containers of hazardous substances appropriately. Do not remove the manufacturer's label from a container as long as the material or residues of the material remain in the container. The manufacturer's label should have the following information:
   i. The identity of the hazardous substance.
   ii. Appropriate warning words and statements.
   iii. Appropriate precautionary measures.
   iv. Name and address of manufacturer or importer.
b. Label all containers into which hazardous substances are transferred with the identity and concentration of the hazardous substance and a description of the hazards and precautionary measures. In containers smaller than one quart, descriptions can be limited to signal words such as "FLAMMABLE, CORROSIVE, TOXIC";
c. Label all original chemical and reagent containers with the date received and opened and with the opened expiration date if applicable.
d. Label all containers into which reagents and chemicals have been transferred with the date transferred, the expiration date and the opened expiration date.
e. Unlabeled containers of chemicals should not be opened. Such materials should be disposed of promptly; they require special handling procedures.
f. Global Harmonization System symbols should be used when labeling containers.



Liquid and Solid Hazardous Chemical Waste

1. Collect hazardous wastes in containers that are compatible with the intended contents and that are in good condition.
   a. Consult SDSs and manufacturers of hazardous waste containers for appropriate containers
2. Label containers with contents, date of initial collection, and with appropriate hazard labels

3. Keep collection containers securely closed except when adding hazardous material.
4. Placed sharps and broken glassware contaminated with hazardous chemicals in a puncture resistant container.

HANDLING HAZARDOUS CHEMICALS

Personal Protective Equipment (PPE)

1. Wear eye and face protection when there is probability of injury that can be prevented by such equipment.
2. Wear gloves and lab coats to protect from chemicals that are readily absorbed by the skin, or from substances that are corrosive to the skin.

Control Measures

1. Ensure there is sufficient ventilation
2. Use shields or barriers, protective clothing and appropriate eyewear, masks and gloves when using chemicals that may be absorbed in injurious levels by the skin.
    a. Inspect shields for cracks or other damage before each use.
3. Consider permeation and degradation factors of protective clothing and equipment when making selections.

Chemical-Specific Information

1. If diluting strong acids, add acid to water as water has a higher heat capacity and can absorb the heat generated by the dilution reaction. Never add water to acid
2. Never mix formalin with bleach

Housekeeping

a. Keep laboratory free of clutter.
b. Clean working areas at the beginning and end of each shift.
c. Clean small spills of chemicals immediately.
d. Clean larger spills with the Chemical Spill kit immediately
e. Keep safety showers, eyewashes, fire alarms and fire extinguishers free from any obstruction that would prevent access and use.
f. Keep access to emergency exits clear at all times.
g. Keep floor clean and free of slip hazards by reasonable cleaning and immediate clean-up of spills.
h. Dispose of old containers, compromised containers, and chemical wastes promptly

SPILLS AND ACCIDENTS

1. Know the information on the Emergency Preparedness Procedures Chart—Code Orange—Hazmat/Chemical Spills, follow the steps
2. Know the location of the emergency spill kit, including instructions
3. Know the location of emergency showers, eyewashes, first aid kits, and emergency exits
    a. Showers and emergency eyewashes are routinely inspected by the maintenance department in accordance with regulatory requirements
4. Consult the Safety Data sheets found on your PC → LAB(U:) → SAFETY DATA SHEETS to obtain safety information
    a. Paper copies of SDS are also stored in a binder in the training room
5. If medical attention is needed, provide the SDS to the caregiver
6. In case of fire, refer to the information on the Emergency Preparedness Procedures Chart—Code Red Fire Safety—there is a copy of this chart in every room

Chemical Splashes

1. Chemical splashes in the Eyes
    a. Immediately wash the eyes using the eyewash for at least 15 minutes.
    b. If chemicals have entered the eyes while wearing protective eyewear, remove eyewear as quickly as possible and wash eyes in eyewash.
    c. In cases where the eyewear has not been breached by the chemical, remove the protective eyewear after head and face have been thoroughly washed.
    d. Forcibly hold the eyelids open and tell the injured person to roll his/her eyes while continuously irrigating.
    e. Do not use any substance other than potable water to wash the eyes.
    f. Get medical assistance.

2. Chemical Splashes on the Skin
    a. Remove contaminated clothing and PPE
    b. Flush the injured area with large amounts of potable water--under emergency shower if necessary. Never use anything other than water or mild soap and water to clean chemicals from exposed skin.
    c. Wash for 15 minutes or longer. Wash any part of the skin that may have had chemical contact or contact with contaminated wash water.
    d. Remove contaminated clothing while under the emergency shower
    e. Give special attention to areas that may be missed--behind earlobes, underneath arms, the crotch, between toes, the creases at the sides of the nose, a deep cleft in the chin, etc.
    f. Get medical assistance. Provide the appropriate SDSs to medical personnel.
    g. Wash yourself after washing victim to prevent injury from diluted chemicals that may have washed off victim

Medical Consultation and Examinations

1. The hospital provides medical consultation and examination to:
    a. Personnel who develop symptoms associated with a hazardous chemical used in the lab
    b. Personnel who have had an exposure level above the Permissible Exposure Limit
    c. Personnel contaminated or injured by a spill, leak, explosion or other hazardous exposure.
2. Signs and symptoms of exposure to a suspected chemical can be found in the SDS.
3. Report accidents and exposures to a supervisor immediately.
4. Report suspected exposures as soon as possible.
5. All medical examinations are performed by a licensed physician and provided at no cost to laboratory employees.

    Refer to the information on the Emergency Preparedness Procedures Chart—Code Red Fire Safety—there is a copy of this chart in every room

REFERENCES:

- California Code of Regulations (CCR) Title 8 section 5191, "Occupational Exposure to Hazardous Chemicals in Laboratories"
- 29 CFR1910.1450
- CLSI Guidelines

CROSS REFERENCED POLICIES AND PROCEDURES:

None.

RECORD RETENTION AND DESTRUCTION:
Will follow NIHD policy.

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: DI - Communication of Mammography Results to the Patient		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging		
Date Last Modified: 04/12/2023	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/15/2016	

PURPOSE: To define how Northern Inyo Hospital (NIH) will communicate mammography results in lay terms to patients in less than 30 days.

DEFINITION:

1. BI-RADS – Breast Imaging – Reporting and Data System

POLICY:

1. All BI-RADS 1 and 2 (negative and benign) will have a patient lay letter generated and mailed within 96 hours of interpretation of the mammogram.
2. All BI-RADS 0 (needs additional work-up) will have a letter generated and mailed to the patient within 48 hours of interpretation. The Radiology Office staff will call BI-RADS 0 patients within 24 hours of interpretation to schedule follow up imaging.
3. All BI-RADS 3 (short term follow-up) will have a letter generated and mailed to the patient within 48 hours of interpretation. The Mammographer will discuss the results and recommendations from the diagnostic examination with the patient at the time of completion of the examination and will document that discussion in the report, a BIRADS 3 patient notification letter will be provided to patient and scanned into patient's chart. (This will need to be added once the BIRADS 3 letter is approved by forms)
4. All BI-RADS 4 and 5 (suspicious and highly suggestive of malignancy) will have a letter generated and mailed to the patient within 24 hours of interpretation of the diagnostic mammogram. The Mammographer will discuss results and recommendations with the patient at the conclusion of the diagnostic work up. If a biopsy is recommended, the patient will be scheduled for the first available appointment. The Mammographer will document the discussion with the patient in the report of the diagnostic exam.
5. All summary letters shall contain a description of the test results in lay terminology. All letters will contain a description of the next steps for additional examination (annual screening, 6 month follow up, immediate follow up). Each summary will contain the patient name, date of the procedure and the name and address of our facility. Summary letters also indicate that the original images will become part of the patient's permanent medical record and will be available for continuing care.

6. For patients with dense breasts, summary letters shall include the statement below.

   "Breast tissue can be either dense or not dense. Dense tissue makes it harder to find breast cancer on a mammogram and also raises the risk of developing breast cancer. Your breast tissue is dense. In some people with dense tissue, other imaging tests in addition to a mammogram may help find cancers. Talk to your healthcare provider about breast density, risks for breast cancer, and your individual situation."

7. For patients with non-dense breasts, summary letters shall include the statement below.

   "Breast tissue can be either dense or not dense. Dense tissue makes it harder to find breast cancer on a mammogram and also raises the risk of developing breast cancer. Your breast tissue is not dense. Talk to your healthcare provider about breast density, risks for breast cancer, and your individual situation."

8. The written report of the results of the mammographic examination will include an overall assessment of the breast density in one of the following categories:

   (A) The breasts are almost entirely fatty
   (B) There are scattered areas of fibroglandular density
   (C) The breasts are heterogeneously dense, which may obscure small masses
   (D) The breasts are extremely dense, which lowers the sensitivity of mammography

REFERENCES: ACR Practice Parameters for the performance of Screening and Diagnostic Mammography, https://www.federalregister.gov/documents/2023/03/10/2023-04550/mammography-quality-standards-act

RECORD RETENTION AND DESTRUCTION:
Mammography reports will be stored in patient's medical record

CROSS REFERENCED POLICIES AND PROCEDURES:
1. DI – Communication of Mammography Results to the Patient
2. Diagnostic Imaging – Mammography Compliance Requirements
3. DI – Screening Mammography

Supersedes: v.2 DI - Communication of Mammography Results to the Patient

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Peer Review Policy		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging		
Date Last Modified: 07/12/2023	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 02-15-2012	

PURPOSE: To define, in accordance with 2005 ACR Guidelines and Technical Standards, the Northern Inyo Hospital Radiology Peer Review Program

POLICY:

1. The peer review process will include a double reading by two M.D.s - the interpreting radiologist and the reviewing radiologist.
2. A representative sample equal to 2.5 % of the monthly exams per modality will be randomly selected by the department manager or designee for review. Additional cases will be reviewed upon request of a consulting physician or by a radiologist in cases of complications, adverse events, cases with potential for sentinel events and cases identified by critical indicators.
3. The reviewing radiologist will document the level of agreement with the original interpretation in accordance with the following 4-point scale
   a. 1- Concur with interpretation
   b. 2 - Difficult diagnosis, not ordinarily expected to be made
   c. 3 - Diagnosis should be made most of the time
   d. 4 - Diagnosis should be made almost every time - misinterpretation of findings
4. Subgroups 3 and 4 will be considered significant discrepancies. [Suggested courses of action for subgroups 3 and 4 are as follows. Other actions can be substituted as medical staff sees fit
   a. Subgroup 3 - reviewing radiologist and interpreting radiologist discuss review. Addendum should be added to original exam report, referred for Peer Review to Radiology Services.
   b. Subgroup 4 - reviewing radiologist and interpreting radiologist discuss review, referring physician should be notified, and an addendum should be added to original exam report referred for Peer Review to Radiology Services.
5. Summary statistics and comparison data will be generated for each modality.
6. Summary statistics contain confidential Medical Staff information and will be distributed to the Radiology Services Committee and the Medical Staff Office for OPPE (On-going Professional Practice Evaluation) and FPPE (Focused Professional Practice Evaluation)
7. External peer review may be utilized if there are concerns about conflict of interests or the possession of the appropriate level of experience or skill by the internal reviewers.

REFERENCES: ACR Recommended Best Practices

RECORD RETENTION AND DESTRUCTION: Length of practitioners Career +6 years

CROSS REFERENCE POLICIES AND PROCEDURES:

- Diagnostic Imaging – Standards of Care

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Infection Prevention Plan*		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 06/23/2023	Last Review Date: No Review Date	Version: 9
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/13/1999	

PURPOSE:

1. The goal of Northern Inyo Healthcare District (NIHD) is to establish a comprehensive Infection Prevention and Control Program. The program is to ensure that the organization has a functioning coordinated process in place to minimize the risks of endemic and epidemic Healthcare Associated Infections (HAI's) in patients, visitors, and healthcare workers and to optimize use of resources through a strong preventive program while utilizing evidenced base practices and principles. The continuously developing Infection Control Program is part of NIHD ongoing commitment to provide high quality healthcare. Through the Infection Control Program, NIHD systematically involves each team member in the process of maintaining a safe environment for our patients, visitors, team members, and other healthcare providers.
2. The Infection Control (IC) Program incorporates the following on an ongoing basis:
    - Surveillance, prevention and control of infection throughout the organization.
    - Develop alternative techniques to address the real and potential exposure.
    - Select and implement the best techniques to minimize adverse outcomes.
    - Evaluate and monitor the results and revise techniques as needed.
    - Administrative support to ensure adherence to the program standards.
    - Northern Inyo Healthcare District NIHD ensures that all team members are effectively trained and educated on infection control issues and procedures through orientation and an ongoing continuing education program.
3. The infection control process and its supporting mechanisms are based on current scientific knowledge, acceptable practice guidelines, applicable laws and regulations, sound epidemiologic principles and research on HAI's It takes into consideration the following factors: the facility's geographic location, patient volume, patient population served, the hospital's clinical focus and number of team members.

POLICY:

The Infection Prevention and Control Program at NIHD, which allows for a systematic coordinated and continuous approach, is guided and implemented by:

1. Adherence to the established IC Program standards is continuously monitored through surveillance. Problems identified through surveillance are analyzed, evaluated, and monitored for resolution. Surveillance is used to identify opportunities to improve care while playing an integral role in continuous quality improvement effort.
2. OSHA regulations and pertinent federal, state, and local regulation pertaining to infection prevention which are implemented and followed.

3. Education upon hire and again annually with particular emphasis on proper use of personal protective equipment (PPE) for healthcare workers at risk of accidental exposure to blood borne pathogens. In addition, emphasis is placed on educating staff regarding airborne diseases and its mode of transmission.
4. Surveillance will include HAI's among patient and personnel when possible. Targeted studies will be conducted on infection that are high risk, high volume. In addition, selected HAI's and microbiology reports will be monitored.
5. Monitoring and evaluation of key performance aspects of infection control surveillance and management which are:
    - Device related infections.
    - Multi-Drug Resistant Organisms.
    - TB: Suspected, confirmed, or conversion in patients and staff
    - Occupational Exposure to Bloodborne Pathogens
    - Other Communicable diseases
    - Employee Health trends
    - Surgical Site Infections
    - Construction and renovation activities
6. Continuous collection and/or screening of data to identify potential infectious outbreaks.
7. Participating in an organizational proactive education program in an effort to reduce and control the spread of infection.
8. Facilitating a multidisciplinary approach to the prevention and control of infections.
9. Utilizing epidemiologic principles and nosocomial infection research form recognized authoritative agencies.
10. Collaborating with NIHD organization policies and procedures affecting the prevention and control of infections.
11. Interacting with and reporting governmental agencies
12. The Infection Control Program is connected with the Inyo County Health Department to ensure appropriate follow-up of infection is implemented within the communities and rural areas served by Northern Inyo Healthcare District.
13. The Infection Prevention Plan and goals will be reviewed annually; evaluation of pillars will be completed quarterly. The review and evaluation will be presented at the Nurse Executive Committee and the Infection Prevention Committee.

DEFINTIONS:

1. Hospital- Acquired Infections (HAI's): Infection people get while they're receiving healthcare for another condition. HAI's can happen in any healthcare facility.
2. Outbreak- An increase in the occurrence of cases of infection or disease over what is expected in a defined setting or group in a specified time; synonym of epidemic but used more often when limiting the geographic area.

PROCEDURE:

1. When evaluation identifies an area of concern, a specific problem, or an opportunity for improvement, a corrective action plan will be formulated. The corrective action plan is collaborative in nature.
2. When problems or opportunities for improvement are identified; actions taken/recommended will be documented in the appropriate committee meeting minutes.
3. If immediate action is necessary, the Infection Preventionist, Infection Control. Committee, or designee has the authority to institute any surveillance, prevention and control measures if there is reason to

believe that any patient or personnel is at risk. The actions will be reported to the appropriate committee, and leadership.

4. The Infection Control Committee/Infection Preventionist has the responsibility for infection prevention and control activities throughout the organization. This committee is presided by a physician having knowledge of infection control and prevention practices and performance improvement methodologies. The physician guides the committee and decisions for improvement of care through the prevention and control if infections.
5. The responsibility and direct accountability for the surveillance, data gathering, aggregation and analysis is assigned to the Infection Prevention team.
6. Hospital personnel and medical staff members share accountability in reporting of isolation cases suspected or confirmed HAI's. There is collaboration among departments as well as the Infection Control Nurse to identify any HAI trends or pattern that may occur, or opportunities to improve outcome in the reduction and control of infections.
7. The Infection Prevention team will:
    - Review all positive cultures to determine if HAI's or reportable disease.
    - Review and do an evaluation of confirmed infectious cases to assure correct implementation of PPE as appropriate. Periodic observation of clinical department at assure maintenance or standard precautions on all patients.
    - Complete Infection Prevention and Control inspections.
    - Collaboratively review of hazardous waste management and disposal with the maintenance department.
    - Provide a Chairperson for the sharps committee.
    - Participate in product evaluation.
    - Report to governmental and local agencies.
    - Will complete annual Infection Control Risk Assessments and update as needed
    - Will complete Infection Control Risk Assessment (ICRA) related to construction or renovation.
8. Identify and track key performance measure related to process and outcome in an effort to continuously improve the management of HAI's throughout the organization.
9. Work collaborative with District Education to provide education related to infection prevention and control practices to ensure a safe environment for patients and healthcare personnel.
10. The Infection Preventionist work closely with the Quality Council to identify potential quality problems throughout the organization.
11. Work closely with Safety team of possible infectious issues that are potentially hazardous to patients and staff.
12. Monitoring the results of the Infection Prevention (IP) Program allows the hospital to determine if the techniques already in effect are working well, or if changed conditions require new or revised techniques. The process of monitoring provides control and coordination of the IP program and also causes the infection control process to renew itself through new information. Monitoring is achieved through:
    - Committee interaction
    - Daily job functions of the Infection Prevention team
    - Comparisons of current statistical information and historical data and bench marking
    - Policy and procedure reviews; future surveys and inspections, internal and external.
    - Action plans

METHODOLGY:

1. Case findings and identification of demographically important HAI's provide surveillance data. Nosocomial infection data, using, as appropriate, rates stratified by infection risk or focused infection studies, are collected on an ongoing basis.
2. In addition to the use of planned surveillance methods, special studies may be conducted that include:
    - The investigation of clusters of infections above expected levels.
    - The investigation of single cases of unusual or epidemiologically significant HAI's
    - A focus on procedures with significant potential for HAI's, particularly when the procedure is new or substantially changed.
    - The comparison of a group of infected patients with an uninfected control group to detect statistically significant risk factors for which control measures can be developed.
3. The Infection Control Manager or designee will conduct outbreak investigations whenever appropriate by following any or all of the below steps if indicated:
    - Verify the diagnosis and confirm possible outbreak
    - Implement immediate control measures if needed
    - Define the outbreak; refine as the outbreak investigation progresses
    - Conduct case findings by making a line listing that may contain:
        i. Name and Medical Record Number
        ii. Age, sex, diagnosis
        iii. Unit or location
        iv. Date of Admission
        v. Date of Symptom Onset
        vi. Procedures
        vii. Symptoms
        viii. Positive Cultures and pertinent labs
    - Form Outbreak Control Team, if preliminary assessment suggests actual outbreak. The team may include all or some of the following:
        i. Infection Preventionist
        ii. Infection Control Medical Staff Chairperson
        iii. Microbiologist
        iv. Lab Manager
        v. Administrator on call
        vi. Inyo County Health Officer
        vii. Strategic Communications Specialist
        viii. Administrative Assistant
    - Hospital Incident Command Center will be followed as necessary.
    - Evaluate control case (ex: any new cases)
    - Communicate findings with leadership.
    - Keep record of all data and communication.
    - Contact CDC or other agencies for advice or assistance if deemed appropriate or necessary.
4. Interventions to reduce infections risks other than those directly related to prevention of transmission may include the following strategies:
    - The Surveillance function itself.
    - Review positive microbiology/Lab results
    - Institution of prevention and control measure as indicated (e.g. isolation, improved hand hygiene, active surveillance of cultures, and environmental cleaning)
    - Perform Surveillance for healthcare –associated infection by:

i. Follow CDC National Healthcare Safety Network (NHSN) definitions
ii. Prospective surveillance: Monitor patients during hospitalization and post discharge
iii. Retrospective surveillance: Identify infections via chart reviews

- Monitored incidence of healthcare-associated. device-related or procedure-related infections:
  i. Central catheter-associated bloodstream infections
  ii. Ventilator -associated events
  iii. Surgical site infections
  iv. Catheter-associated urinary tract infections
  v. MDRO infections
- Conduct Periodic tracer activity
- Ensure compliance with The Joint Commission Critical Access Hospital requirements and the California Department of Public Health regulations.

5. The assessment of reasons for infection rates not being reduced by surveillance alone and interventions undertaken to address problems in the following areas:
   - Knowledge – innovative educational approaches beyond the routine or standard in services.
   - Behavior – activities by managers to change behavior.
   - Systems – such as staffing, sink number and placement, control of over-crowding, lack of proper equipment and supplies.

POLICIES AND PROCEDURES:

1. Policies and procedures are based on recognized guidelines and applicable law and regulations. Policies and procedures address prevention and control mechanisms used in all patient care and service areas to prevent the transmission of infection among patients, team members, medical staff, contractors, volunteers and visitors; and also, address specific environmental issues.
2. Policies and procedures address the following:
   - Measures that is scientifically valid, applicable in all seeing, and practical to implement.
   - The relationship between team member activities and the infection prevention and control program.
   - Various methods used to reduce the risk of transmission of infection between or among team members and patients.
   - Appropriate patient care practices, sterilization, disinfection and antisepsis, and pertinent environmental controls.
   - Educational and consultative roles of the Infection Preventionist.
3. Infection control policies and procedures will be reviewed/revised annually or every three years as needed by the Infection Preventionist Manager with approval of the Clinical Consistency Oversight Committee (CCOC) and Infection Control Committee and prior to submission to the Medical Executive Committee.

LEADERSHIP AND RESPONSIBILITY:

1. Board of Directors has the final authority and oversight of the Infection Control Program. The Board monitors and supports organizational efforts to continuously improve the quality of patient care services and customer satisfaction. The Board ensures the necessary resources and education for the hospital to achieve these goals. The Board delegates the responsibility of maintenance of the Infection Control Program to the Medical Executive Committee and Chief Executive Officer.
2. Medical Executive Committee is responsible for overseeing the Infection Control Program and delegates the development and monitoring of infection surveillance, prevention and control processes to the Infection Control Committee. The Medical Executive Committee receives information related to actions

taken to resolve issues of infection control and, if necessary, acts upon any issues related to infection control. The Medical Executive Committee grants the Infection Preventionist Manager authority, under the direction of the Infection Control Committee Chair or his/her designee, to institute surveillance, prevention and control measures of studies, when there is reason to believe that any patient or team member may be in danger. In the absence of the Infection Preventionist Manager, nursing staff trained in Infection Prevention practices assumes the Infection Control responsibilities and are able to take appropriate actions as outlined in Infection Control Policies.

3. Chief Executive Officer serves as a liaison between the Board of Directors and the Medical Executive Committee. He/she ensures that all hospital departments, programs, and disciplines participate in and provide support for the Infection Control Program.
4. NIHD administration is responsible for supporting the Infection Preventionist and the Infection Control Committee, by supporting efforts to prevent and control the spread of infection.
5. Infection Control Medical Staff Chairperson acts as a resource for the Infection Control Manager. This person will have training and/or experience in infection control as stated in *Senate Bill 158* (Attachment 1) and will review the Infection Control Program, including rates, make recommendations as needed and have input into policies and procedures.
6. Infection Preventionist assumes the responsibility of managing and carrying out the infection surveillance, prevention and control functions within NIHD. This person has training in infection surveillance, prevention and control as well as knowledge and job experience in the areas of epidemiological principles and infectious disease, sterilization, sanitation and disinfection practices. This individual also is knowledgeable in adult education principles and patient care practice. This person maintains records and logs of incidents related to infections and communicable disease. The Infection Preventionist Manager and/or designee reviews culture and sensitivity testing, reviews antibiotic usage reports, reports suspected infections, conducts department specific periodic rounding, infection control annual risk assessment and implements isolation procedures in accordance with hospital policy, maintain policies and procedures that are specific to patient care activities and are based on recognized guidelines and applicable laws and regulations. The Infection Preventionist Manager has input into staff education to ensure all team members are competent to participate in infection monitoring, prevention and control activities. The Infection Preventionist Manager refers cases for physician review and communicates pertinent clinical infection control information to the Infection Control Committee.
7. Clinical staff is responsible for being familiar with infection prevention and control policies and procedures.
8. Quality Council is responsible for review and assistance in performance activities related to infection prevention and control.

REPORTING AND COMMUNICATION:

1. Information about infections is reported both internally and to public health agencies, providing clinical practitioners with valid epidemiological measures of the risk of infection in their patients. This will allow them to take action to reduce those risks and decrease infection rates.
9. When the hospital becomes aware that it received a patient from another organization who has an infection requiring action and the infection was not communicated by the referring organization, the Infection Preventionist Manager will inform the referring organization. Upon discharge, the case manager and/or nurse caring for the patient will inform the accepting facility of any infections the patient may have, site treatment and any special precautions. If the patient is transferred to another facility and there are pending laboratory results the transfer form will be completed indicating "Pending Lab Culture and the ordering physician will be notified via telephone and fax with laboratory results. If

the ordering physician is no longer caring for the patient, the ordering physician will inform the laboratory technician of the physician or facility caring for the patient.

10. Donor/Tissue postoperative infections/complications identified through surveillance activities that are suspected of being directly related to the use of the tissue will be investigated promptly. Notification of the post-transplant infection or adverse event will be reported to the tissue supplier by the Infection Preventionist Managers as soon as the hospital becomes aware of the event.
11. Infection Control committee meetings will be conducted not less than quarterly and more often as needed. Minutes will be recorded by the Medical Staff Office.
12. Findings, quality assessment activities, performance improvement recommendations, actions and follow-up evaluations will be forwarded to Infection Control Committee members, other medical staff committees as appropriate, Medical Executive Committee and the Board of Directors.
13. Review of infections-and surveillance data within the hospital will be completed quarterly through Infection Prevention Pillars, annual goals, Infection Committee, National Health Safety Network (NHSN) Database.

INFECTION CONTROL AND PREVENTION RESOURCES:

There are multiple resources for information about infection prevention and control. Although not an exhaustive list, several professional associations and governmental websites are listed below. In addition, local and health state departments offer a wealth of information.

- Center for Disease Control and Prevention
  www.cdc.gov
- HICPAC Healthcare Infection Control Practices Advisory Committee

  https://www.cdc.gov/faca/committees/hicpac.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmaso%2Ffacm%2FfacmHICPAC.html
- U.S. Department of Labor – Occupational Safety & Health Administration
  www.osha.gov
- U.S. Food and Drug Administration
  www.fda.gov
- American Public Health Association
  www.apha.org
- American Society for Healthcare Engineering
  www.ashe.org
- Association for Professionals in Infection Control, Inc.
  www.apic.org
- The Society for Healthcare Epidemiology of America, Inc.
  www.shea-online.org
- The Infectious Disease Society of America
  www.idsociety.org
- International Sharps Injury Prevention Society (ISIPS)
  http://www.isips.org/
- World Health Organization (WHO)
  http://www.who.int/en/
- State of California Department of Industrial Relations (Cal/OSHA)

https://www.dir.ca.gov/covid/

REFERENCES:

1. All Facilities Letter 14-36 California Department of Public Health, 12/19/2014, Regarding SB 1311: Antimicrobial Stewardship Programs.
2. APIC Text of Infection Control and Epidemiology. (April 7, 2020). Outbreak Investigations. Retrieved from https://text.apic.org/toc/epidemiology-surveillance-performance-and-patient-safety-measures/outbreak-investigations?token=2AE989223FAE2142
3. Centers for Disease Control and Prevention. (2021) Infection Control in Health Care Facilities. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/
4. Centers for Disease Control and Prevention. (2021). Outbreak Investigations in Healthcare Settings. Retrieved from https://www.cdc.gov/hai/outbreaks/index.html
5. Centers for Disease Control and Prevention. (2016). Infection Prevention and Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf
6. Centers for Disease Control and Prevention. (2012) (Site accessed April 29, 2021). Principles of Epidemiology in Public Health Practice, Third Editions an Introduction to applied epidemiology and biostatistics Lesson 6: Investigating an outbreak. Retrieved from https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section2.html
7. Comprehensive Accreditation Manual for Critical Access Hospital (2021) Infection Prevention and Control (IC) IC.01.01.01, IC.01.04.01, IC.01.05.01., IC.02.01.01, IC.02.05.01, IC.03.01.01,
8. Association for Professionals in Infection Control and Epidemiology (APIC). (Site accessed 4-29-21) Content of an Infection Prevention and Control Plan. Retrieved from https://apic.org/Resource_/TinyMceFileManager/Education/ASC_Intensive/Resources_Page/Content_of_an_Infection_Prevention_and_Control_Plan.pdf

CROSS REFERENCE P&P:

1. NIH Medical Staff Bylaws and Rules Amendment, 01/20/2021 Infection Control Committee Section Article XI Section 11.7 pg. 75-76
2. Infection Control: Northern Inyo Healthcare District Surge Plan
3. Scope of Service –Infection Prevention
4. Scope of Service Employee Health

Supersedes: v.8 Infection Prevention Plan*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 08/02/2023	Last Review Date: 09/16/2021	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to cover the management of drugs and devices for patients of all ages

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.
3. The NP or CNM may initiate, alter, discontinue, and renew medication included on, but not limited to the formulary referenced in Appendix A. Schedule I medications are excluded. NPs and CNMs will be required to have a current "Furnishing Number" which has been obtained from the Board of Registered Nursing. All NP & CNM providers will be required to have a DEA certificate and will prescribe within the constraints of this certification.

PROCEDURE:
1. Database – Nursing Practice
    a. Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
    b. Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
    c. Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.
2. Treatment – Common Nursing Functions
    a. Medications/devices furnished by the NP or CNM may be either over-the-counter or medications/devices requiring a prescription.
    b. Medications/devices may be furnished directly to the patient, or the patient's direct care giver, by the NP or CNM (section 2725.1 of the NPA).

c. Medications may be furnished by transmittal. The NP or CNM may write and sign "transmittal orders" of any prescription personally stated or written by the physician. This is in accordance with the Pharmacy Law, Business and Professions Code, Section 34021

d. Office samples may be dispensed per NIHD policy.
e. The drug or device will be appropriate to the condition being treated:
    i. Dosage will be in the effective range per formulary references
    ii. Not to exceed upper limit dosage per formulary references.
    iii. Indications or uses as specified by the formulary references.
    iv. No absolute contraindications of the use of the drug or device.

f. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.
g. All medications/devices furnished shall be documented in the patient's medical record. The effectiveness of the medication/device shall be documented in the patient's medical record.

3. Patient Education
    a. Provide the patient with information and counseling in regard to the drug or device. Caution the patient regarding potential side effects or complications with chosen drug or device. Document the education process in the medical record.
4. Physician consultation is to be obtained under the following circumstances:

    a. Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.
    b. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    c. Acute decompensation of patient situation.
    d. Problem which is not resolving as anticipated.
    e. History, physical, or lab finding inconsistent with the clinical picture.
    f. Upon request of patient, nurse, or supervising physician.

5. Documentation
    a. A current drug list will be maintained in the patient's record. All medications furnished, changes in medications, and renewals will be documented on this list.
    b. The name and furnishing number of the NP or CNM is written on the transmittal order.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource
2. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.3 Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife

APPENDIX A:

FORMULARY SPECIFICATIONS for

Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant

STANDARDIZED PROCEDURE/PROTOCOL

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

APPROVALS

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

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

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 09/07/2023	Last Review Date: 09/16/2021	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the ordering of laboratory and diagnostic tests.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Laboratory and diagnostic tests may be ordered by the NP or CNM under the following conditions:
    a. As an appropriate adjunct to the determination of diagnosis.
    b. When necessary, to implement, monitor or adjust treatment.
3. Circumstances:
    a. Patient population: neonatal, pediatric, adult and geriatric patients – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Conditions
    a. The following diagnostic tests can be initiated by the NP or CNM without prior consultation with M.D.:
        i. Any blood work
        ii. Urine: any urine test
        iii. Cultures: any culture
        iv. Radiologic/Sonographic: any radiologic/sonographic exam including CT scans and MRI examinations
        v. Audiometric testing/speech evaluation
        vi. Pregnancy Tests
        vii. Cardiac Testing
    b. All other diagnostic tests will be ordered by the NP or CNM in consultation with the physician, including:
        i. When diagnostic test of choice is in doubt.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

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

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

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 08/02/2023	Last Review Date: 09/16/2021	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/20/2018	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to medically manage acute illness and conditions.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure covers the medical management of acute illness, allergies, symptomatic complaints, minor trauma and emergencies in children and adults in the ambulatory care setting.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Data Base
    a. Subjective:
        i. Historical information relevant to the acute illness.
        ii. Historical information regarding concurrent problems.
        iii. Historical information regarding relevant past medical problems.
        iv. Patient's/family's efforts to treat the illness/condition.
        v. History of allergic/adverse reactions to medications.
        vi. Status of patient's functional and instrumental abilities.
    b. Objective:
        i. Perform physical exam pertinent to presenting symptoms.
        ii. Evaluate severity of complaint (i.e., vital sign changes, level of consciousness, unusual or unexpected symptoms).
        iii. Order laboratory testing and diagnostic procedure as indicated.
    c. Assessment
        i. Diagnosis consistent with subjective and objective findings.
        ii. Record data on appropriate areas on patient's chart.

d. Plan
    i. Medications as indicated (see *Furnishing of Medications/Devices Standardized Procedure*).
    ii. Order further diagnostic testing as indicated.
    iii. Patient education appropriate to acute illness and any procedures, diagnostic testing, or medications ordered.
    iv. Order/perform therapeutic procedures as appropriate.
    v. Order medical supplies and necessary equipment for treatment.
    vi. Consult with and/or refer to supervising M.D. for:
        1. Presence of unexpected or ambiguous historical, physical or diagnostic findings.
            a. Signs of sepsis/toxic patient.
            b. Alteration in level of consciousness (i.e., seizure, etc.).
            c. Emergency situations which may be life threatening.
            d. Any patient whose condition warrants hospitalization.
            e. Unresolving problems.
            f. Any needs of the NP or CNM requiring information/confirmation of management plans.
            g. Upon request of patient/family.
    vii. Refer as indicated to other services/specialties.
    viii. Follow-up as indicated.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.3 Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

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

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 12/14/2021	Last Review Date: 10/21/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage chronic illness.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure covers the management of chronic illness in children and adults in the ambulatory setting.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Data Base
    a. Subjective:
        i. Pertinent history including symptoms related to the chronic illness.
        ii. Present state of chronic illness (worse, better, stable).
        iii. Historical information regarding relevant past medical problems.
        iv. Effects of chronic illness on activities of daily living, psychological, physical and financial status.
        v. Patient's attitude and behaviors regarding the chronic illness.
        vi. Patient's physical, social, financial support systems.
        vii. Documentation of complete history updated minimally on an annual basis.
    b. Objective:
        i. Complete pediatric WCC or adult HME annually.
        ii. Physical assessment pertinent to chronic illness.
        iii. Laboratory/diagnostic testing as indicated.
    c. Assessment
        i. Qualification/quantification of chronic illness status.
        ii. Record appropriately on patient chart.
    d. Plan

i. Medications as indicated (see *Furnishing of Medications/Devices Standardized Procedure*).
ii. Laboratory/diagnostic testing as indicated.
iii. Patient education appropriate to chronic illness and any procedures, diagnostic testing, or medications ordered.
iv. Order/perform therapeutic procedures as appropriate.
v. Order medical supplies and necessary equipment for treatment.
vi. Consult with and/or refer to supervising M.D. or patient's specialist for:
    1. Acute decompensation of chronic stable illness.
    2. Ambiguous diagnostic, physical or historical findings.
    3. Any needs of the NP and CNM requiring information/confirmation of management plans.
    4. Upon request of patient/family
vii. Refer as indicated to other services/specialties.
viii. Follow-up as indicated.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.2 Standardized Procedure – Management of Chronic Illness Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

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

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

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 12/14/2021	Last Review Date: 10/21/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor trauma.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure is designed to establish guidelines that will allow NP and CNM to manage ambulatory clients presenting with minor traumatic injuries.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Data Base
    a. Subjective:
        i. Obtain pertinent history related to the injury or traumatic event.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective:
        i. Perform limited physical examinations pertinent to the injury, including any possible involved organ system.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays (see *Laboratory and Diagnostic Testing Standardized Procedure*).
    c. Assessment
        i. Formulate a working diagnosis consistent with date base collected.
    d. Plan
        i. If indicated, develop or initiate a therapeutic regimen including, but not limited to, the following:
            1. Physician consultation prior to management as per policy statement or in the following cases:
                a. Any injury threatening to life or limb.

b. Any laceration requiring complicated suture closure (see *Minor Surgical Procedures – Standardized Procedure*).
c. Any fracture or injury requiring immobilization by full casting.
d. Complicated or extensive burns.
e. Injury that may involve litigation or compensation.
f. Any case where surgical intervention may be needed.

2. Further diagnostic tests.
3. Skin/wound care appropriate to injury.
4. Apply or furnish appropriate medications and/or immunizations.
5. Refer to appropriate support services which may include Rehabilitative services.
6. Develop appropriate follow-up care plan to maximize healing and rehabilitation.
    a. Provide appropriate health education materials including, but not limited to, cast care and precautions, head trauma, suture care, and use of oral or topical medications.
    b. Schedule follow-up appointments as appropriate.
7. Update problem list.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.2 Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

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

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 12/14/2021	Last Review Date: 09/16/2021	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor surgical procedures.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure is designed to establish guidelines that will allow NP and CNM to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients presenting to the listed settings.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Conditions
    a. After appropriate training and experience (which includes a minimum of 5 proctored procedures each by a supervising physician), minor surgical procedures that can be performed by the NP or CNM without direct physician supervision include:
        i. Pessary placement
        ii. Electrocautery of external, non-malignant lesions, e.g. warts
        iii. Epidermal cyst removal
        iv. Incision and drainage of abscess (excluding peri-rectal abscesses)
        v. Suture laceration without nerve or tendon involvement
        vi. Mole removal (non-facial)
        vii. Punch or shave biopsy
        viii. Toe nail removal
        ix. Cryotherapy
        x. IUD insertion and removal
        xi. Excision of simple lesions
        xii. Simple foreign body removal

xiii. Endometrial biopsy
xiv. Arthrocentesis/Steroid joint injection
xv. Excision of hemorrhoid thrombus
xvi. Nexplanon insertion/removal
xvii. Circumcision of newborn

2. Data Base
    a. Subjective
        i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
        ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.
    b. Objective
        i. Perform physical examination pertinent to assessment of the problem.
        ii. Collect appropriate diagnostic/radiological studies.
    c. Assessment
        i. Formulate diagnosis consistent with the above data base.
    d. Plan
        i. Develop therapeutic regimen
        ii. Provide informed consent. Utilize universal protocol "Time Out" prior to all invasive procedures.
        iii. Perform appropriate procedure utilizing standard aseptic technique.
        iv. Obtain additional diagnostic studies as indicated.
        v. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
        vi. Patient education and self-care techniques.
        vii. Development of appropriate follow-up care plan.
        viii. Update problem list.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.3 Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

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

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

1. _____ _____
   NAME DATE

2. _____ _____
   NAME DATE

3. _____ _____
   NAME DATE

4. _____ _____
   NAME DATE

5. _____ _____
   NAME DATE

6. _____ _____
   NAME DATE

7. _____ _____
   NAME DATE

8. _____ _____
   NAME DATE

9. _____ _____
   NAME DATE

10. _____ _____
    NAME DATE

Cardiovascular Disease - Telemedicine

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 Internal Medicine. **AND** Completion of an ACGME accredited fellowship training program in Cardiovascular Disease or an AOA accredited fellowship training program in Cardiology.
Certification	Current certification or active participation in the examination process leading to certification in Internal Medicine by the American Board of Internal Medicine or AOA equivalent. **AND** Current certification or active participation in the examination process leading to certification in Cardiovascular Disease by the American Board of Internal Medicine or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of cardiovascular disease services representative of the scope and complexity of the privileges requested during the previous 24 months. (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications for Device Related Privileges	Applicant must have completed manufacturer designated training including human subjects experience when device related privileges are requested OR provide documentation of training and current clinical competence if training occurred during fellowship.

Core Privileges in Cardiovascular Disease	
Description: Evaluation, diagnosis, consultation and treatment of patients with acute and chronic cardiovascular conditions.	
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
☐	Evaluate, diagnose, provide consultation and medically manage and treat patients with cardiovascular complaints. Privileges include medical management of general medical conditions which are encountered in the course of caring for the cardiovascular patient.

FPPE (Department Chief to select)	
☐	5 retrospective chart reviews reflective of the scope and complexity of privileges granted

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

Nurse Practitioner - General

Delineation of Privileges

Applicant's Name: ,

Instructions:

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

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of a master's/post-master's or doctorate degree in an accredited nursing program accredited by the Commission on the Collegiate of Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC) with emphasis on the NPs specialty area.
Certification	Current certification by the American Nurses Credentialing Center (ANCC), American Academy of Nurse Practitioners (AANP) or National Certification Board of Pediatric Nurse Practitioners & Nurses (NCBPNP&N) or (NAPNAP). **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	Applicant must have a supervising or collaborating physician in the same practice specialty. **AND** Current California furnishing certificate and DEA Registration with schedules 2, 2N, 3, 3N, 4 and 5 **AND** Current BLS certification **AND** The NP must abide by the applicable Northern Inyo Healthcare District Standardized Procedures.

Core Privileges in Nurse Practitioner - General	
Description: Assessment of Health Status, Diagnosis and Development of Treatment Plan	
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

☐	Perform, order and interpret preventive and non-invasive diagnostic tests
☐	Formulate a diagnosis and establish priorities to meet the patient's health and medical needs
☐	Furnish/order pharmacologic and non-operative therapeutic interventions
	Procedures
☐	Arthrocentesis and joint injection
☐	Bladder catheterization
☐	Cerumen impaction removal
☐	Circumcision, pediatric only
☐	Cryo ablation of superficial lesions
☐	Incision and drainage or aspiration of abscess or cyst
☐	Laceration repair, simple
☐	Local anesthetic techniques including nerve blocks, peripheral nerve blocks and trigger point injections
☐	Nail removal
☐	Perform simple skin biopsy or excision
☐	Remove non-penetrating foreign body from the eye, nose, or ear
☐	Simple superficial debridement; wound closure; and general care for wounds including performance of topical or field infiltration of anesthetic solutions. Select and apply appropriate wound dressings including liquid or spray occlusive materials, removal of drains, application of immobilizing dressing (soft or rigid)
☐	Stabilization of non-displaced closed fractures and uncomplicated dislocations including skeletal immobilization techniques (e.g., splinting, slings)
☐	Subungual hematoma drainage
☐	Treatment of burns, superficial and partial thickness
☐	Thrombosed external hemorrhoid incision and drainage (less than 48 hours)
☐	Vasectomy
	Gynecology and Reproductive Health
☐	Pap smear and endocervical culture
☐	Biopsy of cervix, endometrium
☐	Excision/biopsy of vulvar lesions
☐	IUD placement
☐	IUD removal
☐	Insertion/removal of implanted contraceptive device (e.g., Nexplanon)

FPPE (Department Chief to select)	
☐	100% chart review for two weeks
☐	5 directly observed procedures by a practitioner who has privileges in that procedure

Core Privileges in Medication Assisted Treatment
Description: Provide on-going recovery support/coaching to high-risk patients who are in active addiction or early recovery, who are struggling with Substance Use Disorders (SUD) and may be struggling with co-occurring disorders.

Qualifications

Continuing Education	Participates in trainings required by the funding source and/or as required by their practice area.
Certification	Buprenorphine waivered practitioner
Clinical Experience (Initial)	Verification of current clinical competence as achieved via training, education and reference reviews.
Clinical Experience (Reappointment)	Verification of current clinical competence as achieved via peer review or other comparable methods.

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
☐	Coordination of Medication Assisted Treatment (MAT) / Referral
☐	Provide care coordination regarding Substance Use Disorder (SUD) and Mental Health, including assisting patients in identifying their specific needs and working with them to identify and access resources in the community to meet those needs

FPPE (Department Chief to select)

☐	Direct observation by a clinician for the first 2 weeks

Point of Service Provider Performed Microscopy

Description: Microscopic exam of fluids at the point of service by a non-pathologist.

Qualifications

Clinical Experience (Initial)	For practitioners new to NIHD or newly requesting PPM privileges, successful initial competency testing must be completed and followed by a 6-month and 12-month evaluation. After the first year, all practitioners will be evaluated annually or as needed. Initial competency testing includes: (1) successful completion of an online module for each type of test and (2) completion of observed assessment by an observer holding PPM privileges.
Clinical Experience (Reappointment)	Documentation of successful completion of organization sponsored annual training and skills validation in provider performed microscopy as per policy.

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
☐	Urine Sediment (Rural Health Clinic only)
☐	KOH (potassium hydroxide) preparation

☐	Direct Wet Mount
☐	Fern Test (Women's Clinic only)

FPPE (Department Chief to select)	
☐	Concurrent review (over-reading) of 1 PPM in each type of exam by a practitioner with unrestricted privileges in this area or lab personnel as outlined in policy.

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

Physician Assistant - General

Delineation of Privileges

Applicant's Name: ,

Instructions:

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

Facilities
☑ **NIHD**

Required Qualifications	
Education/Training	Completion of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).
Certification	Current PA-C designation. To attain the PA-C designation, PAs must pass the Physician Assistant National Certifying Exam (PANCE) administered by the National Commission on Certification of Physician Assistants.
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 provide documentation of provision of clinical services in the specific privileges requested during the past 24 months.
Additional Qualifications	Applicant must have a supervising physician in the same practice specialty. **AND** Current DEA Registration with schedules 2, 2N, 3, 3N, 4 and 5 and proof of completion of a controlled substance education course as per CA law (one-time; initial). **AND** Current BLS certification **AND** The PA must abide by the applicable Northern Inyo Healthcare District Standardized Protocols.

Core Privileges in Physician Assistant - General	
Description: Assessment of Health Status, Diagnosis and Development of Treatment Plan	
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
☐	Perform, order and interpret preventive and non-invasive diagnostic tests
☐	Formulate a diagnosis and establish priorities to meet the patient's health and medical needs
☐	Prescribe/order pharmacologic and non-operative therapeutic interventions
	Procedures
☐	Arthrocentesis and joint injection
☐	Bladder catheterization
☐	Cerumen impaction removal
☐	Circumcision, pediatric only
☐	Cryo ablation of superficial lesions
☐	Incision and drainage or aspiration of abscess or cyst
☐	Laceration repair, simple
☐	Local anesthetic techniques including nerve blocks, peripheral nerve blocks and trigger point injections
☐	Nail removal
☐	Perform simple skin biopsy or excision
☐	Remove non-penetrating foreign body from the eye, nose, or ear
☐	Simple superficial debridement; wound closure; and general care for wounds including performance of topical or field infiltration of anesthetic solutions. Select and apply appropriate wound dressings including liquid or spray occlusive materials, removal of drains, application of immobilizing dressing (soft or rigid)
☐	Stabilization of non-displaced closed fractures and uncomplicated dislocations including skeletal immobilization techniques (e.g., splinting, slings)
☐	Subungual hematoma drainage
☐	Treatment of burns, superficial and partial thickness
☐	Thrombosed external hemorrhoid incision and drainage (less than 48 hours)
☐	Vasectomy
	Gynecology and Reproductive Health
☐	Pap smear and endocervical culture
☐	Biopsy of cervix, endometrium
☐	Excision/biopsy of vulvar lesions
☐	IUD placement
☐	IUD removal
☐	Insertion/removal of implanted contraceptive device (e.g., Nexplanon)
	Surgical
☐	Act as surgical first assistant, including privileges to perform deep and simplified tissue closure/cautery, cutting tissue; application of appliances and any other action delegated and directly supervised by the physician

FPPE (Department Chief to select)	
☐	100% chart review for two weeks

☐	5 directly observed procedures by a practitioner who has privileges in that procedure

Core Privileges in Medication Assisted Treatment

Description: Provide on-going recovery support/coaching to high-risk patients who are in active addiction or early recovery, who are struggling with Substance Use Disorders (SUD) and may be struggling with co-occurring disorders.

Qualifications

Continuing Education	Participates in trainings required by the funding source and/or as required by their practice area.
Certification	Buprenorphine waivered practitioner
Clinical Experience (Initial)	Verification of current clinical competence as achieved via training, education and reference reviews.
Clinical Experience (Reappointment)	Verification of current clinical competence as achieved via peer review or other comparable methods.

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
☐	Coordination of Medication Assisted Treatment (MAT) / Referral
☐	Provide care coordination regarding Substance Use Disorder (SUD) and Mental Health, including assisting patients in identifying their specific needs and working with them to identify and access resources in the community to meet those needs

FPPE (Department Chief to select)

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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
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☐	Fern Test (Women's Clinic only)

FPPE (Department Chief to select)

☐	Concurrent review (over-reading) of 1 PPM in each type of exam by a practitioner with unrestricted privileges in this area or lab personnel as outlined in policy.

Acknowledgment of Applicant

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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 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: September 5, 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. Policies (*action item*)
   1. *Chemical Hygiene Plan for Clinical Laboratory*
   2. *DI – Communication of Mammography Results to the Patient*
   3. *Diagnostic Imaging – Peer Review Policy*
   4. *Infection Prevention Plan*
   5. *Standardized Procedure – Furnishing Medications/Devices Policy*
   6. *Standardized Procedure – Laboratory and Diagnostic Testing Policy*
   7. *Standardized Procedure – Management of Acute Illness Policy*
   8. *Standardized Procedure – Management of Chronic Illness Policy*
   9. *Standardized Procedure – Management of Minor Trauma Policy*
   10. *Standardized Procedure – Minor Surgical Procedures Policy*

B. Medical Staff Appointments (*action item*)
   1. Elizabeth Haun, FNP (*family practice*) – APP Staff
   2. Maria Ramirez, MD *(hospitalist)* – Courtesy Staff
   3. James Tur, MD *(hospitalist)* – Active Staff
   4. Steven Arbogast, DO *(teleneurology)* – Telemedicine Staff
   5. Swati Laroia Coon, DO *(teleneurology)* – Telemedicine Staff
   6. Aravind Reddy, MD *(teleneurology)* – Telemedicine Staff
   7. Gautam Sachdeva, MD *(teleneurology)* – Telemedicine Staff

C. Staff Category Changes (*action item*)
   1. Joy Engblade, MD (*internal medicine*) – change from Active Staff to Courtesy Staff
   2. Monika Mehrens, DO (*family medicine*) – change from Active Staff to Courtesy Staff

D. Privilege Forms (*action item*)
   1. Cardiovascular Disease
   2. Nurse Practitioner
   3. Physician Assistant

E. Medical Staff Resignations in Good Standing (*action item*)
   1. Alissa Dell, NP (*family practice*) – effective 7/14/23

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

CALL TO ORDER	The meeting was called to order at 5:30 p.m. by Mary Mae Kilpatrick, Northern Inyo Healthcare District (NIHD) Board Chair.
PRESENT	Mary Mae Kilpatrick, Chair Melissa Best-Baker, Vice Chair Jean Turner, Secretary Ted Gardner, Treasurer Jody Veenker, Member-at-Large Stephen DelRossi, MSA, Interim Chief Executive Officer / Chief Financial Officer Allison Partridge RN, MSN, Chief Nursing Officer / Chief Operations Officer (present via zoom) Alison Murray, Chief Human Resources Officer (present via zoom) Stefan Schunk, MD, Chief Medical Officer
OPPORTUNITY FOR PUBLIC COMMENT	Chair Kilpatrick reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. No comments were heard from the public.
NEW BUSINESS	
CHIEF OF STAFF REPORT (TAKEN OUT OF ORDER)	Chair Kilpatrick called attention to the Chief of Staff report. Dr. Arndal reported for Dr. Bourne.
MEDICAL STAFF APPOINTMENTS	Dr. Arndal introduced the Medical Staff appointments and asked if the Board had any questions. Jean Turner motioned to approve medical staff appointments a-f as presented, Jody Veenker seconded, and the motion passed 5-0. Dr. Arndal called attention to the medical staff resignations and thanked the providers for their service. Ted Gardner motioned to approve the medical staff resignations, Melissa Best-Baker seconded, and the motion passed 5-0. Dr. Arndal provided an overview of the policies and procedures for approval.

a. *DI CT Radiation Safety Policy*
b. *Nursing Bedside Swallow Screen*

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

MEDICAL EXECUTIVE COMMITTEE REPORT

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

AD HOC COMMITTEE REPORTS

Chair Kilpatrick called attention to Ad Hoc Committee reports.
Jean Turner reported the Governance Committee has submitted the first grouping of policies for approvals on this agenda. The rest will follow in the August and September Board of Directors meetings.

CHIEF EXECUTIVE OFFICER REPORT

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

- Bi-monthly Town Halls will continue indefinitely, once in the morning and once in the evening for better employee access.
- Anesthesia Department has had two resignations. Staff is working to optimize the OR department, and they are continuing recruitment efforts for new anesthesiologists.
- New Urologist and General Surgeon, Dr. Davis and Dr. Wiles, will be joining NIHD in August.
- Accountable Care Organization (ACO) Update: Staff is currently vetting two organizations. They will continue work on it throughout the next few months. Jean Turner asked for an explanation of what an ACO is. Dr. Schunk stated ACOs consist of groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs. ACOs are compensated by sharing in the savings they create by improving care. Currently the government allows this to be a voluntary program, but as of 2030 it will be mandatory.
- Beta Insurance Review: CEO DelRossi reported at the time of renewal for our Beta insurance, we did not have time to vet the entire insurance package, but we did vet workers comp which resulted in Beta lowering their fees by $57,000.
- Legislation, hospital revenue: There are two State bills in effect or upcoming that will impact NIHD. We have applied for part of $150M loan for hospitals in distress. This is a 7 year, 0 interest loan, with the possibility of forgiveness.
- Contract Savings: Neil’s team in Material Management renegotiated our contract with GE, and the contract was lowered by approximately $85,000 per year for the next 5 years

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

FINANCIAL & STATISTICAL REPORTS

CFO DelRossi reported with respect to the month of May, we had more inpatient days and more outpatient visits than this time a year ago, but RHC visits, outpatient surgeries, emergency room visits, nursing visits and observations were all down. We were busier with inpatient days, outpatient visits, clinic visits, inpatient surgeries, diagnostic imaging and rehab. Mr. DelRossi pointed out we had an error with respect to Pharmacy resulting in the financial statements are misstated by approximately $300,000. As a whole, the hospital lost about $1,200,000 change in net position and we lost about $1,450,000 in terms of operating income.

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

FY 2023 BUDGET EXTENSION

CFO DelRossi reported he is in the process of reviewing the FY 2024 budget with management. It will be finished in next two weeks, and he will present it at next meeting. CFO DelRossi asked for approval to extend the FY 2023 budget through August.

It was motioned by Jean Turner to approve the extension of the FY 2023 budget through August, seconded by Ted Gardner and the motion passed 5-0.

FY 2022 AUDIT DEFICIENCIES

CFO DelRossi stated he will report audit deficiencies quarterly. The FY 2022 Audit findings included:

- Balance Sheet reconciliations: The Accounting department is in final stages of reconciling all balance sheets and he is confident we will not have a finding with balance sheets this year, except for two cash clearing accounts which will take 6-8 months to reconcile.
- Pension administration: Records were not available for the FY 2022 audit, but they were here in the building and will be available for this year's audit.
- The Pension program had been reported as an expense; this has been corrected.
- Contractual allowance in third party settlements: The last controller wrote the balances off in FY 2022. We reestablished those balances and will continue to audit them as settlements roll through.

TAG UPDATE

The Labor Committee has worked through a high of 459 FTEs last fiscal year, and it is now at 404 paid FTEs. With respect to Supply Chain, we continue to see improvement from Neil's team in Purchasing. Improvements in Services and Revenues are coming at a slower pace than we originally expected. We want to be very thoughtful about where we trim services.

PMA BUILDING MOVE UPDATE

Internal Medicine's move will be complete next week. Roofing supplies have been ordered for the PMA building, and work should begin in the next 45 days. Vendors are in the process of drawing plans for the Rehab clinic.

RSM UPDATE

Chair Kilpatrick called attention to the RSM Update. CFO DelRossi introduced Michael Brown who provided an update on RSM's engagement. All objectives were completed except for the implementation of denial analytics which was removed and in its place they completed charge bill audit to identify opportunities to capture more revenue. They are now in a transition period, and they are ensuring NIH employees are fully trained.

REVISED AMENDMENT NO.2 TO THE NORTHERN INYO HEALTHCARE DISTRICT

Chair Kilpatrick called attention to the revised Amendment No. 2 to the Northern Inyo Healthcare District 401(a) Retirement Plan.

Alison Murray, Chief Human Resources Officer, presented a summary of the amendment. The amendment was originally approved by the Board on May 17, 2023, but needed further clarification regarding how long the contributions would continue from the District and when the actual effective date was going to be for the matching contributions would come from the employees. The clarifying language is included in this amendment.

It was motioned by Jean Turner to approve the revised Amendment No. 2 to the Northern Inyo Healthcare District, seconded by Jody Veenker and the motion passed 5-0.

CHIEF NURSING OFFICER/CHIEF OPERATIONS OFFICER REPORT

Chair Kilpatrick called attention to the Chief Nursing Officer/Chief Operations Officer Report. Allison Partridge reported department updates.

- Cardiopulmonary welcomed Adam Wells, one of the District's respiratory therapists, to the Echocardiograpy training program.
- Diagnostic Imaging is optimizing current workflows and expanding opportunities to provide services to the community.
- In Pharmacy, Jeff Kneip, Director of Pharmacy is expecting their annual inspection by the Pharmacy State Board toward the end of August.
- In the Facilities department, the Chiller project is close to complete and should be done by the end of the year. The Pharmacy project is moving along, also on track for end of year.
- Environmental Services is working in collaboration with Sterile Processing to help assist with picking up and delivering instruments that go out to other departments and make it a more efficient process.
- Security conducted a security assessment, and as a result they will add security cameras.

- Within Inpatient Nursing, Med-surg currently has one open full-time position, and they are using three travelers; ICU is completely staffed with our own team members and they have no travelers; the perinatal department is using a third party agency to recruit permanent staff.
- With regard to Outpatient Nursing, the ER is fully staffed with one traveler who will be exiting shortly, PACU is fully staffed with no travelers.
- Infection Prevention is preparing for next flu season, and they are implementing an antibiotic use and resistance program.

Chair Kilpatrick asked when the Pharmacy will be up and running. Allison Partridge stated it is on track to be up and running by the end of the year.

Chair Kilpatrick asked how many nurses have left the District in the past six months. Allison Partridge did not have the exact statistic, but stated it is a small number.

CONSENT AGENDA

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

1. *Approval of minutes of the June 21, 2023 Regular Board Meeting*
2. *Chief Medical Officer Report*
3. *Compliance Department Quarterly Report*
4. *Department Reports*
5. *Approval of Policies and Procedures*
    i. *Leaves of Absence – Leave Donation*
    ii. *District Competency Plan*
6. *Approval of Policies and Procedures – Biennial Review*
    i. *Chief Executive Officer Compensation Philosophy*
    ii. *Compensation of the Chief Executive Officer*
    iii. *Authority of the Chief Executive Officer for Contracts and Bidding*
    iv. *Basis of Authority Role of Directors*
    v. *Reimbursement of Expenses*

Jody Veenker motioned to approve the Consent Agenda, Melissa Best-Baker seconded, and the motion passed 5-0.

REPORTS FROM BOARD MEMBERS

Chair Kilpatrick opened up reports to Board Members.

Chair Kilpatrick recognized the passing of Dr. John Ungersma, who served on the NIHD Board for many years. His service will be in October. Ms. Kilpatrick thanked him very much for his contributions to NIHD and the community.

Chair Kilpatrick also reported she attended quite a few meetings, including the Chamber of Commerce, Healthy Lifestyles presented by Dr. Richard Meredick, the District's first town hall meeting with the employees, and the Foundation meeting. Ms. Kilpatrick asked how many grants the District has outstanding. CEO DelRossi stated there are three grants. Chair Kilpatrick announced the Foundation is planning a Meet and Greet fundraiser in September with Dr. Clayton Davis, our new Urologist.

Jean Turner stated she shares Chair Kilpatrick's appreciation of CEO DelRossi's thoughtful comments at the employee town hall. She also reminded the Board members of the ACHD conference coming up in September.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Chair Kilpatrick announced at this time, persons in the audience may speak only on items listed on the Closed Session portion of this meeting. She announced there is one case on item b. There were no public comments.

ADJOURNMENT TO CLOSED SESSION

At 7:33, Chair Kilpatrick announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

a. Conference with Legal Counsel – Anticipated Litigation. Government Code 54956.9(d)(4). Number of potential cases (1).

b. Conference with Legal Counsel – Existing Litigation. Government Code 54956.9(d)(1). Name of case: Tillemans v. NIHD

c. Conference with Legal Counsel – Anticipated Litigation. Government Code 54956.9(d)(2). Number of potential cases (4).

d. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1). Title: Interim CEO

Reconvened to open session at 8:43 p.m.

Chair Kilpatrick reported the Board voted 5 to 0 to reject a claim that was presented in closed session.

ADJOURNMENT

Adjournment at 8:43 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
Stephen DelRossi, MSA, Interim Chief Executive Officer / Chief Financial Officer
Allison Partridge RN, MSN, Chief Nursing Officer / Chief Operations Officer (present via zoom)
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, Chief Human Resources Officer, present via Zoom

OPPORTUNITY FOR PUBLIC COMMENT

Chair Kilpatrick reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. No comments were heard from the public.

NEW BUSINESS

CHIEF OF STAFF REPORT (TAKEN OUT OF ORDER)

Chair Kilpatrick called attention to the Chief of Staff report. Dr. Bourne presented the MEC report.

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

a. *Medical Ethics Referrals and Consultation*
b. *Medical Records Delinquency Policy*
c. *Medical Staff History & Physical (H&P) Policy*

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

MEDICAL EXECUTIVE COMMITTEE REPORT

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

- From the ED committee, it was reported Reach has replaced Coast to Coast for local EMS services.
- They are continuing to work with UASI to get feedback on provider documentation.

- The Surgery Tissue committee is looking into optimizing OR room utilization.
- The District welcomed Dr. Conner Wiles of general surgery and Dr. Clayton Davis in urology.
- Dr. Lindsey Ricci is our new Peri-peds chair

Dr. Arndal reported she received 45 minutes of great feedback on coding from USAI.

AD HOC COMMITTEE REPORTS

Chair Kilpatrick called attention to Ad Hoc Committee reports.

Governance, Jean Turner reported the consent agenda includes Board policies that are up for annual review. She called attention to corrections needed to replace the titles "President" and "Vice President" with "Chair" and "Vice Chair" as was approved in August 2020.

Finance, Melissa Best-Baker reported she attended the Finance Meeting. Stephen did good job explaining the financials and budget.

CHIEF EXECUTIVE OFFICER REPORT

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

- The Chiller project has been completed ahead of schedule, we have moved Internal Medicine into the RHC.
- The Executive Team is looking at 11 topics they are going to work on over next month.
- We have signed an agreement with Dr. Rowan to provide cardiology services once a month. This service has no extra cost resulting in a pure contribution margin.
- Greg Bissonette provided an update on the Foundation's FY 2024 budget. They are implementing the Grateful Patient program, and are holding a fundraiser in October.

  Jean Turner asked if the total budget for the Foundation is $30,000 or is the District subsidizing the Foundation at all. CEO DelRossi stated this department runs the Foundation and Grant Writing with a combined budget which is considerably more than $30,000. Greg stated grants tend to bring in hundreds of thousands of dollars and the Foundation typically brings in $20,000 to $30,000 per year through fundraising efforts.

  Ted Gardner stated it is important to look back 5-10 years for what has occurred in fundraising and he is very proud of the Foundation's efforts.

- CEO DelRossi introduced the new Chief Medical Officer, Dr. Adam Hawkins.

CHIEF FINANCIAL OFFICER REPORT

Chair Kilpatrick introduced the Chief Financial Officer report.

FINANCIAL & STATISTICAL REPORTS

CFO DelRossi reported the FY 2023 audit has started; the auditors, CLA, are satisfied at this point, there are no surprises, and the audit is well underway.

CFO DelRossi highlighted several projects:

- RSM finished their official engagement and are now in the maintenance phase which will last six months.
- Staff is looking at Chart Assist in Cerner, which looks for missing documentation with a charge. If documentation is missing or does not match a charge, it sends a message to the provider.
- Staff is also looking at the Insurance Contract Management portion of the software. This provides guidance on whether we have been underpaid by insurance.
- Staff has sent over 18,000 charts to Novus, our Medicaid data clearing house.
- Staff has also been working on I2I, a software solution for reminding patients.
- Staff is working to optimize the accounting software Multiview, which was implemented incorrectly. Multiview has the ability to propose a budget using statistics. It is also the capable of using optical character recognition where we can scan invoices and the software will code them for payment. This will free up time for the AP team to check for variances and work on other projects.

CEO DelRossi introduced Andrea Mossman to present the financials for the month of June.

- June was pretty strong, volumes are stable year over year. Surgical volume was down due to issues with anesthesia, resulting in the OR being down for one week.
- Net patient revenue was down about $3,000,000 from the prior year due to methodology changes in revenue analysis.
- Expenses were up for the month of June, as well as year to date. The main driver of that is wages. MOU negotiations this year resulted in wage increases. The increases are offset by savings in benefits which will result in a net zero increase, but the savings are not realized in this month.
- Net income showed a $5,000,000 loss of for June, and a loss of $17,400,000 for the year.

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

TAG UPDATE

CEO DelRossi stated the TAG committee's efforts are making a difference, however some of the savings are anticipated and not yet realized. Changes to the benefit plans will go into effect in August. Reduction in labor will show benefits. The Internal Medicine clinic's relocation to the RHC was just completed and has not yet yielded the financial benefits that will result. Relocation of surgery clinic to the PMA building will eliminate a modular building and the related expense. RSM's work has already shown positive net cash flow with an expectation that it will increase over time. TAG committee has a list of eleven places to look for more revenue, better cost savings, or more efficient work flow throughout the hospital.

Chair Kilpatrick asked if the hospital will pay to have the vacated modular buildings removed. CEO DelRossi stated Scott Hooker was able to confirm the company that owns the buildings is responsible for the cost of removing them.

Chair Kilpatrick asked if staff is still looking at services that may have to be eliminated. CEO DelRossi stated staff is looking at this but they are not ready to report on it.

Jean Turner stated she appreciates the high level of detail reported every month with respect to the financials.

Melissa Best-Baker asked if RSM gave us the tools to continue the work they implemented, and CEO DelRossi confirmed they did.

REVENUE CYCLE REPORT

Chair Kilpatrick called attention the Revenue Cycle Report. CEO DelRossi stated we have seen tremendous professional growth in staff, and we have seen 45 - 52 corrections in Cerner. The front end staff is working very well in onboarding patients. Our billing and coding companies are stepping up their dedication to us as a result of Gloria Sacco, Revenue Cycle Director, working with them every day and pushing them very hard.

SECURITY REPORT

Chair Kilpatrick called attention to the Security Report. Bryan Harper, ITS Director, introduced Jon Sternstein, CEO of Stern Security. Mr. Sternstein presented results of the 2023 Penetration Test.

Ted Gardner asked if Mr. Sternstein had any observations in general on the types of detrimental activity in the healthcare industry. Mr. Sternstein reported physical theft used to be the highest risk and is now the lowest form of breach. Hacking is now the top form of breach, including an increase in ransomware and phishing.

ITS Director Bryan Harper reported the IT department is addressing the vulnerabilities sited in the penetration test.

DISASTER PLAN MANUAL

Chair Kilpatrick called attention to the Disaster Plan Manual. Bryan Harper, ITS Director, presented the Disaster Plan Manual.

Jody Veenker and Jean Turner commended Bryan for creating the plan and preparing for a table top exercise.

It was motioned by Jean Turner to approve the Disaster Plan Manual, seconded by Ted Gardner and the motion passed 5-0.

BUSD AND NIHD MOU FOR BRONCO CLINIC

Chair Kilpatrick called attention to the BUSD and NIHD MOU for Bronco Clinic.

Patty Dickson, Compliance Officer, stated this is an update to the MOU to be sure it is consistent with regulations and District policy. The MOU allows the hospital to continue the Bronco Clinic.

Melissa Best-Baker asked if NIHD is providing services the school nurse is capable of providing. CNO Allison Partridge stated the scope of services we provide as outlined in the MOU are not within the purview of the school nurse.

Jean Turner asked if the hospital is billing for services performed at the Bronco Clinic. CEO DelRossi stated every patient is billed and we should be at break even with the cuts to the schedule.

Jody Veenker stated students and parents appreciate the access to healthcare provided by the Bronco Clinic and she thanked Colleen McEvoy, NP for her efforts.

It was motioned by Melissa Best-Baker to approve the BUSD and NIHD MOU for Bronco Clinic, seconded by Jean Turner and the motion passed 5-0.

CONSENT AGENDA

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

1. *Approval of minutes of the July 17, 2023 Regular Board Meeting*
2. *Approval of Policies and Procedures – Biennial Review*
    i. *Attendance at Meetings*
    ii. *NIHD Board Meeting Minutes*
    iii. *Northern Inyo Healthcare District Board of Directors Meetings*
    iv. *Officers and Committees of the Board of Directors*
    v. *Requests for Public Funds, Community Grants, Sponsorships*
    vi. *Use by NIHD Directors of District Email Accounts*

It was motioned by Jean Turner to approve the Consent Agenda with the corrections noticed in the Board policies and previously discussed, Ted Gardner seconded, and the motion passed 5-0.

REPORTS FROM BOARD MEMBERS

Chair Kilpatrick opened up reports to Board Members.

Jody Veenker reported this will be her last meeting as a Board member and she submitted a letter of resignation to Chair Kilpatrick and CEO DelRossi.

Jean Turner reported SB525, the healthcare minimum wage law, was heard in the Assembly Appropriations Committee and was moved to the suspense file. It will be heard last week of this month and is expected to pass the Assembly.

ADJOURNMENT

Adjournment at 6:52 p.m.

_____
Mary Mae Kilpatrick, Northern Inyo Healthcare District, Chair

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

Northern Inyo Healthcare District
www.nih.org

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

Date: 09/08/2023
To: Board of Directors
From: J. Adam Hawkins, DO Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Project Updates:

- We are working closely with the Specialty Clinic leadership to quickly expand cardiology services. This will both fill a vital clinical need for our community and provide sustainable revenue for The District.
- I am working closely with our RHC leaders to improve efficiency with the aim of improving patient access to primary care and increasing revenue.
- We have worked to make adjustments to Sue Park's schedule in the Behavioral Health / Psychiatry clinic which has already improved patient volumes. We will be offering tele-health visits through this department which will also greatly improve much needed access to care and also will allow for a significant increase in revenue.

Physician Recruitment update:

- We have invited Dr. Catherine Manuel, MD to Bishop for an in person visit and interview for the open pediatrician appointment. We have had two additional pediatricians inquire about the open position.
- We have received a contract proposal from an anesthesiologist who would like to take over staffing of our Anesthesia Department starting next year. We have been engaged in these discussions over multiple months and feel very optimistic about the future of this service line.
- We are in the process of vetting the possibility of new service lines to be offered through the Specialty Clinic that will fill a clinical need in our community and also contribute to increased revenue generation for The District.

Quality Department update

- I am very proud to announce that the Quality Department successfully completed the HSAG audit of QIP PY5 (2022). As a result, The District will receive approximately 1.4 million dollars for the following 4 measures that we reported on:
    - Developmental Screening in the First Three Years of Life
    - Exclusive Breast Milk Feeding
    - Timeliness of Prenatal Care
    - Timeliness of Postpartum Care

- I meet with the Quality Department team on a weekly basis to monitor our progress on the metrics we are tracking for PY6 (2023) and to strategize how to improve our reporting for the upcoming reporting year.

Dietary Department

- We have recently received two inquiries regarding our open per-diem position. Interviews are being conducted this month.

Rehab Department

- We currently have two full-time physical therapy positions and one physical therapy aide position posted and available.

First Month on the Job

The first month serving as the Chief Medical Officer for The Northern Inyo Healthcare District has not been without its challenges. That being said, I feel a deep sense of both humility and motivation as I have had the opportunity to work with the other members of the executive team and the leaders throughout The District. I am deeply proud of the clinical care that is provided throughout The District. I am honored to serve as a liaison between The District and the Medical Staff to enhance our partnership. I recognize there are challenges that still lie ahead. I am energized by the progress we have already made and I look forward to the work yet to come.

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

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

DATE: September 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Stephen DelRossi, Interim CEO
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION

At the July and August board meetings the upcoming fundraising event was discussed. The District leadership had approached the Foundation to support the new urology service and that will be the focus of the fundraising event. I reached out to Dr. Davis to request he be present to speak at the event and he is on board to support however he can. The date of Saturday, October 7th was selected. I and a board member approached the Catholic Church as a possible venue and secured that location. Entertainment and a caterer have also been hired for the event. Corporate vendors of the District have been approached as potential sponsors and the Foundation Board is actively seeking raffle prizes as well as selling tickets. Notice has been sent out to staff and physicians about supporting the event either through volunteering or purchasing tickets.

GRANT WRITING

The new grant opportunity to help support the adoption of AB 133, CalHHS' Data Exchange Framework is being pursued and an application was submitted for this grant in the amount of $100,000. We are waiting to hear back on funding announcements. Administration and maintenance for all other current grants is ongoing.

NORTHERN INYO HEALTHCARE DISTRICT

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

150 Pioneer Lane
Bishop,California 93514

(760) 873-5811

DATE: September 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Stephen DelRossi, Interim CEO
Tanya De Leo, Patient Access

RE: Department Update

REPORT DETAIL

NEW BUSINESS

None

OLD BUSINESS

Auth & Referral moved to the Administration Bldg. All is going well.

Auth & Referral will be adding a new team member which will be huge help to our current team.

RHC phones are now being answered in the Administration Building which provides a quiet space to communicate with patients.

RHC has added a 3rd check-in window, avoiding long lines for patients checking in.

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

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

DATE: September 2023

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Stephen DelRossi, Interim CEO
Barbara Laughon, Manager, *Marketing, Communications, & Strategy*

RE: Department Update

REPORT DETAIL

With sincerest apologies for shortened report, illness kept me out for 10 days.

COMMUNITY OUTREACH:

Healthy Lifestyle Talks: Hoping to return to these this month in collaboration with Dr. Hawkins. High hopes for featuring Dr. Davis (Urology) and Dr. Wiles (General Surgery).

Podcast: ***NIHD's New Mountain Medicine*** podcast is available on our website at https://www.nih.org/resources/nihd-mountain-medicine/ or available on Apple Podcasts, iHeart, Google Podcasts, or Spotify. Newest segment: *Navigating Options for Care in the Later Years* with Dr. Anne Wakamiya.

MARKETING:

Foundation Fall Fundraiser support: Assisted Foundation Executive Director preparing collateral for upcoming Oct. 7th event.

Same Day Care Brochure update: Brochure updated to reflect current service line and staff. Printing waiting for direction from Primary Care Clinic leadership.

New doctors, APP spotlight: Working to introduce Sue Park (Behavioral Health), and Drs. Davis and Wiles to the community using multi-channel marketing and news efforts.

COMMUNICATIONS:

Internal:

- Employee Town Hall held August 17; next scheduled for Monday, Sept. 25, 8:30 a.m.

External:

- Working to develop email newsletter and in-home geo-targeted postcard program.
- We will be pivoting slightly this quarter as we pause work with Scorpion Health and allow our Digital Marketing consultant Amanda Long to handle boosting and paid advertising to better reach people within our geographic zones.

NORTHERN INYO HEALTHCARE DISTRICT

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One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop,California 93514

(760) 873-5811

DATE: September 2023

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Stephen DelRossi, Interim CEO
Jannalyn Lawrence, Outpatient Clinics

RE: Department Update

REPORT DETAIL

NEW BUSINESS

1. Internal Medicine has successfully integrated with RHC. This transition was completed July 24 and has gone very smoothly!

2. Surgery Clinic moved into Suite G on July 24 and the old modular buildings were removed from our campus on 8/30. New surgeon, Dr. Wiles, started 8/14 and is ramping up in clinic and OR.

3. Dr. Davis, urologist, is seeing patients in Specialty Clinic and his schedule is filling rapidly, including many surgeries.

4. Dr. Rowan, cardiologist from Reno, will be starting to see patients in Specialty Clinic end of Sept or early Oct. With departure of Toiyabe's visiting cardiologist, we expect to fill 2-3 clinic days per month with Dr. Rowan.

OLD BUSINESS

None

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Check Signing		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: CEO, CFO, CMO, CNO, COO, CHRO		
Date Last Modified: 08/21/2023	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/16/2003	

PURPOSE: To identify who has approval to sign checks and to set limits as to the amount needed for signatures.

POLICY: The Board of Directors assigns and approves signatory authority for all contracts, legal documents, and related papers to the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Operating Officer (COO), Chief Human Resource Officer (CHRO) and Administrator on Call (AOC). No other person regardless of their position is authorized to sign such documents on behalf of Northern Inyo Healthcare District. This authority is to be used in connection and compliance with the current approved Board policy and all contracts, actions, and borrowings approved by the Board of Trustees.

PROCEDURE:

Disbursement Account

1. A facsimile signature bearing the name of either the CEO, CFO, CMO, COO, CHRO or CNO may be used for signing disbursement account checks not exceeding $9,999.99.
2. Checks exceeding $9,999.99 must be hand signed by at least one of the following – the second signature can be presented via facsimile:
   a. CEO
   b. CFO
   c. CMO
   d. CNO
   e. COO
   f. CHRO
   g. AOC

Payroll Accounts

1. A facsimile signature bearing the name of the CEO, CFO, CMO, COO, CHRO, or CNO may be used for signing payroll checks issued in lieu of direct deposit.

Wire Transfer, ACH, EFT

1. A wire transfer, ACH, and EFT can only be released by the following: CEO, CFO, CMO, COO, CHRO, and CNO.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:

Maintenance of Fiscal records, including documents associated with procurement contracts and purchase orders is for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Purchasing and Signature Authority

Supersedes: v.2 Check Signing

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Compliance Program for Northern Inyo Healthcare District		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 08/16/2023	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/18/2016	

Contents

INTRODUCTION

It is the fundamental policy of NORTHERN INYO HEALTHCARE DISTRICT (hereinafter "NIHD" or "the District"), that quality patient care and governance is provided by the District, its governing board, medical staff, employees and affiliates, in a manner that fully complies with all applicable state and federal laws, and that all of the District's business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of California, all other applicable state and local laws and ordinances, and the ethical standards and practices of the medical profession, the health care industry and this organization.

There is significant concern about "waste, fraud and abuse" in healthcare. In light of this, the Office of the Inspector General (OIG) has issued a document entitled "Compliance Program Guidance for Hospitals." The OIG has recommended that an effective compliance program should contain the following seven elements:

> ***1.*** *The development and distribution of written standards of conduct, as well as written policies and procedures that promote the Company's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;*
>
> ***2****. The designation of a compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;*
>
> ***3****. The development and implementation of regular, effective education and training programs for all affected employees;*
>
> ***4.*** *The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation;*
>
> ***5.*** *The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements;*
>
> ***6.*** *The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and*
>
> ***7.*** *The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.*

This Compliance Program outlines the process NIHD will utilize to assure that it is in compliance with all the various laws and regulations established by both the Federal government as well as the State of California.

This Compliance Program (the "Program") is intended as a guide to help implement this policy of compliance with all applicable standards. The federal, state, and local laws, regulations, and ethical rules that govern health care are too numerous to list in the Program. Fundamentally, all individuals associated with NIHD by employment, contract or otherwise, are expected to conduct all business activities honestly and fairly. Each employee or contractor is responsible for his or her own conduct in complying with the Program.

The Program provides for the designation of a Compliance Officer who has ultimate responsibility and accountability for directing, monitoring, and reporting on compliance matters. The Compliance Officer shall implement and administer this Program, together with training and education as necessary to affect the full participation of District governing board, medical staff, employees, affiliates, and other agents.

This Program provides a framework for individual or departmental compliance efforts, and applies to all District Personnel and activities. However, each individual employee or agent of the District remains responsible and accountable for his or her own compliance with applicable laws, regulations, standards, policies, and procedures.

The Program identifies those organizational imperatives necessary to prevent accidental and intentional non-compliance with applicable laws. It is further designed to detect non-compliance should it occur. Additionally, it is designed to promote such steps as are necessary to prevent future non-compliance, including education and corrective action.

Northern Inyo Healthcare District is committed to maintaining in the community a positive reputation for conduct in accordance with the highest levels of business ethics. This Program supports that objective. The Program fully supports the NIHD mission: Improving our communities, one life at a time. One team. One goal. Your health!

SECTION 1 — COMPLIANCE PROGRAM SUMMARY

Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Affiliate"** means any person or entity controlled by, or under common control with, Northern Inyo Healthcare District.
- **"District"** means Northern Inyo Healthcare District, and all of its subsidiaries and affiliates that are covered by this Compliance Program.
- **"Personnel"** means all members of the governing board, medical staff, employees of the District, and all contractors or others who are required to comply with this Compliance Program. Each of these persons must sign an Acknowledgment of Receipt of District Compliance Program and a Conflict of Interest Questionnaire Form.
- **"Board"** means the Board of Directors of the District.

Purpose of this Compliance Program

Northern Inyo Healthcare District is committed to ensuring compliance with all applicable statutes, regulations, and policies governing our daily business activities. To that end, the District will have a Compliance Program. The document is to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. Additionally this Compliance Program is to serve as a mechanism for preventing violations and for reporting any violation in a manner that protects those that identify and report the lack of compliance with those laws.

While this Compliance Program contains policies regarding the business of Northern Inyo Healthcare District, it does not contain every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. Northern Inyo Healthcare District maintains other policies with which employees are required to comply. If you have questions about which policies apply to you, please ask your supervisor.

It is the policy of the District that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of

retribution; and

- Mechanisms exist to investigate and take corrective actions in the event of noncompliance.

Who is Affected

Everyone employed by Northern Inyo Healthcare District is required to comply with our Compliance Program. Because not all sections will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that end, agreements with contractors may incorporate certain provisions of this Compliance Program.

Please note that compliance requirements are subject to change as a result of new laws and changes to existing laws and regulations. Collectively, we must all keep this Compliance Program current and useful. Therefore, you are encouraged to let the Compliance Officer or your supervisor know when you become aware of changes in law or District policy that might affect this Compliance Program.

How to Use This Compliance Program

The District has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this manual is organized follows.

1. **Section I – Compliance Program Summary**

2. **Section II – Code of Conduct**

This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism, and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel will receive training on this section.

3. **Section III – Compliance Program Systems and Processes**

This section explains the roles of the Compliance Officer and the Compliance and Business Ethics Committee. It also contains information about Compliance Program education and training, auditing, and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Compliance Confidential Report Line at 1-888-200-9764 or by emailing the Compliance Officer directly. All Personnel will receive training on this section.

4. **Section IV – Compliance Policies**

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

Here are some tips on how to use this Compliance Program effectively:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to locate the topic you are looking for quickly.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that you can refer to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.
- **Read it in Context.** The District has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance

Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about if or how a policy applies to you, ask your supervisor.

- **Keep it Handy.** Keep this Compliance Program information easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are applied uniformly. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

SECTION II – CODE OF CONDUCT

Our Compliance Mission

The mission of Northern Inyo Healthcare District's Compliance Department is to promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law in order to improve our communities, one life at a time.

Northern Inyo Healthcare District believes that dedication to high ethical standards and compliance with all applicable laws and regulations is essential to its mission. This Code of Conduct is a critical component of the overall District Compliance Program. It guides and assists the District in carrying out daily activities in accordance with appropriate ethical and legal standards. These obligations apply to the District's relationship with patients, affiliated physicians, third-party payers, regulatory agencies, subcontractors, contractors, vendors, consultants, and one another. They require that all program participants comply with all applicable federal, state and local laws and regulations. Participants must also comply with all Northern Inyo Healthcare District Standards of Conduct. The absence of a specific guideline practice or instruction covering a particular situation does not relieve an employee from exercising the highest ethical standards applicable to the circumstances.

Compliance with Laws

It is the policy of the District, its affiliates, contractors, and employees to comply with all applicable laws. When the application of the law is uncertain, the District Chief Executive Officer or Compliance Officer will seek guidance from legal counsel.

Open Communication

The District encourages open lines of communication among Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the District's attention. Your supervisor is the best place to start, but you can also contact the District's Compliance Officer or call the Compliance Confidential Report Line (1-888-200-9764) to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The District does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

Your Personal Conduct

The District's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the District. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty, trust, and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say

that the District's integrity and reputation are in your hands.

The District's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the District, the District may be required to take corrective action.

The Work Environment

The District strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately address and report to your supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, or other factors that are unrelated to the District's legitimate business interests. The District will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, you should bring such activity to the attention of the District, either by informing your supervisor, the District's Compliance Officer, or by calling the Compliance Confidential Report Line (1-888-200-9764). The District considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type on the premises, except for exempt or authorized Personnel;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale, or possession of illegal drugs or any other controlled substances, except to the extent permitted by law for approved medical purposes.

In addition, Personnel may not be on the District premises or in the District work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed.

Employee Privacy

The District collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the District or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the District's Personnel policies or practices.

Use of District Property

District equipment, systems, facilities, corporate charge cards, and supplies must be used only for conducting

District business or for purposes authorized by management.

Personal items, messages, or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, workspaces, desks, credenzas, or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on District equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at District work locations, the question of making personal use of them frequently arises. The answer is clear: employees may not use District supplies for personal use.

Use of District Computers

The increasing reliance placed on computer systems, internal information, and communications facilities in carrying out District business makes it absolutely essential to ensure their integrity. Like other District assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting District business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of District assets.

While the District conducts audits to help ensure that District systems, networks, and databases are being used properly, it is your responsibility to make sure that each use you make of any District system is authorized and proper.

Personnel are not allowed to load or download software or data onto District computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use District e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on District premises or computer, information, or communication systems.

Use of Proprietary Information

Proprietary Information

Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with District services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; District business and product plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

The value of this proprietary information is well known to many people in the District industry. Besides competitors, they include industry and security analysts, members of the press, and consultants. The District alone is entitled to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports.

Personnel often have access to information that the District considers proprietary. Therefore, it is very important not to use or disclose proprietary information except as authorized by the District.

Inadvertent Disclosure

The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss with any unauthorized person proprietary information that has not been made public by the District. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information. Furthermore, you should not discuss confidential information even with authorized District employees if you are in the presence of others who are not authorized — for example, at a meeting, conference or in a public area. This also applies to discussions with family members or with friends, who might innocently or inadvertently pass the information on to someone else.

Direct Requests for Information

If someone outside the District asks you questions about the District or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the District. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information, or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the District's business, you should refer the request to your supervisor, the office of the District's Chief Executive Officer, or Compliance Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the District or the industry, direct the person to your supervisor.

Disclosure and Use of District Proprietary Information

Besides your obligation not to disclose any District proprietary information to anyone outside the District, you are also required to use such information only in connection with the District's business. These obligations apply whether or not you developed the information yourself.

Proprietary and Competitive Information about Others

In the normal course of business, it is not unusual to acquire information about many other organizations, including competitors (competitors are other Districts and health facilities). Doing so is a normal business activity and is not unethical in itself. However, there are limits to the ways that information should be acquired and used. Improper solicitation of confidential data about a competitor from a competitor's employees or from District patients is prohibited. The District will not tolerate any form of questionable intelligence gathering.

Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the District (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten, miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the District is also strictly prohibited and could lead to civil or even criminal liability for you and the District. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the District.

Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

Gifts and Entertainment

The District understands that vendors and others doing business with the District may wish to provide gifts,

promotional items, or entertainment to District Personnel as part of such vendors' own marketing activities. The District also understands that there may be occasions where the District may wish to provide reasonable business gifts to promote the District's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

General Policy

It is the general policy of the District that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting District business. It is the intent of the District that this policy be construed broadly such that all business transactions with vendors, contractors, and other third parties are transacted to avoid even the appearance of improper activity. Pharmaceutical samples provided to physicians by manufacturers for patient use are generally allowed. Please discuss any concerns with your supervisor or the Compliance Officer.

Spending Limits — Gifts, Dining and Entertainment

The District has developed policies that clearly define the spending limits permitted for items such as gifts, dining, and entertainment. Occasional gifts from vendors, of nominal value (less than $10), that do not influence or appear to influence the objective judgment of personnel, such as sales promotional items (an inexpensive pen), or business related meal or snack for a department are permitted with approval. All Personnel are strictly prohibited from making any expenditure of District or personal funds for gifts, dining or entertainment in any way related to District business, unless such expenditures are made in strict accordance with District policies.

Marketing and Promotions in Health Care

As a provider of health care services, the marketing and promotional activities of the District may be subject to anti-kickback and other laws that specifically apply to the health care industry. The District has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the District that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the District.

Marketing

The District has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Parts of those efforts involve advertising, marketing, and other promotional activities. While such activities are important to the success of the District, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the District closely monitor and regulate advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with District objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the District. In addition to those policies, it is the general policy of the District that no Personnel engage in any advertising, marketing, or other promotional activities on behalf of the District unless such activities are approved in advance by the appropriate District representative. You should ask your supervisor to determine the appropriate District representative to contact. In addition, no advertising, marketing, or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the District's Chief Executive Officer or Compliance Officer.

All content posted on Internet websites maintained by the District must be approved in advance by the District's Compliance Officer or designee.

Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the District's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the District's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

An obvious conflict of interest is providing assistance to an organization that provides services and products in competition with the District's current or potential services or products. You may not, without prior consent, work for such an organization as an employee (including working through a registry or "moonlighting" and picking up shifts at other health care facilities), independent contractor, a consultant, or a member of its Governing Board. Such activities may be prohibited because they divide your loyalty between the District and that organization. While many of these activities are approved with a management plan or Non-Disclosure agreement, failure to obtain prior consent in advance from the District's Compliance Officer may be grounds for corrective action, up to and including termination.

Outside Employment and Business Interests

You are not permitted to work on any personal business venture on the District premises or while working on District time. In addition, you are not permitted to use District equipment, telephones, computers, materials, resources, or proprietary information for any business unrelated to District business. You must abstain from any decision or discussion affecting the District when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the District's Compliance Officer or Chief Executive Officer.

Contracting with the District

You may not contract with the District to be a supplier, to represent a supplier to the District, or to work for a supplier to the District while you are an employee of the District. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the District.

Required Standards

All decisions and transactions undertaken by Personnel in the conduct of the District's business must be made in a manner that promotes the best interests of the District, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed elsewhere in the Compliance Program.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.

2. Personnel must disclose their "significant" (defined below) financial interests in any entity that they know to have current or prospective business, directly or indirectly, with the District. There are two types of significant financial interests:
    a. Receipt of anything of monetary value from a single source. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and
    b. Ownership of an equity interest exceeding 5 percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange; certificates of deposit; mutual funds; and brokerage accounts managed by third parties.
3. Personnel must disclose any activity, relationship, or interest that may be perceived to be a conflict of interest so that these activities, relationships, and interests can be evaluated and managed properly.
4. Personnel must disclose any outside activities that interfere, or may be perceived to interfere, with the individual's capacity to satisfy his or her job or responsibilities at the District. Such outside activities include leadership participation (such as serving as an officer or member of the board of directors) in professional, community, or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements with entities other than the District.
5. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the District. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation, or entertainment from vendors, contractors, or other third parties that have current or prospective business with the District. Questions regarding the gifts should be directed to the District's Compliance Officer.
6. Any involvement by Personnel in a personal business venture shall be conducted outside the District work environment and shall be kept separate and distinct from the District's business in every respect.
7. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the District, the use of any of the District's equipment, supplies, or property, or any direct relationship with the District's business or operation. Certain emergency situations may require collaboration with suppliers, vendors, or other healthcare organizations. Disclosure and approval by Chief Executive Officer or Compliance Officer at an appropriate time would further clarify compliance; however, nothing in this Program should be interpreted as interfering with the provision of high quality, efficient patient care in a legally compliant manner. Questions should be directed to the District's Compliance Officer.
8. Personnel must guard patient and District information against improper access, disclosure, or use by unauthorized individuals.
9. The District's materials, products, designs, plans, ideas, and data are the property of the District and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
10. Personnel must avoid even the appearance of impropriety when dealing with clinicians and referral sources.
11. All vendors and contractors who have or desire business relationships with the District must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the District must report these to their supervisor, manager, the District Compliance Officer, or by using the Confidential Compliance Report Line (1-888-200-9764).
12. Personnel shall not sell any merchandise on District premises and shall not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the District, whether on or off District premises, unless prior approval is obtained from the District's Compliance Officer.

13. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the District's Compliance Officer.
14. Personnel may not endorse any product or service without explicit prior approval to do so by the District's Compliance Officer.

Disclosure of Potential Conflict Situations

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Questionnaire Form within 90 days of being subject to this Compliance Program (that is, being hired by the District, beginning to volunteer at the District, or assuming any responsibilities at the District). At least annually thereafter, you must review this Compliance Program and Conflict of Interest Questionnaire. You are required to file a Conflict of Interest Questionnaire Form annually, and when there is a change in your circumstances that you have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your questionnaire form and contact the District's Compliance Officer. It is your responsibility to report promptly any actual or potential conflicts.

All questionnaire forms must be sent to the District's Compliance Officer. The Compliance Officer will review all disclosures and determine which disclosures require further action. The Compliance Officer will consult with the Business Compliance Team if an actual or perceived conflict of interest may exist. The District's Chief Executive Officer or legal counsel may be consulted by the Compliance Officer as needed to determine if further action is required. The outcome of these consultations will result in a written determination stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of interest, which may include that:

1. The conflict of interest is not significant and is generally permissible;
2. The activity may represent a potential or perceived conflict of interest, but in many cases would be permitted to go forward after disclosure with a Management Plan or Non-Disclosure Agreement;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest;
4. The activity represents an actual conflict of interest which may be permitted to go forward after disclosure with an appropriate Management Plan or Non-Disclosure Agreement to eliminate the conflict, safeguard against prejudice toward Northern Inyo Healthcare District activities, and provide continuing oversight; or
5. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Compliance Officer, or designee, will review any written determination with you and discuss any necessary action you are to take.

Anti-Competitive Activities

If you work in community relations, sales, or marketing, the District asks you to perform your job not just vigorously and effectively, but fairly, as well. False or misleading statements about a competitor are inappropriate, invite disrespect and complaints, and may violate the law. Be sure that any comparisons you make about competitors' products and services are fair and accurate. (Competitors are other Districts, hospitals, and health facilities.)

Reporting Violations

The District supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies, or this Code of Conduct.

The District has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the District Compliance Program, including this Code of Conduct, must report the improper conduct to the District's Compliance Officer. That officer, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

District policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the District that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to corrective action, if after an investigation the District reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts either to cause harm to someone else or to protect or benefit himself or herself.

Additional, detailed information may be found in the NIHD Code of Business Ethics and Conduct.

SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the District has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the District has established for the purpose of providing structure and support to the Compliance Program.

Compliance Officers and Committee

Compliance Officer

The District has a Compliance Officer who serves as the primary supervisor of this Compliance Program. The District's Compliance Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance Program. The Compliance Officer is responsible for assuring that the Compliance Program is implemented to ensure that the District at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Compliance Officer provides frequent reports to the Governing Board about the Compliance Program and compliance issues. The Governing Board is ultimately responsible for oversight of the work of the Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Board oversees all of the District's compliance efforts and takes any appropriate and necessary actions to ensure that the District conducts its activities in compliance with the law and sound business ethics.

The Compliance Officer and Governing Board shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

Responsibilities of the Compliance Officer

The Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Board (no less than quarterly) on the progress of implementation and operation of the Compliance Program and assisting the Governing Board in establishing methods to reduce the District's risk of fraud, waste, and abuse.
- Periodically revising the Compliance Program in light of changes in the needs of the District and changes in applicable statutes, regulations, and government policies.

- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the Program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the District are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the District have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any other federal or state heath care program.
- Ensuring that the District does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.
- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as quality improvement, coding, billing and clinical departments.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Compliance Officer has direct access to the Governing Board, Chief Executive Officer and other senior management, and to legal counsel.

Compliance and Business Ethics Committee

The District has established a Compliance and Business Ethics Committee to advise the Compliance Officer and assist in monitoring this Compliance Program. The Compliance and Business Ethics Committee (CBEC) provides the perspectives of individuals with diverse knowledge and responsibilities within the District.

Members of the Compliance and Business Ethics Committee

The Compliance and Business Ethics Committee consists of multiple representatives. The members of the CBEC include those individuals designated below and other members as requested, including representatives of senior management, chosen by the District's Chief Executive Officer in consultation with the Compliance Officer:

- Compliance Officer
- Chief Financial Officer
- Cybersecurity Officer

- Chief Medical Officer
- Chief Nursing Officer
- Chief Executive Officer
- Chief Human Resource Officer
- Board of Directors' Representative
- As appropriate, Health Information Management Manager, Revenue Cycle Director, or department designee from Emergency, Human Resources Director Laboratory, Pharmacy, Imaging, Purchasing, and other areas

The Compliance Officer serves as the chairperson of the Compliance and Business Ethics Committee. The CBEC serves in an advisory role and has authority to adopt or implement policies following Board approval. The Compliance Officer will consult with members of the CBEC on a regular basis and may call meetings of all or some members of the CBEC.

The Board of Directors' representative to the CBEC shall be appointed by the full Board of Directors. The Board of Directors' representative shall meet the following qualifications prior to consideration for appointment:

- Completion of ethics and governance training as required by AB1234; and,
- Attended an Association of California Healthcare District (ACHD) Leadership Academy within past two years; and,
- Has completed and filed CA Form 700; and,
- NIHD Conflict of Interest for Members of the Board of Directors has been completed, returned, and reviewed by the Business Compliance Team.

Each member of the CBEC shall sign a Non-Disclosure Agreement (NDA).

Functions of the Compliance and Business Ethics Committee
The Compliance and Business Ethics Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Compliance Officer to develop standards of conduct and policies to promote compliance.
- Development on Annual Compliance Department Work Plan and Audit Plan, including review and re-prioritizing as necessary
- Recommending and monitoring, in conjunction with the Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate, and respond to complaints and problems related to compliance.
- Assisting the Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance and Business Ethics Committee work.
- Consulting with vendors of the District on a periodic basis to promote adherence to this

Compliance Program as it applies to those vendors and to promote their development of formal Compliance Programs.

The tasks listed above are not intended to be exhaustive. The CBEC may also address other compliance-related matters as determined by the Compliance Officer.

The CBEC may, from time to time, create one or more sub-committees which shall have that authority specifically designated thereto. Each sub-committee shall answer directly to the respective Compliance and Business Ethics Committee.

The District has established a Billing, Coding, and Compliance Committee (BCCC), which is a sub-committee of the Compliance and Business Ethics Committee, to advise the Compliance Officer and assist in monitoring of billing, coding, and revenue cycle management. The Billing, Coding, and Compliance Committee shall be renamed the Billing and Coding Compliance Subcommittee (BCCS).

The District has established a Business Compliance Team (BCT) to assist the Compliance Officer in appropriate determinations and plans of action for reported, actual, or perceived conflicts of interest. The Business Compliance Team is a subcommittee of the CBEC.

Compliance as an Element of Performance

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all District employees. Personnel will be trained periodically regarding the Compliance Program, and new compliance policies that are adopted. In particular, all managers and supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following:

- Discuss, as applicable, the compliance policies and legal requirements described in this Compliance Program with all supervised Personnel.
- Inform all supervised Personnel that strict compliance with this Compliance Program is a condition of continued employment.
- Inform all supervised Personnel that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and thus would have provided the District with the opportunity to take corrective action.

Training and Education

The District acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the District requires all Personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by the District for its departments and affiliates based on the needs and requirements of each department and affiliate. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be conducted by qualified internal or external personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at

a minimum the identification of the Personnel participating in the training, the subject matter of the training, the time and date of the training, the training materials used, and any other relevant information.

The Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the District's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the District's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Specific training for appropriate corporate officers, managers, and other employees may include areas such as:

- Restrictions on marketing activities.
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper claims processing techniques.
- Monitoring of compliance with this Compliance Program.
- Methods for educating and training employees.
- Duty to report misconduct.

The members of the District's Governing Board will be provided with periodic training, not less than annually, on fraud and abuse laws and other compliance matters.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

Adherence with the provisions of this Compliance Program, including training requirements, is a factor in the annual evaluation of each District employee. Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs to complement the District's standards of conduct and compliance policies. The Compliance Officer will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions, are maintained.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The District expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

Lines of Communicating and Reporting

Open Door Policy

The District recognizes that clear and open lines of communication between the Compliance Officer and District Personnel are important to the success of this Compliance Program. The District maintains an open door policy in regards to all Compliance Program related matters. District Personnel are encouraged to seek clarification from the Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

Submitting Questions or Complaints

The District has established a telephone hotline for use by District Personnel to report concerns or possible

wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Confidential Report Line."

The Compliance Confidential Report Line contact number is:

Phone: 1-888-200-9764

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Compliance Officer at the following address:

Compliance Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

The Compliance Confidential Report Line number and the Compliance Officer's contact information are posted in conspicuous locations throughout the District's facilities.

All calls to the Compliance Confidential Report Line are treated confidentially and are not traced. The caller need not provide his or her name. The District's Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Confidential Report Line and letters mailed to the Compliance Officer are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Confidential Report Line or in writing that suggest violations of compliance policies, statutes, or regulations are documented and investigated promptly. A log is maintained by the Compliance Officer of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Compliance Officer to the District's Governing Board and Chief Executive Officer.

Non-Retaliation Policy
It is the District's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, District Personnel cannot use complaints to the Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

Enforcing Standards and Policies

Policies
It is the policy of the District to use appropriate corrective action with District Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include oral warnings, suspension, or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with

applicable laws, will also result in sanctions.

- Corrective action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in corrective action.

Because the District takes compliance seriously, the District will respond to Personnel misconduct.

Corrective Action Procedures

Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the District. Any such discipline is within the sole discretion of the District. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Compliance Officer.

Upon determining that an employee of the District or any of its affiliates has committed a violation of this Compliance Program, such employee shall meet with his or her supervisor to review the conduct that resulted in violation of the Compliance Program. The employee and supervisor will contact the Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Compliance Officer during the investigation of the violation. The Chief of Human Resources, Compliance Officer, or Chief Executive Officer may consult legal counsel prior to final actions or disciplinary measures, as appropriate.

Auditing and Monitoring

The District conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Compliance Officer.

The Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the District, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission (including an assessment of the District's billing system), reimbursement, and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The District shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

The periodic review process may include the following techniques:

- Interviews with Personnel involved in management, operations, claim development and submission, and other related activities.
- Questionnaires developed to solicit impressions of the District Personnel.

- Reviews of all billing documentation, including medical and financial records and other source documents, that support claims for reimbursement and claims submissions.
- Presentations of a written report on compliance activities to the Compliance Officer. The report shall specifically identify areas, if any, where corrective actions are needed. In certain cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the District shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

Corrective Action

Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the District's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the District's business and reputation, and can lead to serious sanctions against the District. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Compliance Officer may create a response team to review suspected noncompliance including representatives from the compliance, audit and other relevant departments.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation between the Chief Executive Officer or Compliance Officer and legal counsel.

Depending upon the nature of the alleged violations, the Compliance Officer's internal investigation could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Compliance Officer to assist in an investigation where the Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

Reporting

If the Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over such matter. Such reports will be made by the Compliance Officer on a timely basis.

All overpayments identified by the District shall be promptly disclosed and/or refunded to the appropriate

public or private payer or other entity.

SECTION IV – COMPLIANCE POLICIES

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

REFERENCES:

1. Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858; January 31, 2005)
2. Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987; February 23, 1998)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Authority of the Chief Executive Officer for Contracts and Bidding
2. Business Associate Agreements Execution and Management
3. California Public Records Act – Information Requests
4. Communicating Protected Health Information via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Disposal of Equipment
7. Electronic Communication (Email) Acceptable Use Policy
8. False Claims Act Employee Training and Prevention Policy
9. Family Member and Relatives in the Workplace
10. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
11. Language Access Services Policy
12. NIHD Code of Business Ethics and Conduct
13. Non-Retaliation Policy
14. Nondiscrimination Policy
15. Patient Rights
16. Pricing Transparency Policy
17. Purchasing Signature Authority
18. Equal Employment Opportunity
19. Sanctions for Breach of Patient Privacy Policies
20. Sending Protected Health Information via Fax
21. Using and Disclosing Protected Health Information for Treatment, Payment and HealthCare Operations
22. Vendor Credentialing
23. Workforce Access to His or Her Own Protected Health Information
24. Workforce Investigations
25. InQuiseek – #100 Regulatory Compliance Policy
26. InQuiseek - #105 Formal Corporate or Organization Compliance Plan Policy

Title: Employee Complaints and the Grievance Process		
Owner: Chief Human Resources Officer	Department: Human Resources	
Scope: District Wide – Applies to Employees, travelers, Non-medical Staff contractors, and Temporary Employees		
Date Last Modified: 03/09/2023	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2013	

DEFINITIONS:

Harassment – Under this policy, harassment is verbal, written or physical conduct that denigrates or shows hostility or aversion toward and individual because of the employee's race, color, religion, sex, sexual orientation, gender identity or expression, national origin, age, disability, marital status, citizenship, genetic information, or any other characteristic protected by law, and that: a) has the purpose or effect of creating an intimidating, hostile or offensive work environment, b) has the purpose or effect of unreasonably interfering with an individual's work performance, or c) otherwise adversely affects an individual's employment opportunities.

PROCEDURE:

1. Employees are encouraged, but not required to discuss problems and complaints in an informal manner with their immediate supervisor, Coordinator, Manager, Director, Chief, or Director of Human Resources.
2. If not resolved in step 1, a written formal complaint must be filed with the Human Resources Department within thirty (30) working days of the occurrence of the event. (Reference note a.) Employee Written Formal Complaint Form
3. Within five (5) working days of receipt (Reference note a.): 1) the Human Resources Department will initially respond to the formal written complaint assessing the complaint as: i) discrimination or unfair treatment relating to or caused by gender, race, religious beliefs, age, or other legally protected status; ii) harassment; iii) problems concerning wages or hours; iv) working conditions; v) interpretation or application of policies and procedures; vi) disciplinary action employee(s) feel was not for just cause; or vii) any other matters related to employment. Then, accordingly, two (2) copies of the written complaint and HR response will be forwarded as appropriate up the employee's chain of command by HR. If the subject of the complaint is a Medical Staff member, the Medical Staff Office will be notified and receive copies of the written complaint so it may be addressed through the Medical Staff Practitioner Complaint Resolution Process.
4. Each level of the chain of command, as determined appropriate, will discuss the written complaint with the Director of HR or designee and respond to the employee in writing within five (5) working days of receipt of the written complaint from Human Resources. (Reference note a.)
5. If the employee does not accept the decision of the level of leadership, the employee may appeal the decision in writing up the chain of command, and ultimately to the Chief Executive Officer (CEO) within five (5) working days of the employee's receipt of each leader's decision. (Reference note a.)
6. If it reaches the level of the CEO, the CEO or designee will completely and impartially investigate the complaint and within (5) working days provide the employee with a written decision. (Reference note a.)

7. All decisions of the CEO or designee shall be final and not subject to further appeal.
8. Throughout the complaint and grievance process stated in the policy, if still scheduled to work, the employee is required to continue to perform the employee's duties in a satisfactory manner or be subject to disciplinary action.
9. Employees terminated or suspended, as the result of disciplinary action will remain terminated or suspended during the grievance process stated in this policy.
10. At each stage of the grievance process, if the employee prevails, the employee shall be reinstated. Back pay, in whole or in part, may or may not be granted at the discretion of the CEO or designee.
11. Human Resources will receive a copy of all communication related to the grievance process, for inclusion in the employee's personnel file.
12. Retaliation against the employee making a complaint or using the grievance process is prohibited and will lead to disciplinary action up to and including termination.

Notes:

a. There may be occasions when, because of the time or the particular circumstances involved, either the employee or management of NIHD may request that the time requirements in this procedure be waived or extended.
b. In order to most appropriately or effectively investigate or resolve a complaint/grievance, management may invoke other options during the grievance process, e.g. use of a Task Force or outside consultant or mediator.

RECORD RETENTION AND DESTRUCTION:
Retain employee complaint records for minimum of 6 years.

CROSS REFERENCES POLICIES AND PROCEDURES:
1. Equal Employment Opportunity Procedure
2. Bullying in the Workplace
3. Required - Harassment by Employees (23-01)
3. Medical Staff Professional Conduct Policy
4. InQuiseek - #520 Grievance Policy

Supersedes: Required - Employee Complaints and the Grievance Process (23-02)*
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Nursing Certification		
Owner: Chief Nursing Officer-Interim COO	Department: Nursing Administration	
Scope: Registered Nurses		
Date Last Modified: 06/21/2023	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2016	

PURPOSE: To identify eligible nursing certification for wage adjustments that are not required as part of the position qualifications.

POLICY:

1. Nursing Staff that complete and maintain specialty certification to approved categories may receive an education pay differential.
2. Up to two certifications will be eligible for education pay differential.
3. Certification's that are required as part of the job description will not be eligible for increase.
4. Registered Nurses who have received certification may have the initial RN-BC (Registered Nurse – Board Certified) placed on their identification badge and may include those initials in their signature.

PROCEDURE:

1. The below listed certifications are approved for the following categories of staff:
    a. RN:
        - Acute/Critical Care Knowledge Professional
        - Ambulatory Care Nursing
        - Cardiac Vascular Nursing
        - Certified Emergency Nurse
        - Certified Nurse Operating Room
        - Certified Occupational Health Nurse (COHN)
        - Certified Occupational Health Nurse Specialist (COHN-S)
        - Certified Pediatric Emergency Nurse (CPEN)
        - Certified Vascular Nursing*
        - Certification in Infection Control (CIC)
        - Critical Care Registered Nurse
        - Diabetes Management – Advanced
        - General Nursing Practice*
        - Gerontological Nursing
        - Hemostasis Nursing
        - Informatics Nursing
        - Inpatient Obstetric Nursing – RNC-OB
        - International Board Certified Lactation Consultant
        - Medical-Surgical Nursing

- Nurse Executive
- Nurse Executive Advanced
- Nursing Case Management
- Pain Management Nursing
- Pediatric Nursing
- Perinatal Nursing*
- Trauma Certified Registered Nurse (TCRN)

*Exam retired. The credential can still be renewed

b. CNA:
   - Restorative Certified Aide

c. Department Clerk:
   - Health Unit Clerk Certification

2. Staff that complete certification to approved certification categories (that are not required as part of employment), from the American Nurses Credentialing Center or other designated sources may turn their certificate into their manager for recognition and education pay differential.
   a. The manager completes the Personnel Action Form.
   b. The education pay differential is applied on the first day of the start of new pay period.

3. Once certification has been achieved the RN may have an updated identification badge made within the HR identification badge constraints.
   a. The preferred order of listing credentials is:
      i. Highest earned degree
      ii. Licensure
      iii. State designations or requirements
      iv. National Certifications
      v. Other recognitions
      i.e. John Doe, PhD, MSN.
   b. If you have a second degree in another relevant field you may choose to list it, i.e. John Doe, MBA, MS.
      1. Note that the highest non-nursing degree is listed first followed by the highest nursing degree.
      2. If you have a doctorate and a master's degree, omit the baccalaureate degree. i.e. John Doe PhD, MSN.
   c. Multiple nursing credentials may be listed in the order you prefer, but consider listing them either in order of relevance to your practice or in the order they were obtained with the most recent first. i.e. John Doe, BSN RN, MICN, CEN

4. HR will oversee the record of certifications and the renewal dates.
   a. HR will notify the employee's manager who notifies the employee that the updated certification is due.
   b. If the certification is no longer active, the 2% adjustment will be discontinued.

REFERENCES:

1. *How to List the Order of Credentials After a Name*; Indeed, Editorial Team (October 4, 2021).
2. How to display your credentials; ANCC American Nurse Credentialing Center Certification. (June 2013).

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Licensing of Nursing Personnel

RECORD RETENTION AND DESTRUCTION:
Records are maintained in the workforce member's personnel record for the length of employment, plus 6 years.

Supersedes: v.3 Nursing Certification