Northern Inyo Hospital

September 20 2017 Regular Meeting

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DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

September 20, 2017 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business
   A. Compounding Pharmacy update (*information item*).
   B. Designation of Dietary Director (*action item*).
   C. Keenan Pharmacy Benefits Program Proposal (*action item*).
   D. Policy and Procedure approval, *Employee Complaints and the Grievance Process* (revised) (*action item*).
   E. Policy and Procedure approval, *Orientation* (revised) (*action item*).
   F. Policy and Procedure approval, *Employment of Minors* (revised) (*action item*).
   G. Policy and Procedure approval, *Standards of Conduct* (revised) (*action item*).
   H. Policy and Procedure approval, *Business Associate Agreements* (*action item*).
   I. Policy and Procedure approval, *Performance Transformation Management Model and Plan* (*action item*).
   J. Policy and Procedure Annual approvals (Attachment A to agenda), (*action item*).
   K. NIHD PEPRA Retirement Plan Actuarial Valuation as of 1/1/17 (*action item*).
   L. District Board Resolution 17-04, PPAC Committee transition (*action item*).
   M. District Board Resolution 17-05, LAIF Fund authorization (*action item*).
   N. District Board Resolution 17-06, Banking authorizations (action item).
   O. District Board Resolution 17-07, Benefits and Compensation accounts authorizations (*action item*).

Consent Agenda (action items)

4. Approval of minutes of the August 16, 2017 regular meeting
5. 2013 CMS Validation Survey Monitoring, September 2017
6. Financial and Statistical Reports for the period ending July 31, 2017

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7. Patient Experience Committee report (*information item*).
8. Workforce Experience Committee report (*information item*).
9. Chief of Staff Report; Richard Meredick, MD:

   A. Policies/Procedures/Protocols/Order Sets approvals (*action items*):

   - *Aerosolized Transmissible Disease Plan*
   - *Trophon® Environmental Probe Reprocessor (EPR)*
   - *Guidelines for Management of Health Care Providers with HEB, HEPC and/or HIV*
   - *Thrombolytic Therapy with Alteplace (tPA) for an Acute Ischemic Stroke (with attachments)*
   - *Suspicious Injury Reporting Policy*
   - *Elder and Dependent Adult Abuse*
   - *Use of Hospital-Issued Notice of Noncoverage HINN (with four attachments)*
   - *Surgery Scope of Service*
   - *Scope of Service - PACU*

   B. Temporary Staff Update (*information item*):

   - Amik Reen MD (*temporary hospitalist*)
   - Naomi Lawrence-Reid MD (*temporary pediatrician*)
   - Truong Quach MD (*temporary hospitalist*)

16. Reports from Board members (*information items*).
17. Adjournment to closed session to/for:

   A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).

   B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*).

C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).

D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

18. Return to open session and report of any action taken in closed session.
19. 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.

KPPC
A Keenan Solution

Northern Inyo Hospital

Pharmacy Benefit Review

Keenan Pharmacy Purchasing Coalition (KPPC) represents a different, and we believe superior, way for employers to access Express Scripts (ESI) for the provision of Pharmacy Benefits Management (PBM) services. KPPC is an exclusive group purchase arrangement that offers highly competitive pricing, maximum plan design flexibility and turn-key access to progressive clinical initiatives.

Keenan partnered with Express Scripts (ESI) in 2006 to develop a coalition program designed to help employers manage escalating pharmacy benefit costs. KPPC is currently marketed in all 50 states and has over 500,000 members. Since inception, KPPC clients in aggregate have saved over $100 million in *audited* savings in their first year when compared to the cost of their prior programs. When annual market savings are added cumulatively to KPPC clients, the savings are more than $200 million.

The following information highlights some of the key custom features offered through the program.

- **Leveraged Pricing** -- Clients of all sizes receive highly competitive pricing that typically is available only to large buyers. Thus, smaller self-funded, hospitals receive the same highly competitive discounts, fees and rebates that typically are available only to much larger entities. All clients, regardless of size, are covered by the same contract and terms. With the KPPC, Northern Inyo will receive the same pricing as much larger hospital systems.

- **Annual Market Checks** – Contract terms (Pricing, fees and rebates) are refreshed annually thereby providing members with real-time pricing improvements without waiting until the end of the contract period.

- **100% Pass-Through of Rebates** – KPPC clients receive 100% of manufacturer rebates collected by ESI based on their own claims experience, or a minimum guarantee, **whichever is greater**.

- **Aggressive Financial Performance Guarantees** – Clients receive **guaranteed** minimum AWP discounts on retail, mail, and specialty scripts. All guarantees stand alone, there is no commingling of performance results by ESI in order to cover a deficit in one channel with surpluses from other channels.

- **Quarterly Audits** - An independent consulting firm specializing in PBM contracting and audits performs quarterly audits of **all** paid claims to monitor contract compliance and rebate administration, ensuring that the clients receive the savings and rebates promised. Keenan has negotiated for ESI to pay the full cost of this program – there is no cost to clients for this valuable service.

Northern Inyo Hospital Cost Comparison
Date Range of Claims 5/1/2016 to 4/30/2017
800 Members

	Current/ Incumbent	Proposed KPPC/ ESI Plan	KPPC vs. Current Cost
Rx Count	2,649	2,649	
AWP	$450,836	$450,836	
Ingredient Cost	$248,065	$230,767	-$17,298
Dispensing Fee	$4,264	$1,697	-$2,567
PBM Admin Fee	$4,026	$0	-$4,026
Gross Cost Before Rebates	$256,355	$232,464	-$23,891
Less Rebates	$3,361	$51,927	$48,566
Gross Cost	$252,994	$180,537	-$72,457
Less: KPPC Service Fee ($2.00 x 800 x 12 months)			**$19,200**
Final KPPC Cost Comparison			**-$53,257** **-21.05%**

Title: Required - EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS (23-02)*	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date: ~~04/15/2015~~09/20/2017

PURPOSE:

To outline the Employee Complaints and the Grievance Process policy and procedure to provide methods: 1) for employees to register complaints about discrimination, harassment, or problems concerning wages, hours, working conditions, the interpretation or application of policies and procedures, disciplinary action employees feel was not for just cause, or any other matters related to their employment; and 2) to afford management the opportunity to explain, respond, and take corrective action in a timely manner.

POLICY:

All employees have the right to voice their complaints.

We recognize the meaningful value and importance of full discussion in resolving misunderstandings and preserving good relations between management and our employees. As such we encourage employees to communicate problems arising from work situations in an open manner, without fear of recrimination or retaliation. For minor employees, the parent/legal guardian shall be included in this process. Accordingly, we believe that the following procedure will ensure that complaints receive full consideration.

Should a condition exist that an employee feels is unsatisfactory, it is important that he or she bring it to the attention of the appropriate person in the proper manner. For minor employees, either the assigned mentor, a representative from Human Resources, or the parent/legal guardian shall assist in bringing any matter to the attention of the appropriate person in the proper manner. Normally that person is the employee's immediate supervisor. If the supervisor is the source of the complaint (e.g., unlawful harassment), the employee is to contact human resources. Any employee who perceives problems in the course of their work or who believes their rights and privileges under hospital policies and rules have been applied unfairly must adhere to this procedure to file a complaint and enter the grievance process.

It is the intent of this policy that complaint resolution be accomplished by supervisory levels described in Step 1 of the procedure (preferably the immediate supervisor). Matters more appropriately resolved at the first step are not to be deferred to succeeding steps of the procedure and grievance process. Human Resources will assess complaints 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, including workplace bullying.

Title: Required - EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS (23-02)*	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date: ~~04/15/2015~~09/20/2017

Nothing in this policy alters or should be interpreted as altering the at-will employment relationship between Northern Inyo Hospital and its employees.

Title: Required - EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS (23-02)*	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date: ~~04/15/2015~~09/20/2017

DEFINITIONS:

Harassment – Under this policy, harassment is verbal, written or physical conduct that denigrates or shows hostility or aversion toward and individual because of his or her 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, or that of his or her relatives, friends or associates, 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 Chief Human Relations Officer. For minor employees, either the assigned mentor, a representative from Human Resources, or the parent/legal guardian shall assist in bringing any matter to the attention of the appropriate person in the proper manner at any step in this procedure.
2. If not resolved in step 1, a written formal complaint must be filed with the Human Relations 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 Relations 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.
4. Each level of the chain of command, as determined appropriate, will discuss the written complaint with the Chief Human Relations Officer or designee and respond to the employee in writing within five (5) working days of receipt of the written complaint from Human Relations. (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 Administrator within five (5) working days of the employee's receipt of each leader's decision. (Reference note a.)

Title: Required - EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS (23-02)*	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date: ~~04/15/2015~~09/20/2017

6. If it reaches the level of the Administrator, the Administrator 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 Administrator 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 his/her 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, he/she shall be reinstated. Back pay, in whole or in part, may or may not be granted at the discretion of the Administrator or designee.
11. Human Relations 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 the hospital 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.

~~b.~~c. For matters involving an employee who is a minor, the minor's assigned mentor, a representative from Human Resources, and/or the minor's parent/legal guardian must be involved in any process under this policy.

CROSS REFERENCE P&P:
Required - EQUAL EMPLOYMENT OPPORTUNITY (03-01)
Required - HARASSMENT POLICY (23-01)
STANDARDS OF CONDUCT (18-02)

Title: Required - EMPLOYEE COMPLAINTS AND THE GRIEVANCE PROCESS (23-02)*	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date: ~~04/15/2015~~09/20/2017

Approval	**Date**
Senior Management	~~02/02/2015~~09/5/2017
Board of Directors	~~04/15/2015~~09/20/2017

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 02-03 ORIENTATION	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date:September, 2017

POLICY:

There will be a general orientation program for each new employee shortly after the date of employment. This is the time when the new employee will be taken on a tour of the ~~hospital~~ District's facilities and have the fire and disaster plan explained, emergency codes reviewed, and other relevant ~~hospital~~District-wide policies discussed. Prior to employment, each employee who is a minor shall receive age-appropriate general orientation to District employment including a tour of the District's facilities and explanations/discussions about the fire and disaster plan, emergency codes, and other relevant District-wide policies.

Employees will also receive detailed introductions and orientation ~~of~~ to their specific department and job responsibilities by their supervisor. Each minor employee shall be assigned a District-trained mentor who shall assist the supervisor in giving age-appropriate introductions and orientation to the specific department and job responsibilities of the minor employee.

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 02-03 ORIENTATION	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date:September, 2017

Approval	**Date**
Personnel/Payroll Advisory Committee	
Human Resources	9/5/2017
Administration	9/5/2017
Board of Directors	11/20/2002
Last Board of Director review	~~1/18/17~~9/20/2017

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 04-02 EMPLOYMENT OF MINORS	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date: September 2017

POLICY:

We abide by the state and federal regulations that govern the employment of minors. Therefore, we require any applicant who has not reached his/her eighteenth birthday to obtain a work permit from school before being accepted for employment.

Any minor employed by the District shall receive age-appropriate orientation and professional development to the District's workplace. Each minor shall be assigned a District-trained mentor who shall assist in developing the workplace skills and competencies of the minor to whom the mentor is assigned.

Approval	**Date**
Personnel/Payroll Advisory Committee	
Human Resources	9/5/2017
Administration	9/5/2017

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 04-02 EMPLOYMENT OF MINORS	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date: September 2017

Board of Directors	11/20/2002
Last Board of Director review	~~1/18/17~~9/20/2017

Title: 18-02 STANDARDS OF CONDUCT	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date: September 2017

POLICY:

In order to provide employees of Northern Inyo Hospital some guidance concerning unacceptable behavior, the following are some examples of types of conduct considered impermissible. Employees who engage in any misconduct or whose performance is unsatisfactory may be subject to disciplinary action, up to and possibly including immediate termination. The list is intended simply to provide some examples of disciplinary offenses.

1. Unsatisfactory performance on the job such as:

   Absence without proper notification/explanation, chronic absenteeism or chronic tardiness. Chronic absenteeism or chronic tardiness results when an employee is absent or tardy without excuse two or more times in a 30-day period; or is absent or tardy without excuse five or more times in a 90-day period.

   Leaving assigned work without permission.

   Breach of professional confidence.

   Gross insubordination; outright refusal to follow directions or obey legitimate orders of supervisor.

   Refusal to wear appropriate personal protective equipment.

   Willful negligence in performance on the job.

   Sleeping, or giving the appearance of sleeping, while on duty.

2. Falsification of or making a material omission on forms, records, or reports, including punch detail reports, application materials, or other records. Examples are:

   Failure to report an incident in accordance with the hospital's guidelines for the use of incident reports.

   Knowingly making false entries on another employee's punch detail report or edit sheet, or allowing someone else to make false entries on your punch detail report or edit sheet; or falsification of punch detail reports or edit sheets in any manner.

Title: 18-02 STANDARDS OF CONDUCT	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date: September 2017

3. Violating safety or health rules or practices or engaging in conduct that creates a safety or health hazard such as:

   Smoking in unauthorized areas.

   Failure to report an accident or incident involving a patient, visitor or yourself.

   Threatening, intimidating, coercing, or interfering physically with fellow employees, patients or visitors on hospital property; unauthorized possession of firearms, explosives or knives.

   Workplace bullying which is repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators. It is abusive conduct that is:

   - Threatening, humiliating, or intimidating, or
   - Work interference — sabotage — which prevents work from getting done, or
   - Verbal abuse

   Demonstrating incompetency, inefficiency or negligence where a patient's welfare is concerned.

   Ignoring a fire alarm, fire drill, disaster alarm or disaster drill.

   Reporting for work under the influence of alcohol or narcotics, or using either on the hospital's premises or in hospital-owned vehicles whether on or off duty.

4. Other types of misconduct include:

   Willful abuse of the building or equipment.

   Unauthorized posting or removal of materials on official hospital bulletin boards.

   Violation of the hospital's solicitation and distribution rules.

   Abusive or obscene language.

   Sexual intercourse, oral copulation, or sodomy, committed on the hospital premises, whether or not such conduct is lawful.

   Stealing from fellow employees, patients, the hospital, or others on hospital premises; taking hospital property, records, or hospital information without permission.

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: 18-02 STANDARDS OF CONDUCT	
Scope: Hospital Wide	Manual: Human resources – Employee Handbook
Source: Human Resources	Effective Date: September 2017

Approval	**Date**
~~Personnel/Payroll Advisory Committee~~	
Human Resources	9/5/2017
Administration	9/5/2017
Board of Directors	11/20/2002
Last Board of Director review	~~5/17/17~~9/20/2017

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Business Associate Agreements	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 10/1/2017

PURPOSE:

To establish guidelines for Northern Inyo Healthcare District to identify those relationships which meet the HIPAA definition of a "business associate" and provide direction on the process by which a business associates agreement will be established.

DEFINITIONS:

Business Associate (BA): an individual or entity, who is not a member of Northern Inyo Healthcare District's workforce, who performs functions or activities on behalf of, or provides services to, NIHD that involve access by the business associate to PHI

Business Associate Agreement (BAA): a written contract with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the HIPAA Privacy and Security Rules' requirements to protect the privacy and security of protected health information

Covered Entity (CE): health plans, providers of health services, and clearinghouses that transmit any health information in electric form; for the purposes of this policy NIHD is a "provider" CE

Protected Health Information (PHI): information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity and can be linked to an individual (also called Individually Identifiable Health Information)

POLICY:

1. Business Associate Agreements will be established with all Business Associates who create, receive, maintain, or transmit PHI on behalf of Northern Inyo Healthcare District.

2. BAAs will meet the applicable requirements of 45 CFR § 164.504(e).

3. BAAs will be revised and re-signed as laws and regulations governing BAAs are updated and implemented by the Federal Government.

4. Departments currently receiving services from the Business Associate will, in collaboration with the Privacy Officer, identify Business Associates.

5. The Privacy Officer or Chief Executive Officer may execute Business Associate Agreements.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Business Associate Agreements	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 10/1/2017

PROCEDURE:

1. For any new contractual agreements to be entered into by the District, District administration will ensure that the Compliance Department is notified to assess the need for a BAA.

2. The Compliance Department will send the BAA to the correct contact for the BA.

3. Once completed, the fully executed BAA will be maintained as a PDF in the Compliance Department electronic files. A copy of the BAA will also be sent to the Administration Office to be maintained with the contract for the BA.

4. The Privacy Officer will maintain an up-to-date list of Business Associates for compliance reviews and updates as required.

REFERENCES:

1. 45 CFR § 164 Subpart E
2. 45 CFR § 164.502(e)(1)

Committee Approval	Date
Board of Directors	

BCLC

Responsibility for review and maintenance:
Index Listings:
Developed:
Revised: 8/31/2017
Reviewed: 12/16/15

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Performance Transformation Management Model and Plan	
Scope: District-Wide	Manual: Quality Assurance and Performance Improvement
Source: Performance Improvement	Effective Date: September, 2017

POLICY:

Northern Inyo Healthcare District (NIHD) embraces a systematic approach to change management and performance improvement, also known as performance transformation. A systematic approach to implementing change places the responsibility on leadership to understand stakeholder characteristics. A systematic approach to performance transformation can include planning and practicing various scenarios and identifying likely implementation strategies and communication priorities on an ongoing basis prior to implementing organizational change that will transform the way in which NIHD does business. Such a systematic approach also identifies potential barriers to a smooth implementation of a change while giving sufficient time to plan to such barriers.

The resulting streamlining of the performance transformation process assures adequate consideration of each stakeholder's interest prior to the transformation taking place. Unintended consequences are assessed against desired outcomes. This performance transformation plan is designed to build on NIHD's existing change management strategies and initiatives and is expected to be implemented by all NIHD departments.

PROCEDURE:

I. NIHD's Performance Transformation Model: PDSA

The Plan-Do-Study-Act model of performance Transformation is based on the 1950 Model developed in Japan by Dr. W. Edwards Deming. Also known as the Deming Cycle, this model is one of logical sequence of four repetitive steps with expected outcomes for continuous quality improvement and learning. The concept of PDSA is based on two prior models. The first is the scientific method "hypothesis" – "experiment" – "evaluation" championed by Francis Bacon in his work entitled "*Novum Organum*" in 1629 and the second is the Shewhart cycle of "specification" – "Production", and "inspection" authored by Walter A. Shewhart in 1939. There are four steps to the PDSA model that cover a broad area and are easy to use.

A. Plan: Identify an Opportunity and Plan for Improvement.

This is the first step in the model as it establishes the basis for what will set the other three steps in motion. Transforming performance requires anticipating and preparing for that transformation. In this step, the originator of the change plans for the object of the test or observation, including a plan for collecting data. An analysis of the data is needed to determine the possible and probable impact of any improvement on the organization. A thorough understanding of the external environment is needed to assess the change as it may occur locally, regionally, nationally and/or globally. Identifying the implications for the organization is a key component of this step. The originator, in this step, states the objective of the test and makes predictions about what will happen and why. Then, a plan to test the change is developed answering the questions of who, what, when, where and what data need to be collected. Once the Plan is defined in this way, goals for appropriate action to be taken can be defined.

Topics to consider when developing plans include:

- Involving all possible stakeholders, including staff and leadership in the planning and implementation of
  the transformation. Research is required to identify the target audience's informal and formal leadership
  during this step as including target audience leaders results in a natural acknowledgement to change
  because of consultation and involvement.
- Achieving credibility through endorsement of the change by organizations (health, scientific, professional, etc.), experts (economic, health, environmental, etc.), informal and formal leaders (employee, community, professional, religious), etc.
- Effectively using the stakeholders' existing culture by tying strategies to existing work patterns, social customs and behaviors, artifacts, and belief systems whenever possible.
- Identifying and communicating the strongest motivations (perceived benefit) for change acceptance. The strongest motivations are normally economic, status, health/safety, and convenience, but other motivations will also exist. Learn and confirm them through target audience research accomplished during this step. Use more than one motivation in organizational communication for maximum effectiveness.
- Identifying processes that will start stop and/or continue pre, during and post change implementation.
- Establishing a balance among results, time and resource requirements e.g. employees, equipment or technology to facilitate the change.
- Listing tasks and activities that will achieve the goals of the transformation.
- Sequencing activities in the most efficient manner.
- Designing educational and/or informational programs as needed.
- Planning to assure consistency and frequency of communication. E.g. determining communication channels (formal and informal, verbal and non-verbal) preferred by the audience targeted for change. Knowledge of the communication taking place among target audience members is also critical for the correction of communication during the change process.

B. Do: Carry Out the Plan

In this step, the plan is carried out, in essence, tested. During this step, problems are documented and unanticipated observations or outcomes are collected. Data are collected and analyzed in an effort to establish baselines, identify root causes of the problem for which a solution is being sought and then suggest possible solutions (organizational learning). This process is important to all aspects of NIHD's operations, and is a crucial step in both performance transformation and quality improvement processes. The analyses conducted in this step will lead to the identification of any adjustments that will need to be made to optimize the transformation. Steps to minimize

identified threats presented by this change will be made during this step. Therefore, part of the implementation of the plan is to accurately evaluate the target audience's desire for change or acceptance of change. This step allows NIHD to identify potential barriers in persuading a target audience to accept change and the types of influence and/or forcing functions that may be necessary to accomplish the change (precursor to adopting the changed process). Pilot studies can be implemented to evaluate the acceptability of a change.

C. Study**:** Study the Results

In this step, baseline data established at the Plan step and data collected throughout the Do step is analyzed. Ensure that the data is valid and reliable (Plan step). Effectiveness of implementation will be based on the congruence among members of stakeholders and conferring with Quality professionals is strongly recommended in building the new strategy for implementation of the transformation. A summary of what was achieved, learned and accomplished should be completed. Any modifications to the Plan, or pilots, should cycle through these steps and data collected for each is to be analyzed in this step. Ongoing measurement and monitoring is done to capture deviations, take corrective actions (organizational learning), collect evaluations and information from stakeholders and team members and adapt resource levels as needed to ensure hardwiring.

D. Act: Take Action to Hardwire the Transformation

In this step, based on evaluative data, plans may be refined to capitalize on successes and minimize failures, or plans may be stabilized when it is evident that the change is integrated into the formal structure of the organization with policies, prompts, reward systems, artifacts, and cultural behaviors.

These four steps are critical to successfully implement change (integration to all stakeholders). The process can be repeated on an ongoing basis so barriers will continually be recognized and resolutions put in place. This process also helps to facilitate the continuity of the newly implemented change and to ensure changes are "hard-wired" into the fabric of the organization. A sample template to implement the PDSA is attached to this policy as a guide.

III. The PDSA Model applies to the following types of changes:

- Change required to prevent sentinel events or near miss activities.
- Change required for patient safety.
- Change required to improve patient care outcomes as evidenced by measurable parameters.
- Change required to improve customer service focusing on improved satisfaction.

Title: Performance Transformation Management Model and Plan	
Scope: District-Wide	Manual: Quality Assurance and Performance Improvement
Source: Performance Improvement	Effective Date: September, 2017

- Change required for cross functional/departmental problem solving.
- Change required to modify staffing or scope of practice.
- Change required for cost containment.
- Change required for improving NIHD's competitive position.
- Change required based on the health priorities identified by NIHD.
- Change that Leadership determines would be more successful if the PDSA model is used.
- Change that includes assessment of education, training, and competencies for scope of practice changes.

RESPONSIBILITIES:

A. Originator. The Originator identifies need for a transformation, notifies their leader in their chain of command of the pending transformation, and may assist in providing background and research, assist in documenting the requested transformation, identify potential risks associated with the transformation and the scope and operational impacts as possible. The chain of command should report all of the information to the Department Head. The Originator retains documentation supporting the transformation, the resulting evaluation and follow up. The Originator will report appropriate metrics to appropriate departments/committees and the Quality Department.

B. Department Heads. The Department Head receives notice of an impending transformation, performs initial evaluation and analysis with the originator and/or others in the chain of command including:

- Impact of the project scope and quality
- Impact to patient care or other operations
- Impact to the operational/capital costs

The Department Head uses the principles and practices contained in the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK) for the initial and ongoing evaluation and implementation of the transformation.

REFERENCES:

The Joint Commission Standards: PI.01.01.01; LD.03.05.01
Quality Assurance & Performance Improvement (QAPI) Plan
Performance Improvement and Risk Management Overview Policy

Approvals	**Date**
Quality Assurance and Performance Improvement	
Senior Leadership	
Board of Directors	
Last Board of Directors Review	

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Performance Transformation Management Model and Plan	
Scope: District-Wide	Manual: Quality Assurance and Performance Improvement
Source: Performance Improvement	Effective Date: September, 2017

Plan-Do-Study-Act (PDSA) – Sample Worksheet for a Test of Change

(**Note**: To test an idea may require one or more multiple PDSA cycles)

TEAM/PROJECT NAME: _____ **Date:**_____

Idea testing:_____ **PDSA Cycle #:**_____

Describe your first (or next) test of change	**Person Responsible**	**When to be done**	**Where to be done**

Plan

List the tasks needed to set up this test of change	**Person Responsible**	**When to be done**	**Where to be done**
1- 2- 3- 4- 5-			

Predict what will happen when the test is carried out	**Measures to determine if prediction is correct**
1- 2- 3- 4-	1- 2- 3- 4-

Do **Conduct the test. Describe what actually happened when you ran the test**

Study **Describe the measured results and how they compared to the predictions**

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

ATTACHMENT A

(TO THE BOARD PACKET FOR SEPTEMBER 20, 2017)

COMPLIANCE DEPARTMENT

ANNUAL POLICY & PROCEDURE APPROVALS

SEPTEMBER, 2017

1. Auditing of Employee Access to Patient Information
2. Family Member and Relatives in the Workplace
3. Non-Retaliation Policy

Medical Staff Services Policy and Procedure Manual

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1. Credentialing – da Vinci Robotic Surgery
2. Credentialing Health Care Practitioners in the Event of a Disaster
3. Focused and Ongoing Professional Practice Evaluation (FPPE/OPPE)
4. Medical Staff and Allied Health Professional Application Fee Processing
5. Order Set Approval Policy
6. Practitioner Complaint Resolution Process
7. Professional Conduct. Prohibition of Disruptive or Discriminatory Behavior
8. Request for Establishment of New Privilege or New Service

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August 31, 2017

Ms. Carrie Petersen
Chief Accounting Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514-2599

Northern Inyo Healthcare District PEPRA Retirement Plan
Actuarial Valuation as of January 1, 2017

Dear Carrie:

Enclosed is our Actuarial Valuation as of January 1, 2017 for the PEPRA defined benefit plan. This valuation includes the determination of the required annual employee and employer contributions, as well as the GASB 67 and 68 disclosures for the fiscal year ended June 30, 2017.

The total normal cost rate for 2017 has been determined to be 23.50%. This means that the employee contribution rate for 2018 will be 50% of that rate rounded to the nearest 0.25%, which computes to 11.75%. The employee contribution rate for 2017 was 12.0%.

Contributions for 2017 Plan Year	
Total Required Contribution (Employee and Employer)	$ 27,915
2017 Employee Contributions (12.0%[1] Employee Contribution Rate)	(14,253)
Net Employer Contribution	$ 13,662

[1] *Applies only to compensation up to PEPRA Compensation Limit ($118,775 for 2017).*

If you have any questions or would like to review the report with me, please give me a call at (415) 394-3716 or e-mail me at rich.wright@milliman.com.

Sincerely,

Rich Wright

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enc.
cc: Kristina Gritsutenko
Evelyn Campos-Diaz
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Northern Inyo Healthcare District
PEPRA Retirement Plan

Actuarial Valuation as of January 1, 2017

Prepared by:

Richard A. Wright
FSA, MAAA

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August 31, 2017

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August 31, 2017

Northern Inyo Healthcare District
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Northern Inyo Healthcare District PEPRA Retirement Plan
Actuarial Valuation as of January 1, 2017

As part of our engagement with the Healthcare District, we have made an actuarial valuation of the Northern Inyo Healthcare District PEPRA Retirement Plan as of January 1, 2017. The purpose of this valuation is to determine the recommended contribution pursuant to the Healthcare District's funding policy, and to provide the computations to fulfill financial accounting requirements under GASB Statement No. 67 and 68.

In preparing this report, we have relied without audit on information (some oral and some in writing) provided by Matrix Trust Company and the Healthcare District. This information includes, but is not limited to, financial information, census data, and plan provisions. We found this information to be reasonably consistent and comparable with information used for other purposes. The valuation results depend on the integrity of this information. If any of this information is inaccurate or incomplete the results may be different and the calculations may need to be revised.

All costs, liabilities, rates of interest, and other factors for the Fund have been determined on the basis of actuarial assumptions and methods which are individually reasonable (taking into account the experience of the Plan and reasonable expectations); and which, in combination, offer our best estimate of anticipated experience affecting the Fund.

This valuation report is only an estimate of the Plan's financial condition as of a single date. It can neither predict the Plan's future condition nor guarantee future financial soundness. Actuarial valuations do not affect the ultimate cost of Plan benefits, only the timing of Plan contributions. While the valuation is based on an array of individually reasonable assumptions, other assumption sets may also be reasonable and valuation results based on those assumptions would be different. No one set of assumptions is uniquely correct. Determining results using alternative assumptions is outside the scope of our engagement.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the Fund's funded status); and changes in plan provisions or applicable law. Due to the limited scope of our assignment, we did not perform an analysis of the potential range of

future measurements. The Healthcare District has the final decision regarding the appropriateness of the assumptions and actuarial cost methods.

Actuarial computations presented in this report are for purposes of determining the recommended funding amounts for the Healthcare District and for fulfilling financial accounting requirements under GASB Statement No. 67 and 68. The computations prepared for these two purposes may differ as disclosed in our report. The calculations in the enclosed report have been made on a basis consistent with our understanding of the Healthcare District's funding policy and goals. Determinations for other purposes may be significantly different from the results contained in this report. Accordingly, additional determinations may be needed for other purposes.

Milliman's work is prepared solely for the internal business use of the Healthcare District. To the extent that Milliman's work is not subject to disclosure under applicable public records laws, Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work product. Milliman's consent to release its work product to any third party may be conditioned on the third party signing a Release, subject to the following exception(s):

(a) The Healthcare District may provide a copy of Milliman's work, in its entirety, to the Healthcare District's professional service advisors who are subject to a duty of confidentiality and who agree to not use Milliman's work for any purpose other than to benefit the Healthcare District.

(b) The Healthcare District may provide a copy of Milliman's work, in its entirety, to other governmental entities, as required by law.

No third party recipient of Milliman's work product should rely upon Milliman's work product. Such recipients should engage qualified professionals for advice appropriate to their own specific needs.

The consultants who worked on this assignment are pension actuaries. Milliman's advice is not intended to be a substitute for qualified legal or accounting counsel.

On the basis of the foregoing, we hereby certify that, to the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally accepted actuarial principles and practices which are consistent with the applicable Actuarial Standards of Practice of the American Academy of Actuaries. The undersigned is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Sincerely,

Richard A. Wright, FSA, MAAA
Consulting Actuary

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INTRODUCTION

This report sets forth the results of our valuation of the Northern Inyo Healthcare District PEPRA Retirement Plan, as of January 1, 2017. In Section II we furnish certain financial statements and actuarial exhibits of the Fund for the 2016 plan year. Section III presents the determination of the contribution requirement for the 2017 plan year. Section IV presents the required disclosures under GASB 67 and 68.

A summary of the Plan is set forth in Appendix A, and the actuarial assumptions and cost method used in determining the costs and liabilities are described in Appendix B. The membership data is shown in Appendix C.

HIGHLIGHTS

The total normal cost rate for 2017 has been determined to be 23.50%. This means that the employee contribution rate for 2018 will be 50% of that rate rounded to the nearest 0.25%, which computes to 11.75%. The employee contribution rate for 2017 was 12.0%.

The mortality assumption for valuing the actuarial accrued liability has been updated to incorporate the MP-2016 projection scale that was published by the Society of Actuaries in October 2016. This projection scale is applied to the RP-2014 Mortality Table starting from a base year of 2006, and applies a generational projection going forward. In the previous valuation, the MP-2015 projection scale was used, along with the same base table. This change resulted in a decrease of (0.33%) in the 2017 total normal cost rate.

For the 2017 plan year, the total required contribution is $27,915. The expected employee contribution is $14,253, which results in a net employer contribution of $13,662 for 2017, assuming payments are made throughout the 2017 plan year.

RATIONALE FOR SIGNIFICANT ASSUMPTIONS

Mortality. The mortality assumption has been updated to incorporate the MP-2016 projection scale that was published by the Society of Actuaries in October 2016. This projection scale is applied to the RP-2014 Mortality Table starting from a base year of 2006, and applies a generational projection going forward. This assumption is expected to be a best estimate of future mortality experience, being based on the latest published study by the Society of Actuaries. In the prior year's valuation, the MP-2015 projection scale was used, along with the same base table.

Interest. For the pre-retirement interest assumption, as well as for the post-retirement interest assumption for those electing the annuity form of payment at retirement, we have assumed an interest rate of 5.00%. Our current long-term expected returns for various asset classes are shown below.

Asset Class	Expected Nominal Return	Asset Allocation
U.S. Fixed Income	3.69%	60.00%
Global Equity	7.89%	40.00%
Expected Average Return (1 yr)		5.37%
50th Percentile Return (20 yrs)		5.12%

Based on the above asset allocation, we expect the 1-year nominal rate of return to be 5.37%. The 50th percentile average return over the next 20 years is expected to be 5.12%.

Inflation. We have assumed a long term inflation rate of 2.5% per annum. This is the rate at which the PEPRA limit on pensionable compensation - which is currently at $118,775 for 2017 - is assumed to grow in the future. This assumption represents a best estimate of anticipated experience, and is the same as the prior year's assumption.

RESULTS OF VALUATION

The following table compares the principal valuation results with those of the prior plan year.

	January 1, 2017	January 1, 2016
Number of Participants		
Active – Fully vested	0	0
– Partially vested	0	0
– Nonvested	1	1
– Total	1	1
Terminated vested	0	0
Retired	0	0
Total participants	1	1
Covered Payroll (Reflecting PEPRA Limit)	$ 118,775	$ 117,020
Actuarial Accrued Liability	$ 27,914	$ 0
Actuarial Assets	$ 27,992	$ 0
Total Normal Cost	$ 27,915	$ 27,992
As a percentage of applicable payroll	23.50%	23.92%
Employee Contribution	$ 14,253	$ 14,042
As a percentage of applicable payroll	12.00%	12.00%
Employer Contribution	$ 13,662	$ 13,950
As a percentage of applicable payroll	11.50%	11.92%
Investment Return (Calendar Year Basis)		
Current annual yield	n/a[1]	n/a[1]
GASB 67/68 Measurements as of Fiscal Year End	**June 30, 2017**	**June 30, 2016**
Net Pension Liability		
Total Pension Liability (TPL)	$ 42,389	$ 0
Fiduciary Net Position (FNP)	46,236	0
Net Pension Liability (NPL)	(3,847)	0
FNP as % of TPL	109.08%	n/a
GASB 68 Pension Expense for Fiscal Year	$ 18,311	$ 0

[1] Measurement is not yet applicable since there were no plan assets until the very end of 2016, when the first employee and employer contributions were made to the plan.

EXHIBIT 1. SUMMARY OF PLAN ASSETS

The valuation assets as of January 1, 2017, are shown below. There were no plan assets until the first employee and employer contributions were made on December 30, 2016, shortly following the establishment of the Plan. Therefore, plan assets as of January 1, 2017 are entirely in cash, not having yet been transferred to the trust account subsequently established with the Matrix Trust Company. Development of the assets is as follows:

	January 1, 2017	January 1, 2016
Plan Assets		
Cash	$ 23,330	$ 0
Accrued Employee Contributions	4,662	0
Actuarial Assets	$ 27,992	$ 0
Asset Allocation		
Cash	83.3%	0.0%
Accrued Employee Contributions	16.7%	0.0%
Total	100.0%	0.0%

Note: We have not audited the fund's assets shown above. We have relied on the information furnished by the Healthcare District.

EXHIBIT 2. SUMMARY OF CHANGES IN PLAN ASSETS

Plan assets increase or decrease each year due to employee contributions, employer contributions, investment income, benefit payments to retiring participants, plan expenses paid by the trust fund, and any realized and unrealized gains and losses from investments.

	PLAN YEAR ENDING	
	December 31, 2016	December 31, 2015
Beginning Balance	$ 0	$ 0
Additions:		
Employee contributions	9,380	0
Employer contributions	13,950	0
Investment income	0	0
Total	23,330	0
Subtractions:		
Benefit payments	(0)	(0)
Administrative expenses	(0)	(0)
Total	0	0
Ending Balance	$ 23,330	$ 0

EXHIBIT 3. DEVELOPMENT OF NORMAL COST

The normal cost is calculated according to the actuarial cost method. Under the entry age normal cost method, the normal cost is calculated as the sum of the normal costs for individual participants. A participant's normal cost is calculated by allocating the value of future benefits as a level percentage of earnings over the participant's working lifetime. The normal cost is as follows:

	PLAN YEAR BEGINNING	
	January 1, 2017	January 1, 2016
Total Normal Cost	$ 27,915	$ 27,992
Covered Payroll	118,775	117,020
Total Normal Cost Rate	23.50%	23.92%
PEPRA Employee Contribution Rate – Current Year (50% of Prior Year Total Normal Cost Rate, Rounded to Nearest 0.25%)	12.00%	12.00%
Total Normal Cost	$ 27,915	$ 27,992
Expected employee contributions	(14,253)	(14,042)
Employer Normal Cost for 2017	13,662	13,950
Employer Normal Cost Rate	11.50%	11.92%
PEPRA Employee Contribution Rate – Next Year	11.75% for 2018	12.00% for 2017

EXHIBIT 4. ACTUARIAL ACCRUED LIABILITY

The actuarial accrued liability has been calculated using the entry age normal actuarial cost method, and is equal to the present value of benefits for all members less the present value of future normal costs for active employees. Any actuarial liability in excess of the plan's assets is called an unfunded actuarial accrued liability.

	As of January 1, 2017	As of January 1, 2016
Present Value of Benefits		
Active participants	$ 349,998	$ 339,648
Terminated vested participants	0	0
Participants currently receiving payments	0	0
Total PVB	$ 349,998	$ 339,648
Present Value of Future Normal Cost		
Active employees	$ 322,084	$ 339,648
Actuarial Accrued Liability		
Active participants	27,914	0
Terminated vested participants	0	0
Participants currently receiving payments	0	0
Total actuarial accrued liability	$ 27,914	$ 0
Actuarial Assets	$ 27,992	$ 0
Unfunded Actuarial Accrued Liability	$ 0	$ 0

EXHIBIT 5. SUMMARY OF PLAN ASSETS AS OF FISCAL YEAR END

The Plan assets are maintained by Matrix Trust Company (account #a7722). Plan assets are the market value of assets as of the measurement date.

	June 30, 2017	June 30, 2016
Matrix Trust Company		
– Cash Equivalents	$ 46,236	$ 0
Total Assets	$ 46,236	$ 0
Asset Allocation		
Cash Equivalents	100.0%	n/a

Note: We have not audited the fund's assets shown above. We have relied on the information furnished by Matrix Trust Company.

EXHIBIT 6. CHANGES IN PLAN ASSETS OVER FISCAL YEAR

Plan assets increase or decrease each year due to employee contributions, employer contributions, investment income, benefit payments to retired participants, and plan expenses paid by the trust fund.

	FISCAL YEAR ENDING	
	June 30, 2017	June 30, 2016
Beginning Balance	$ 0	$ 0
Additions		
Employee contributions	$ 23,164	$ 0
Employer contributions	23,072	0
Investment income	0	0
Total	$ 46,236	$ 0
Subtractions		
Benefit payments	$ (0)	$ (0)
Administrative expenses	(0)	(0)
Total	$ (0)	$ (0)
Ending Balance	$ 46,236	$ 0

EXHIBIT 7. MONEY WEIGHTED INVESTMENT RETURN

GASB 67 requires the disclosure of the money-weighted rate of return on plan investments. The money-weighted rate of return considers the changing amounts actually invested during a period and weights the amount of pension plan investments by the proportion of time they are available to earn a return during that period. External cash flows are determined on a monthly basis and are assumed to occur at the beginning of each month. External cash inflows are netted with external cash outflows, resulting in a net external cash flow in each month. The money-weighted rate of return is calculated net of investment expenses.

	Net External Cash Flows	Periods Invested	Period Weight	Net External Cash Flows with Interest
Beginning Balance – July 1, 2016	$ 0	12	1.00	$ 0
Monthly Net External Cash Flows:				
July	0	11.5	0.96	0
August	0	10.5	0.88	0
September	0	9.5	0.79	0
October	0	8.5	0.71	0
November	0	7.5	0.63	0
December	23,330	6.5	0.54	23,330
January	6,615	5.5	0.46	6,615
February	6,615	4.5	0.38	6,615
March	5,278	3.5	0.29	5,278
April	733	2.5	0.21	733
May	2,199	1.5	0.13	2,199
June	1,466	0.5	0.04	1,466
Ending Value – June 30, 2017	$ 46,236			$ 46,236

Year Ending June 30	Money Weighted Investment Return
2017	0.00%
2016	n/a
2015	n/a
2014	n/a
2013	n/a
2012	n/a
2011	n/a
2010	n/a
2009	n/a
2008	n/a

EXHIBIT 8. NET PENSION LIABILITY

The Total Pension Liability was determined by an actuarial valuation as of the valuation date, calculated based on the discount rate and actuarial assumptions listed below and shown in Appendix B, and was then projected forward to the measurement date taking into account any significant changes between the valuation date and the fiscal year end as prescribed by GASB 67 and 68.

The liabilities are calculated using a discount rate that is a blend of the expected investment rate of return and a high quality bond index rate. The expected investment rate of return applies for as long as the plan assets (including future contributions) are projected to be sufficient to make the projected benefit payments. If plan assets are projected to be depleted at some point in the future, the rate of return of a high quality bond index is used for the period after the depletion date. Since there is no depletion date for this plan, the expected rate of return is used as the discount rate.

	June 30, 2017	June 30, 2016
Total Pension Liability	$ 42,389	$ 0
Fiduciary Net Position	46,236	0
Net Pension Liability	$ (3,847)	$ 0
Fiduciary Net Position as a % of Total Pension Liability	109.08%	n/a
Covered Payroll	$ 117,020	$ n/a
Net Pension Liability as of % of Covered Payroll	(3.29%)	n/a
Valuation Date	1/1/2017	1/1/2016
Measurement date	6/30/2017	6/30/2016
GASB 67 Reporting date	6/30/2017	6/30/2016
Depletion date	None	None
Discount rate	5.00%	5.00%
Expected rate of return, net of investment expenses	5.00%	5.00%
Municipal bond rate	n/a	n/a

	As of June 30, 2017		
Sensitivity Analysis	1% Decrease in Discount Rate 4.00%	Current Discount Rate 5.00%	1% Increase in Discount Rate 6.00%
Total Pension Liability	$ 49,811	$ 42,389	$ 36,037
Fiduciary Net Position	46,236	46,236	46,236
Net Pension Liability	$ 3,575	$ (3,847)	$ (10,199)

EXHIBIT 9. CHANGES IN NET PENSION LIABILITY

GASB 67 requires disclosure of the changes in the Net Pension Liability.

	Fiscal Year Ending June 30, 2017 Increase / (Decrease)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability
Balance as of Beginning of Year	$ 0	$ 0	$ 0
Service cost	$ 0	$ 0	$ 0
Interest on the total pension liability	0	0	0
Changes of benefit terms	42,389	0	42,389
Differences between actual and expected experience with regard to economic or demographic factors	0	0	0
Changes of assumptions	0	0	0
Benefit payments	0	0	0
Employer contributions	0	23,072	(23,072)
Employee contributions	0	23,164	(23,164)
Net investment income	0	0	0
Administrative expense	0	0	0
Total changes	$ 42,389	$ 46,236	$ (3,847)
Balance as of End of Year	$ 42,389	$ 46,236	$ (3,847)

EXHIBIT 10. SCHEDULE OF CHANGES IN NET PENSION LIABILITY

GASB 67 requires a 10-Year schedule of changes in the Net Pension Liability.

	June 30, 2017	June 30, 2016	June 30, 2015	June 30, 2014	June 30, 2013
Total Pension Liability - Beginning of Year	$ 0	$ n/a	$ n/a	$ n/a	$ n/a
Service cost	0	n/a	n/a	n/a	n/a
Interest on the total pension liability	0	n/a	n/a	n/a	n/a
Changes of benefit terms	42,389	n/a	n/a	n/a	n/a
Differences between actual and expected experience with regard to economic or demographic factors	0	n/a	n/a	n/a	n/a
Changes of assumptions	0	n/a	n/a	n/a	n/a
Benefit payments	(0)	n/a	n/a	n/a	n/a
Total changes	$ 42,389	n/a	n/a	n/a	n/a
Total Pension Liability - End of Year	$ 42,389	$ n/a	$ n/a	$ n/a	$ n/a
Fiduciary Net Position – Beginning of Year	$ 0	$ n/a	$ n/a	$ n/a	$ n/a
Employer contributions	23,072	n/a	n/a	n/a	n/a
Employee contributions	23,164	n/a	n/a	n/a	n/a
Net investment income	0	n/a	n/a	n/a	n/a
Benefit payments	(0)	n/a	n/a	n/a	n/a
Administrative expense	(0)	n/a	n/a	n/a	n/a
Total changes	$ 46,236	n/a	n/a	n/a	n/a
Fiduciary Net Position – End of Year	$ 46,236	$ n/a	$ n/a	$ n/a	$ n/a
Net Pension Liability - End of Year	$ (3,847)	$ n/a	$ n/a	$ n/a	$ n/a
Fiduciary Net Position as a % of TPL	109.08%	n/a%	n/a%	n/a%	n/a%
Covered Payroll	$ 117,020	$ n/a	$ n/a	$ n/a	$ n/a
Net Pension Liability as a % of Covered Payroll	(3.29%)	n/a%	n/a%	n/a%	n/a%

EXHIBIT 11. SCHEDULE OF CONTRIBUTIONS

GASB 67 requires disclosure of the Schedule of Employer Contributions.

Fiscal Year Ending June 30	Actuarially Determined Contribution	Actual Employer Contribution	Contribution Deficiency (Excess)	Covered Payroll	Contribution as a % of Covered Payroll
2008	N/A	N/A	N/A	N/A	N/A
2009	N/A	N/A	N/A	N/A	N/A
2010	N/A	N/A	N/A	N/A	N/A
2011	N/A	N/A	N/A	N/A	N/A
2012	N/A	N/A	N/A	N/A	N/A
2013	N/A	N/A	N/A	N/A	N/A
2014	N/A	N/A	N/A	N/A	N/A
2015	N/A	N/A	N/A	N/A	N/A
2016	N/A	N/A	N/A	N/A	N/A
2017	$ 13,950	$ 13,950	$ 0	$ 117,020	11.92%

The above schedule shows the applicable amounts for the calendar plan year ending within fiscal year, on which the Actuarially Determined Contribution is based.

EXHIBIT 12. DEPLETION DATE PROJECTION

GASB 67 and 68 generally require that a blended discount rate be used to measure the Total Pension Liability (the Actuarial Accrued Liability calculated using the Individual Entry Age Normal Cost Method). The long-term expected return on plan investments may be used to discount liabilities to the extent that the plan's Fiduciary Net Position (fair market value of assets) is projected to cover benefit payments and administrative expenses. A 20-year high quality (AA/Aa or higher) municipal bond rate must be used for periods where the Fiduciary Net Position is not projected to cover benefit payments and administrative expenses.

Determining the discount rate under GASB 67 and 68 will often require that the actuary perform complex projections of future benefit payments and asset values. GASB 67 and 68 (paragraph 29) do allow for alternative evaluations of projected solvency, if such evaluation can reliably be made. GASB does not contemplate a specific method for making an alternative evaluation of sufficiency; it is left to professional judgment.

The following circumstances justify an alternative evaluation of sufficiency for the Northern Inyo Healthcare District PEPRA Retirement Plan:

- The Actuarially Determined Contribution is based on a closed amortization period, which means that payment of the Actuarially Determined Contribution each year will bring the plan to a 100% funded position by the end of the amortization period.

- GASB 67 and 68 specify that the projections regarding future solvency assume that plan assets earn the assumed rate of return and there are no future changes in the plan provisions or actuarial methods and assumptions, which means that the projections would not reflect any adverse future experience which might impact the plan's funded position.

Based on these circumstances, it is our professional opinion that the detailed depletion date projections outlined in GASB 67 and 68 will show that the Fiduciary Net Position is always projected to be sufficient to cover benefit payments and administrative expenses.

EXHIBIT 13. CALCULATION OF PENSION EXPENSE

GASB 68 requires the calculation of the pension expense for fiscal years beginning on or after June 15, 2014.

Pension Expense	For the Fiscal Year Ending June 30, 2017	For the Fiscal Year Ending June 30, 2016
Service cost	$ 0	$ 0
Interest on the total pension liability	0	0
Effect of plan changes	42,389	0
Administrative expense	0	0
Employee contributions	(23,164)	(0)
Expected investment return, net of investment expenses	(1,142)	(0)
Recognition of Deferred Inflows/Outflows of Resources		
Economic/demographic (gains) or losses	0	0
Assumption changes or inputs	0	0
Investment (gains) or losses	$ 228	$ 0
Total Recognition	$ 228	$ 0
Pension expense	$ 18,311	$ 0

Deferred Inflows / Outflows of Resources	As of June 30, 2017 Deferred Inflows of Resources	As of June 30, 2017 Deferred Outflows of Resources
Differences between expected and actual experience	$ 0	$ 0
Changes of assumptions	0	0
Net difference between projected and actual earnings	914	0
Contributions made subsequent to measurement date	$ 0	$ 0
Total	$ 914	$ 0

Amounts currently reported as deferred inflows and outflows of resources related to pensions will be recognized in pension expense as follows:

Fiscal Year Ending June 30	Recognized Deferred Inflows/Outflows
2018	$ 228
2019	228
2020	228
2021	230
2022	0
Thereafter	0

EXHIBIT 14. SCHEDULE OF DEFERRED INFLOWS AND OUTFLOWS OF RESOURCES

Investment (gains)/losses are recognized in pension expense over a period of five years. Economic/demographic (gains)/losses and assumption changes or inputs are recognized over the average remaining service life for all active and inactive members.

Date Established	Original Amount	Original Recognition Period	Amount Recognized in Expense FYE 2017	Balance of Deferred Inflows 6/30/17	Balance of Deferred Outflows 6/30/17
Investment (gains) or losses					
6/30/2017	$ 1,142	5.0	$ 228	$ 0	$ 914
Economic/demographic (gains) or losses					
6/30/2017	$ 0	n/a	$ 0	$ 0	$ 0
Assumption changes or inputs					
6/30/2017	$ 0	n/a	$ 0	$ 0	$ 0

APPENDIX A. SUMMARY OF PENSION PLAN

The following paragraphs are only a brief summary of the more important provisions of the plan. In the event there are any inconsistencies between statements contained in this Appendix and the plan document, the provisions of the plan document shall control.

Effective Date: January 1, 2016.

Plan Eligibility: The CEO of the Northern Inyo Healthcare District.

Vesting: 100% vesting after 5 years of Credited Service, or upon total and permanent disability.

Normal Retirement Date: The first day of the month coinciding with or following the later of the Participant's attainment of age 62 or the 5th anniversary of participation.

Normal Retirement Benefit: 2% of Average Annual Compensation multiplied by years of Credited Service.

Average Annual Compensation: Average of compensation for the highest consecutive 36-month period preceding the determination date. Compensation is the normal monthly rate of pay or base pay of the employee paid in cash for services rendered on a full time basis during normal working hours. Compensation recognized by the plan may not exceed the limit specified by PEPRA, which is $118,775 for 2017.

Accrued Benefit: Normal Retirement Benefit based upon credited service to date.

Normal Form of Retirement Benefit: Life Annuity.

Early Retirement: Eligible beginning at age 52 with at least 5 years of credited service. The benefit rate is reduced by 0.025% for each calendar quarter early (0.1% per year). For example, the benefit rate is 1% for early retirement at age 52.

Postponed Retirement: For retirements after age 62, the benefit rate is increased by 0.025% for each calendar quarter postponed (0.1% per year), up to a maximum benefit rate of 2.5% for retirements at age 67 or later.

Pre-Retirement Death Benefit: If a vested participant dies prior to retirement, his or her beneficiary will receive the actuarial equivalent of his or her accrued benefit.

Employee Contributions: 50% of the normal cost rate, rounded to the nearest 0.25%.

APPENDIX B. ACTUARIAL COST METHOD AND ASSUMPTIONS

The following cost method and assumptions were used in valuing the benefits of all participants.

	January 1, 2017	January 1, 2016
Actuarial Cost Method	Entry Age Normal Cost Method	Entry Age Normal Cost Method
Form of Payment Election	100% are assumed to elect an annuity.	100% are assumed to elect an annuity.
Interest Rate		
Pre-retirement	5.00%	5.00%
Post-ret. (Annuity elected)	5.00%	5.00%
Mortality		
Pre-retirement	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2016	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2015
Post-ret. (Annuity elected)	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2016	RP-2014 Healthy Mortality with Generational Projection from 2006 Base Year using Scale MP-2015
Salary Scale	4.00%	4.00%
Inflation	2.50%	2.50%
Administrative Expenses	None	None
Disability		
Disablement Rate	None	None
Disabled Annuitants Mortality	N/A	N/A
Withdrawal Rates	None	None
Retirement Age	Age 65	Age 65
Asset Valuation Method	Market value	Market value

APPENDIX C. SUMMARY OF PARTICIPANT DATA

Active Participants as of January 1, 2017

	YEARS OF SERVICE							
Age	0-4	5-9	10-14	15-19	20-24	25-29	30+	Total
Under 25	0	0	0	0	0	0	0	0
25 - 29	0	0	0	0	0	0	0	0
30 – 34	0	0	0	0	0	0	0	0
35 - 39	0	0	0	0	0	0	0	0
40 - 44	0	0	0	0	0	0	0	0
45 - 49	0	0	0	0	0	0	0	0
50 - 54	1	0	0	0	0	0	0	1
55 - 59	0	0	0	0	0	0	0	0
60 - 64	0	0	0	0	0	0	0	0
65 - 69	0	0	0	0	0	0	0	0
70 & Over	0	0	0	0	0	0	0	0
Total	1	0	0	0	0	0	0	0

APPENDIX D. GLOSSARY OF KEY TERMS

Actuarial Accrued Liability. The Present Value of Future Benefits allocated to past service in accordance with the actuarial cost method.

Accumulated Benefit Obligation (ABO). The present value of benefits accrued as of the valuation date. The ABO includes both vested and nonvested benefits, but does not include the cost of additional service or compensation increases after the valuation date.

Actuarial Gains and Losses. Changes to the funded status due to deviations from the actuarial assumptions. The deviations may result from gains and losses from investments, employee turnover, disability, retirement, mortality, and administrative expenses.

Actuarially Determined Contribution. A target or recommended contribution to a defined benefit pension plan for the reporting period, determined based on the funding policy and most recent measurement available when the contribution for the reporting period was adopted.

Deferred Inflows/Outflows of Resources. Portion of changes in net pension liability that is not immediately recognized in Pension Expense. These changes include differences between expected and actual experience, changes in assumptions, and differences between expected and actual earnings on plan investments.

Fiduciary Net Position. Equal to market value of assets.

Funded Status. A comparison of the plan assets against liabilities for future benefits. The funded status will differ depending on which benefit liability is being compared. For example, the actuarial accrued liability can include the value of future compensation increases, but the present value of accumulated benefits does not. The funded status is also dependent on the interest rate used to discount future benefits back to the present.

Money-Weighted Rate of Return. The internal rate of return on pension plan investments, net of investment expenses.

Municipal Bond Rate. Yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher.

Net Pension Liability. Total Pension Liability minus the Plan's Fiduciary Net Position.

Normal Cost or Service Cost. The value of benefits earned for one year of service. The normal cost is calculated in accordance with the actuarial cost method. The accumulation of all normal costs assigned to past service equals the Actuarial Accrued Liability. The ABO normal cost is the increase in the ABO due to one additional year of service and one additional year of compensation increases.

Present Value of Accumulated Benefits. This is the same as the ABO.

Present Value of Future Benefits. The sum of all benefits expected to be paid in the future by the plan, with the payments discounted to the present using the valuation interest rate. This includes benefits to be earned in the future for current employees.

Present Value of Future Normal Cost. The sum of all future normal costs expected for current employees, with the costs discounted back to the present using the valuation interest rate.

Projected Benefit Payments. All benefits estimated to be payable through the pension plan to current active and inactive employees as a result of their past service and expected future service.

Total Pension Liability. The portion of actuarial present value of projected benefit payments that is attributable to past periods of member service using the Entry Age Normal cost method based on the requirements of GASB 67 and 68.

Vested Benefits. These include benefits to which a plan participant has earned a nonforfeitable right as a result of having satisfied the applicable service requirement(s) for such benefits under the plan, which include normal retirement benefits, early retirement benefits, and the pre-retirement spouse's survivor annuity.

NORTHERN INYO HEALTHCARE DISTRICT
RESOLUTION NO. 17-04

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT TO TRANSITION ALL DUTIES AND RESPONSIBILITES OF THE PERSONNEL PAYROLL ADVISORY COMMITTEE (PPAC) TO THE WORKFORCE COUNCIL

WHEREAS, the Board of Directors ("Board") of the Northern Inyo Healthcare District ("District") previously approved the Northern Inyo Healthcare District's Personnel Payroll and Advisory Committee (the "PPAC") on or about November of 1993; and

WHEREAS, guidelines were adopted on November 17, 1993 setting forth the mission, composition and functions of the PPAC;

WHEREAS, the Board approved establishing the Workforce Experience Committee and the Workforce Council on April 20, 2016 pursuant to the District's Quality Assurance and Performance Improvement (QAPI) Organizational Structure;

WHEREAS, the mission, vision and goals of the Workforce Experience Committee and the Workforce Council are substantially similar to those of the PPAC;

NOW, THEREFORE, be it resolved, determined, and ordered by the Board of Directors of the Northern Inyo Healthcare District as follows:

That, effective September 20, 2017, the Board approves the elimination of the PPAC and the transition of the mission and guidelines to the Workforce Experience Committee and the Workforce Council.

ADOPTED this 20th day of September, 2017.

_____

Peter Watercott, President
Northern Inyo Healthcare District Board of Directors

ATTEST:

Northern Inyo Healthcare District Board of Directors

NORTHERN INYO HEALTHCARE DISTRICT

DISTRICT BOARD RESOLUTION 17-05

WHEREAS, pursuant to Chapter 730 of the statutes of 1976 Section 16429.1 was added to the California Government Code to create a Local Agency Investment Fund in the State Treasury for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District does hereby find that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with the provisions of Section 16429.1 of the Government Code for the purpose of investment as stated therein as in the best interests of the Northern Inyo Healthcare District,

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of the Northern Inyo Healthcare District does hereby authorize the deposit and withdrawal of Northern Inyo Healthcare District monies in the Local Agency Investment Fund in the State Treasury in accordance with the provisions of Section 16429.1 of the Government Code for the purpose of investment as stated therein, and verification by the State Treasurer's Office of all banking information provided in that regard.

BE IT FURTHER RESOLVED by the Northern Inyo Healthcare District Board of Directors, meeting in regular session this 20th day of September, 2017 that the Chief Executive Officer Kevin S. Flanigan, MD, MBA, Chief Operating Officer, Kelli Huntsinger and Chief Financial Officer John Tremble, or their successors in office, shall be authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund.

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____ _____
Peter Watercott, President Date
Northern Inyo Healthcare District

Attest: _____ _____
M.C. Hubbard, Secretary Date
Northern Inyo Healthcare District

NORTHERN INYO HEALTHCARE DISTRICT

DISTRICT BOARD RESOLUTION 17-06

WHEREAS, pursuant to Chapter 932 of the statutes of 1933 was added to the California Government Code to create Health Care Districts; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District does hereby find that the deposit and withdrawal of money, the creation and maintenance of accounts for the operation of the Health Care District and its business entities as outlined in Section 1, Division 23, Article 2 of the Statute and,

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of Northern Inyo Healthcare District does hereby authorize the creation and maintenance of accounts for the deposit of monies and withdrawal of monies of Northern Inyo Healthcare District for the purpose of operating the business entities of the District and,

BE IT FURTHER RESOLVED by the Northern Inyo Healthcare District Board of Directors, meeting in regular session this 20th day of September, 2017 that the Chief Executive Officer Kevin S. Flanigan, MD, MBA; Chief Operating Officer, Kelli Huntsinger; and Chief Financial Officer John Tremble, or their successors in office, shall be authorized to operate accounts as listed in Addendum A and to create additional accounts as needed to meet the business needs of the Healthcare District in accordance with Section 1, Division 23, Article 2 of the California Chapter 932 Statute.

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____ _____
Peter Watercott, President Date
Northern Inyo Healthcare District

Attest: _____ _____
M.C. Hubbard, Secretary Date
Northern Inyo Healthcare District

NORTHERN INYO HEALTHCARE DISTRICT

DISTRICT BOARD RESOLUTION 17-07

WHEREAS, pursuant to Chapter 932 of the statutes of 1933 was added to the California Government Code to create Health Care Districts; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District does hereby find that the deposit and withdrawal of money, the creation and maintenance of accounts for the benefits and compensation of the employees of the Health Care District and its business entities as outlined in Section 1, Division 23, Article 2 of the Statute and,

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of the Northern Inyo Healthcare District does hereby authorize the creation and maintenance of accounts the deposit of monies and withdrawal of monies of Northern Inyo Healthcare District for the purpose of operating the business entities of the District and,

BE IT FURTHER RESOLVED by the Northern Inyo Healthcare District Board of Directors, meeting in regular session this 20th day of September, 2017 that the Chief Executive Officer Kevin S. Flanigan, MD, MBA; Chief Human Resources Officer, Evelyn Campos-Diaz; and Chief Financial Officer John Tremble, or their successors in office, shall be authorized to operate accounts as listed in Addendum A. and to create additional accounts as needed to meet the business needs of the Healthcare District in accordance with Section 1, Division 23, Article 2 of the California Chapter 932 Statute.

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____ _____

Peter Watercott, President Date
Northern Inyo Healthcare District

Attest: _____ _____

M.C. Hubbard, Secretary Date
Northern Inyo Healthcare District

CALL TO ORDER	The meeting was called to order at 5:30 pm by John Ungersma MD, Vice President.
PRESENT	John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer Phil Hartz, Member at Large Kevin S. Flanigan MD, MBA, Chief Executive Officer Kristina Gritsutenko, Chief Financial Officer Carrie Petersen, Chief Accounting Officer Evelyn Campos Diaz, Chief Human Resources Officer Sandy Blumberg, Executive Assistant
ABSENT	Peter Watercott, President Richard Meredick MD, Chief of Staff Kelli Huntsinger, Chief Operating Officer Tracy Aspel RN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma asked if any members of the public wished to speak on any items not on the agenda on any matters within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. Comments were heard from Pat West with Pioneer Home Health, who updated the Board on the services that Pioneer provides for this community.
NEW BUSINESS	
LABORATORY POLICY AND PROCEDURE APPROVALS	Chief Executive Officer Kevin S. Flanigan, MD, MBA called attention to the following Laboratory Department policies and procedures: - *Gastric Occult Blood Testing* - *Hemoccult Sensa – Fecal Occult Blood* It was moved by M.C. Hubbard, seconded by Mary Mae Kilpatrick, and unanimously passed to approve both Laboratory policies and procedures as presented.
EMERGENCY PAGING POLICY AND PROCEDURE	Doctor Flanigan also called attention to a hospital wide policy and procedure titled *Emergency Paging*. It was moved by Ms. Kilpatrick, seconded by Phil Hartz, and unanimously passed to approve the *Emergency Paging* policy and procedure as presented.
POLICY AND PROCEDURE ANNUAL APPROVALS	Doctor Ungersma called attention to a list of hospital wide policies and procedures presented for annual approval, as listed on Attachment A to the agenda for this meeting. It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve all policies and procedures listed on Attachment A to the agenda as presented.

BOARD RESOLUTION 17-03	Doctor Flanigan called attention to District Board Resolution 17-03 which authorizes the Chief Executive Officer and Chief Financial Officer to deposit or withdrawal monies from the Local Agency Investment Fund (LAIF). The purpose of the Resolution is to replace outgoing Chief Accounting Officer Carrie Petersen as the person authorized to make LAIF fund transactions, in preparation for her retirement in the month of October. It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve District Board Resolution 17-03 as presented.
CONSENT AGENDA	Doctor Ungersma called attention to the Financial and Statistical Reports for the period ending June 30 2017, requesting that they be removed from the consent agenda and added to the Chief Financial Officer (CFO) report for this meeting. It was moved by Mr. Hartz, seconded by Ms. Kilpatrick, and unanimously passed to approve moving the Financial and Statistical Reports for the period ending June 30 2017 off the consent agenda to include them as part of the Chief Financial Officer report for this meeting. Doctor Ungersma then called attention to the remaining 2 items listed on the Consent Agenda for this meeting: - *Approval of the minutes of the July 19 2017 regular meeting* - *2013 CMS Validation Survey Monitoring, August 2017* It was moved by Mr. Hartz, seconded by Ms. Kilpatrick, and unanimously passed to approve both consent agenda items as presented.
DATA AND INFORMATION COMMITTEE REPORT	Doctor Flanigan introduced Chief Financial Officer Kristina Gritsutenko as the new chairperson of the District's Data and Information Committee. Ms. Gritsutenko provided a Data and Information (D&I) Committee report which included stating that the D & I Committee will join forces with the Athena Implementation group to focus on the District's transition from the McKesson health information system to the AthenaHealth product.
QUARTERLY COMPLIANCE REPORT	Compliance Officer Patty Dickson provided a Quarterly Compliance Report, which included a comprehensive Compliance Program review including a summary of breaches, audits, and Compliance Department projects.
CHIEF EXECUTIVE OFFICER REPORT	Doctor Flanigan reviewed Medical Staff Administration Pillars of Excellence for July 1 2016 through June 30 2017, which will be provided on a quarterly basis going forward.
CHIEF OPERATING OFFICER REPORT	On behalf of Chief Operating Officer Kelli Huntsinger, Doctor Flanigan reported that the NIHD Lab recently underwent a Joint Commission survey, and was re-accredited as a result. He additionally noted that the NIHD Quality Department now reports to Ms. Huntsinger, and reported that the Dietary Department is implementing improvements to hospital food services.

CHIEF FINANCIAL OFFICER REPORT

Chief Financial Officer Kristina Gritsutenko reviewed the preliminary financial and statistical reports for the year ending June 30 2017, and noted the following:

- Wipfli LLP is on site this week to conduct the District's annual audit. The financial and statistical reports presented today will be adjusted as a result of their findings and some changes have already been made since the initial reports were published.
- The statement of operations for the fiscal year ending (FYE) 6/30/17 shows a significant loss for the year, and it appears that the loss may be adjusted even further to the negative. Significant negative adjustments have already been made relating to the employee pension plan and tax revenue adjustments.
- Gross patient revenue was under budget for the year and appears to be trending downward.
- Total expenses were over budget for the year by approximately 1 million dollars. Increases were also seen in bad debt and charity care, and inventory on hand seems very high.
- The District's overall financial picture has deteriorated significantly from the previous year. Leadership will address this immediately and determine if strategic changes need to be made.

At the conclusion of the financial report it was noted that budget workshops with the Board of Directors will likely be scheduled in the upcoming months. The Board indicated that philosophically, they are interested in expanding services rather than contracting them in order to improve the District's financial picture. It was then moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the preliminary financial and statistical reports for the period ending June 30 2016, with the understanding that they will be adjusted as a result of the District's annual audit.

CHIEF NURSING OFFICER REPORT

On behalf of Chief Nursing Officer Tracy Aspel RN, Doctor Flanigan reported the following:

- The District is implementing additional safety procedures involving patient IV's in order to prevent dirty needle sticks
- The District's Medication Errors Reduction Plan (MERP) is helping to reduce incidents of medication errors

CHIEF HUMAN RELATIONS OFFICER REPORT

Chief Human Relations Officer Evelyn Campos provided a bi-monthly Human Relations department report which included the following:

- Results of the Employee Satisfaction Survey are being rolled out to District employees
- 18 action plans have been put in place to engage the District workforce
- Consideration is being given to combining the PPAC and Workforce Experience Committees into one group

CHIEF OF STAFF REPORT

On behalf of Chief of Staff Richard Meredick, MD, Doctor Flanigan reported following careful review, consideration, and approval by the

appropriate Committees the Medical Executive Committee recommends approval of the following hospital wide Policies, Procedures, Protocols, and order sets:

POLICIES, PROCEDURES, PROTOCOLS, AND ORDER SETS

- *Childbirth Photography/Videotaping*
- *Plan to Eliminate or Substantially Reduce Medication-Related Errors – MERP 2017*
- *Anesthesia in Ancillary Departments*
- *Hydrotherapy Pool Lippincott Procedure with Critical Notes and Consent*
- *Fall Prevention and Management (with attachments)*
- *Patient Transfer/Discharge to Another Facility*
- *Medical Staff and Allied Health Professional Application Fee Processing*

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve all seven Policies, Procedures, Protocols, and order sets as presented.

CORE PRIVILEGE FORMS BY SERVICE

Doctor Flanigan additionally reported that the Medical Executive Committee also recommends approval of the following Core Privilege Forms by Service:

- *Pediatrics*
- *Orthopedic Surgery*
- *General Surgery*

It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and passed to approve all three Core Privilege Forms by Service, with Director Hartz abstaining from the vote.

ANNUAL REVIEW, PEDIATRIC CRITICAL INDICATORS

Doctor Flanigan also reported the Medical Executive Committee recommends annual approval of the *Pediatric Critical Indicators for 2017*. It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve the *Pediatric Critical Indicators for 2017* as presented.

MEDICAL STAFF APPOINTMENT/ PRIVILEGING

Doctor Flanigan then reported the Medical Executive Committee recommends Medical Staff Appointment and Privileging of Arash Radparvar MD (*radiology – provisional active staff*). It was moved by Mr. Hartz, seconded by Ms. Kilpatrick, and unanimously passed to approve the privileging of Arash Radparvar MD as recommended.

MEDICAL STAFF TEMPORARY PRIVILEGES

Doctor Flanigan additionally reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Temporary Privileges for 60 service days in calendar year 2017 (except where noted):

- William Feske, MD (*Bishop Radiology Group*) – 90 calendar days
- Brian Mikolasko, MD (*hospitalist – locums*)
- Kathy Burch, MD (*hospitalist – locums*)
- Louisa Salisbury, MD (*Pediatrics – locums*) – pending the submission of proof of insurance

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve all four temporary privileges as requested.

EXTENSION OF TEMPORARY PRIVILEGES

The Medical Executive Committee additionally recommends extension of temporary privileges for Wilbur Peralta, MD (*hospitalist*) from 8/31/17 to 12/31/17 to provide necessary coverage of the hospitalist service. It was moved by Mr. Hartz, seconded by Ms. Kilpatrick, and unanimously passed to approve the extension of temporary privileges for Wilbur Peralta MD as requested.

MEDICAL STAFF ADVANCEMENT

Doctor Flanigan also reported the Medical Executive Committee recommends advancement from provisional to full active staff for Jay K. Harness MD (*breast surgery*). It was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve the Medical Staff advancement of Jay K. Harness MD as requested.

MEDICAL STAFF RESIGNATIONS

Doctor Flanigan additionally reported the Medical Executive Committee recommends approval of the following Medical Staff resignations:

- Carolyn Saba, MD (*anesthesiology*) – effective 7/26/17
- Shruti Ramakrishna, MD (*family medicine*) – effective 9/5/17
- Manish Pandya, MD (*internal medicine/hospitalist*) – effective 9/1/17

It was moved by Mr. Hartz, seconded by Ms. Hubbard, and unanimously passed to approve all three Medical Staff resignations as requested.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to report on any items of interest. Director Hubbard reported she is pleased to hear that same day visits at the Rural Health Clinic are going well, and Jennifer Figueroa PA who provides those services is being well received by the community. Director Ungersma also commented that the District may want to look into the possibility of obtaining a USDA (United States Department of Agriculture) loan in order to fund construction of a new Rural Health Clinic building. No other comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 7:07 pm Doctor Ungersma announced the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 2 matters pending (*pursuant to Government Code Section 54956.9*).
C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*).

D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:09 pm the meeting returned to open session. Doctor Ungersma reported that the Board took action to settle one pending litigation.

ADJOURNMENT

The meeting adjourned at 8:10pm.

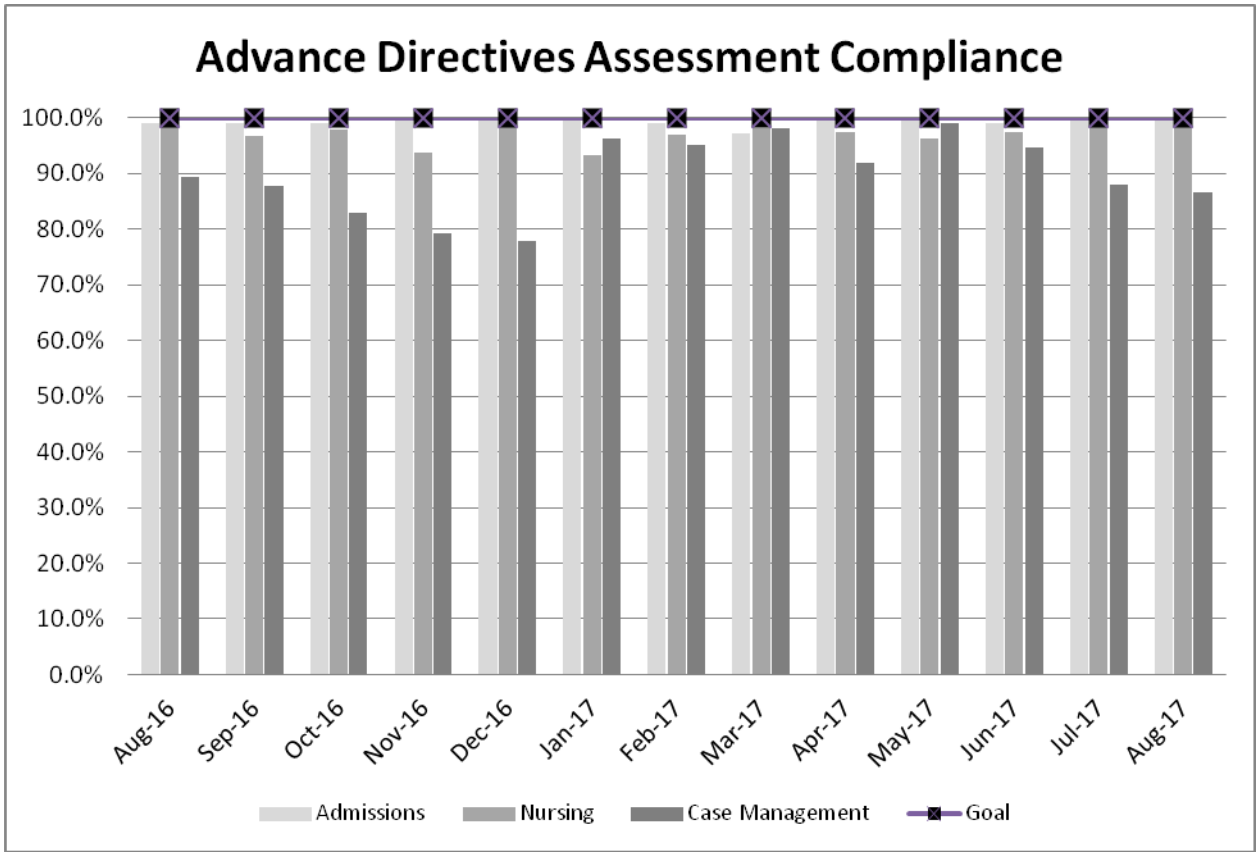
_____
John Ungersma MD, Vice President

Attest: _____
M.C. Hubbard, Secretary

2013 CMS Validation Survey Monitoring-August 2017

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

    a. Advance Directives Monitoring.

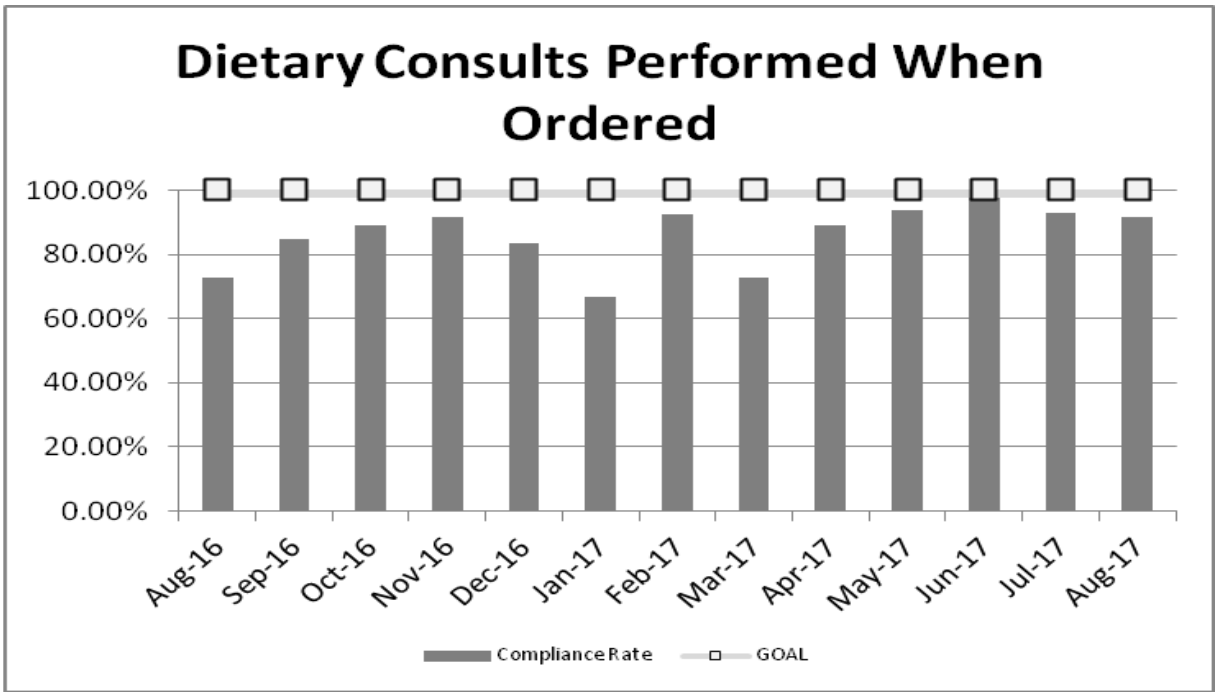


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

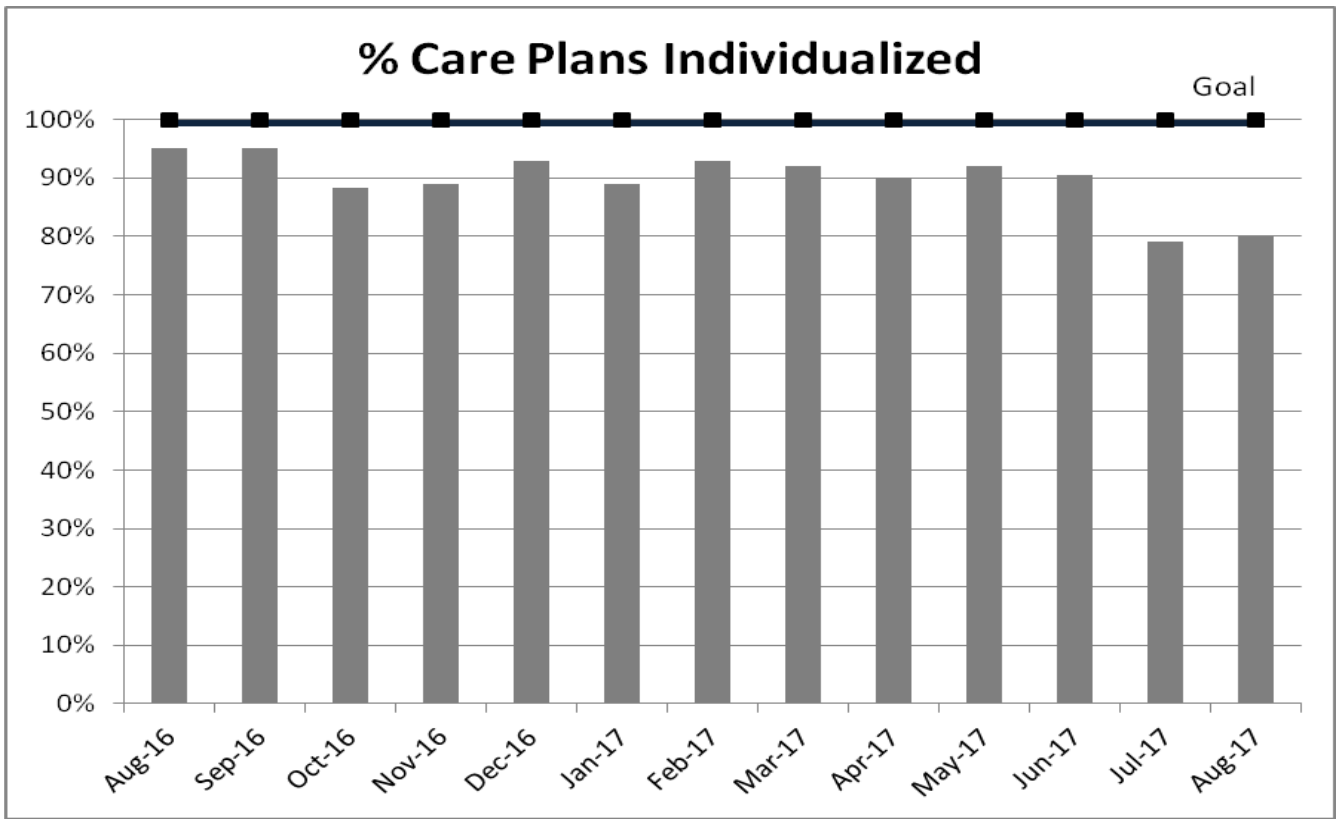
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.

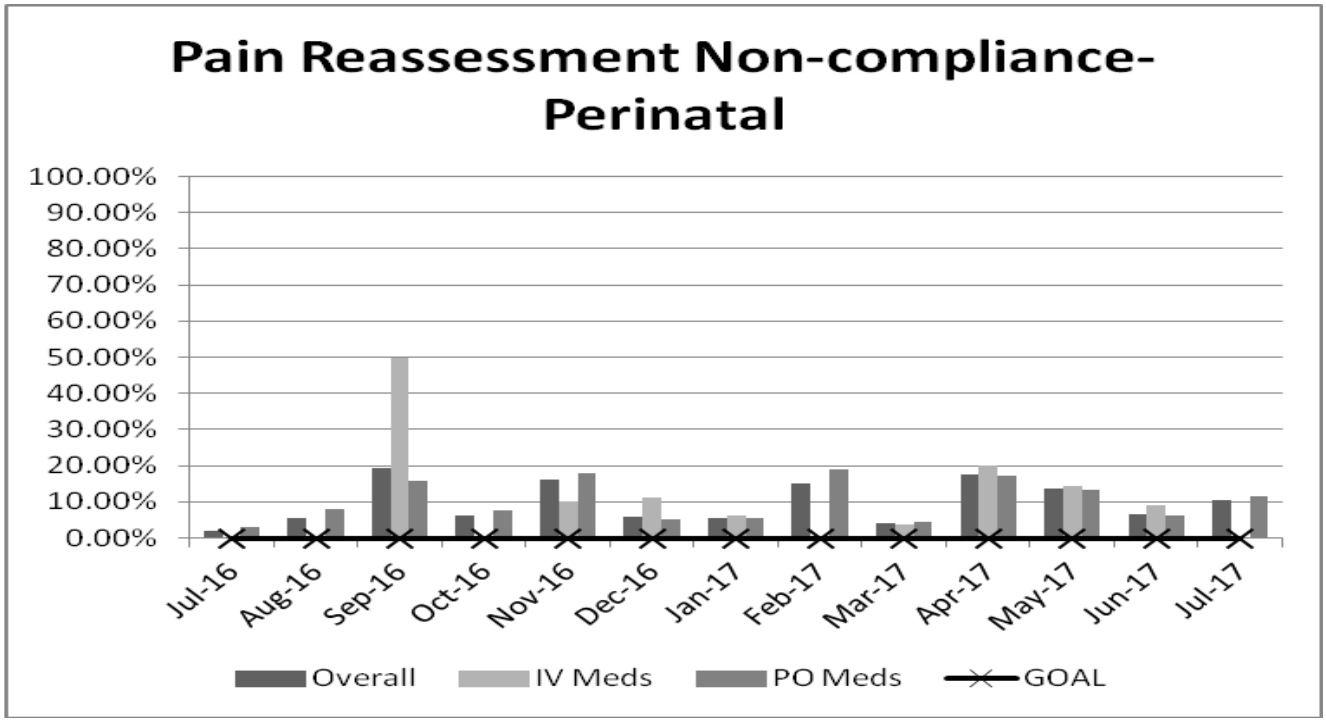


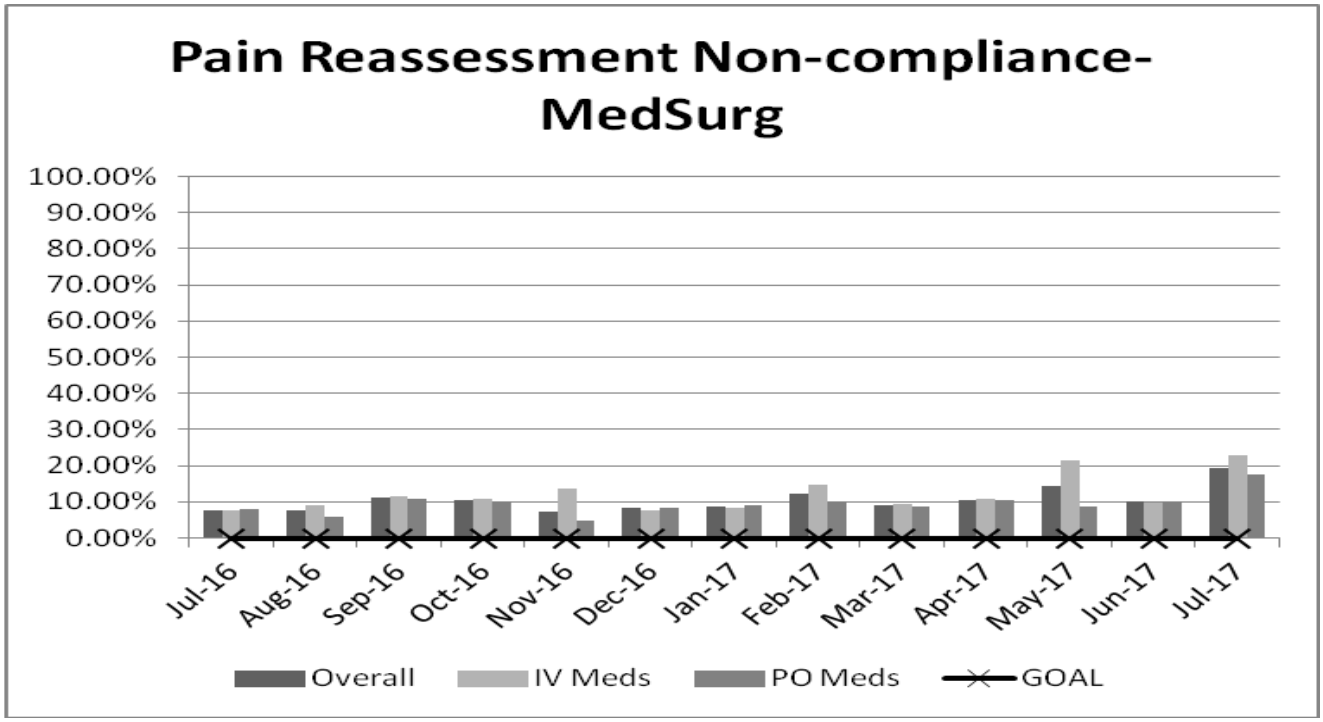
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

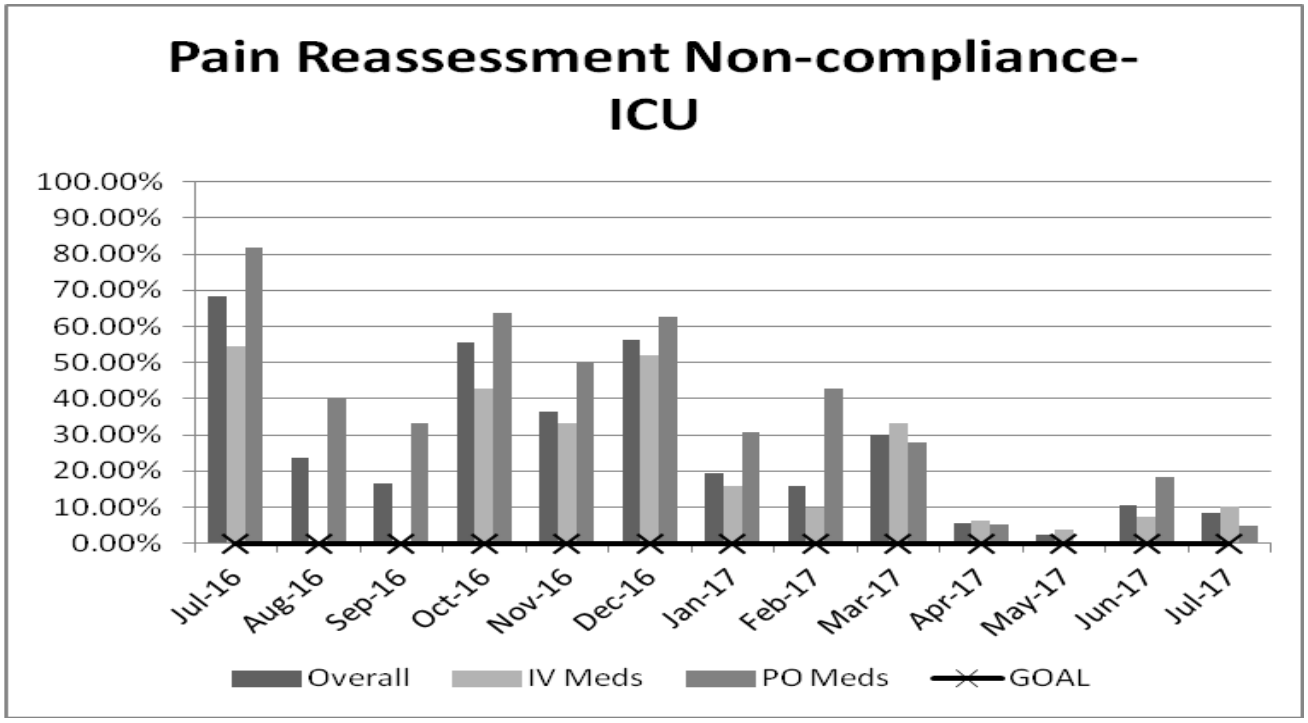


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

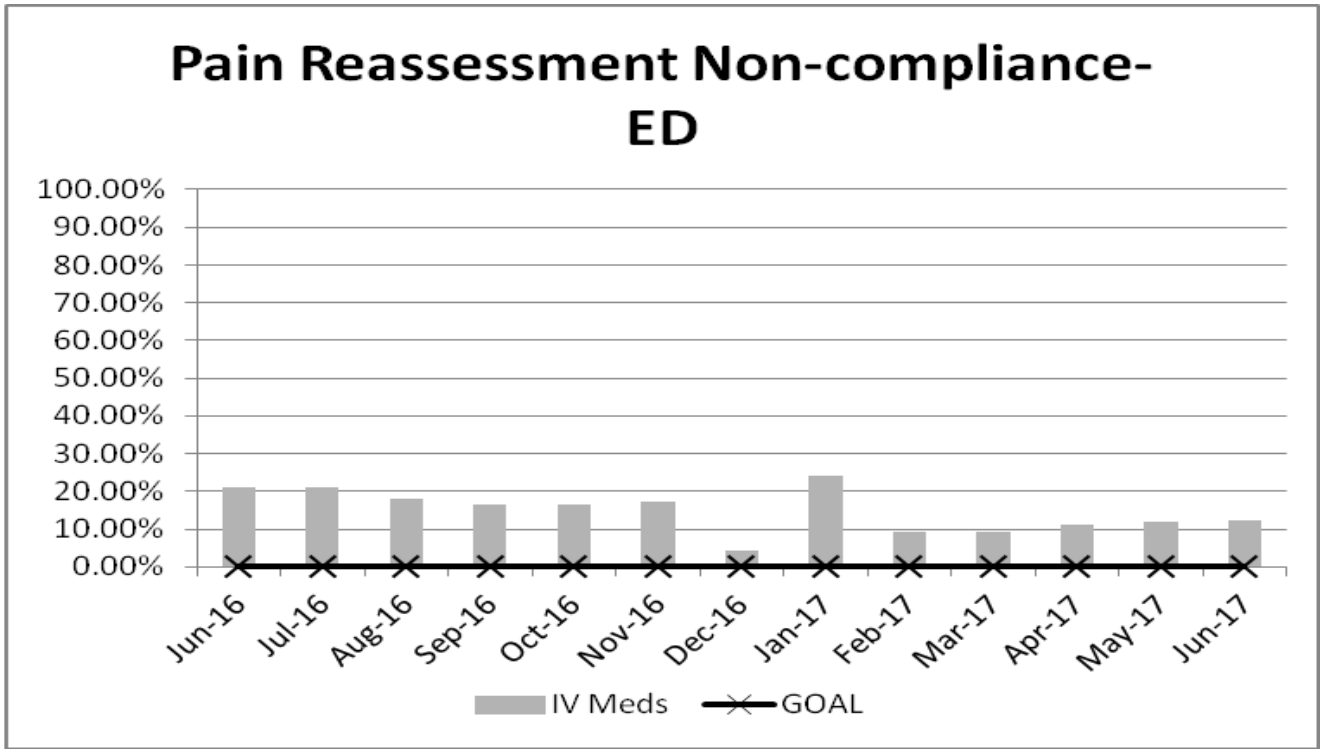
h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.







Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.



*ED July 2017 data not reported

Table 6. Restraint chart monitoring for legal orders.

	Jan 2017	***Feb 2017***	***March 2017***	***April 2017****	***May 2017***	***June 2017***	***July 2017***	***Aug 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	2/2 (100%	1/1 (100%)	1/1 (100%)		2/2 (100%)	2/2 (100%)	3/3 (100%)	3/3 (100%)	100%
Physician signed order within 24 hours	½ (50%)	1/1 (100%)	0/1 (0%)		2/2 (100%)	2/2 (100%)	3/3 (100%)	2/3 (66%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	0/2 (0%)	1/1 (100%)	0/1 (0%)		2/2 (100%)	1/2 (50%)	3/3 (100%)	1/3 (33%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	3/9 (33%)	0/1 (0%)	0/1 (0%)		0/1 (0%)	3/3 (100%)	2/5 (40%)	2/8 (25%)	100%
Orders are for 24 hours	11/11 (100%)	2/2 (100%)	2/2 (100%)		3/3 (100%)	5/5 (100%)	8/8 (100%)	11/11 (100%)	100%
Is this a PRN (as needed) Order	0/11 (0%)	0/2 (0%)	0/2 (0%)		0/3 (0%)	0/5 (0%)	0/8 (0%)	0/11 (0%)	0%

*No restraint orders for this time interval

NORTHERN INYO HEALTHCARE DISTRICT

Hospital-Wide Pillars of Excellence: FY July 1, 2016-June 30, 2017

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. Avatar RHC- % Top Box Overall score	**75.28 Below Average**	**85.0 Better Than Most**	**78.10 Below Average**	**75.5 Below Average[1]**	**75.0 Below Average[1]**	**68.6 Below Average[1]**	**73.0 Below Average[1]**
b. Avatar Emergency Department-Overall score % Top Box	**78.20 Above Average**	**85.0 Better Than Most**	**73.28 Below Average**	**69.8 Below Average [2]**	**75.1 About Average[2]**	**72.8 Below Average[2]**	**71.7 Below Average[2]**
c. HCAHPS Perinatal- % Top Box Overall score	**72.64 Below Average**	**85.0 Better Than Most**	**68.65 Below Average**	**62.5 Below Average[3]**	**78.6 Best in Class[3]**	**75.8 Above Average[3]**	**75.4 Above Average[3]**
d. HCAHPS MedSurg- % Top Box Overall score	**75.86 About Average**	**85.0 Better Than Most**	**74.52 About Average**	**67.5 Below Average[4]**	**70.4 About Average[4]**	**61.2 Below Average[4]**	**66.4 Below Average[4]**
Note: Q1 data is bases on three months due to switch from Avatar to Press Ganey. Data for the Perinatal Unit for Q1 and Q2 should be interpreted with caution due to small sample size. YTD is based on data from Q2, Q3 and Q4 due to transition to Press Ganey. 1. Peer Comparison = All PG Medical Practice Groups. 2. Peer Comparison= Hospitals with 10,000 or less visits/year. 3. Peer Comparison= Hospitals with 20-30 Beds. 4. Peer Comparison= Hospitals with 20-30 Beds.							
Quality							
Adverse Drug Events-Anticoagulants*	**2/44 (4.5%)**	**0**	**1/2 (50%)**	**0/4 (0%)**	**0/10 (0%)**	**0/6 (0%)**	**1/22 (4.5%)**
1. Surgical Site Infections*,[1]	**5/1104 (0.45%)**	**0**	**2/312 (0.64%)**	**3/348 (0.86%)**	**2/362 (.20%)**	**2/398 (.5%)**	**9/1420 (0.63%)**
2. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*	**0/155 (0)**	**0**	**0/79 (0)**	**0/60 (0)**	**0/66 (0)**	**0/47 (0%)**	**0/252 (0)**
3. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*	**0/579 (0)**	**0**	**1/180 (5.55)**	**0/189 (0)**	**0/159 (0)**	**0/183 (0%)**	**1/711 (.14%)**
4. Ventilator Associated Pneumonia*	**0/36 (0%)**	**0**	**0/3 (0%)**	**0/5 (0%)**	**0/9 (0%)**	**0/5 (0%)**	**0/22 (0%)**
5. Falls With Injuries (Per 1000 Patient Days)*	**3/4394 (0.68)**	**0**	**0/943 (0)**	**1/707 (1.41)**	**1/804 (1.24)**	**1/802 (1.24%)**	**3/3256 (0.92%)**
6. 30 Day Readmission Rate (Inpatient)*	**64/1181 (5.4%)**	**<15%**	**10/324[2] (3.1%)**	**7/277 (2.5%)**	**2/281 (0.7%)**	**10/286 (7%)**	**29/1168 (2.4%)**
*Note: Baseline period for these metrics is FY 15-16. 1. SSI National average is about 2.0%. 2. Correction was made in denominator for this data.							
People							
1. Overall Turnover Rate, 3	**89/491 (18.13%)**	**<15%**	**21/432 (4.86%)**	**21/441 (4.76%)**	**14/446 (3.14%)**	**18/457 (3.94%)**	**74/513 (14.42%)**
2. Total Recordable Incident Rate (OSHA) per 100 employees-Modified**, 3	**37/407 (9.09)**	**0**	**14/414 (3.38%)**	**3/416 (0.72%)**	**24/432 (5.56%)**	**11/439 (2.51%)**	**52/425 (12.24%)**
3.Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio	**2.87**	**>2.0**	**2.27**	**3.16**	**3.46**	**3.58**	**3.12**
2. Days Cash on Hand-Short Term Sources	**82**	**>75**	**85**	**72**	**77**	**77**	**78**
3. Debt Service Coverage Ratio	**2.43**	**>1.5-2.0**	**2.67**	**2.30**	**2.16**	**1.89**	**2.26**
4. A/R Days (Inpatient & Outpatient)	**65**	**<60**	**76**	**76**	**81**	**84**	**79**

LEGEND	
	Best-in-Class Performance, Exceeds Goal
	Above Average, Meets Goal
	About Average, Does Not Meet Goal
	Below Average, Does Not Meet Goal

Important General Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero. For example, on Surgical Site infections for Quarter 1, FY 15-16, we did not meet our goal of zero defects, but are still outperforming most of the country with an infection rate of 4 times LOWER than the national average of 2.0%.
2. Patient Satisfaction/Patient Experience-For each department the Top Box Percentile Rank for the chosen Peer Comparison groups was used to classify the performance category based on the following cut points; 90-100 Best in Class (Blue), 75-89 Above Average (Green), 50-74 About Average (Yellow), ≤49 Below Average (Red). It is recommended that specific performance dimensions be further assessed by area leadership to identify specific opportunities for improvement.

Rev. 9/1/17 krb

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

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

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Richard Meredick, MD, Chief of Medical Staff
DATE: September 5, 2017
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:

1. **Policy/Procedure/Protocols/Order Sets (*action items*)**
   - *Patient Food From Non-Hospital Sources*
   - *Aerosolized Transmissible Disease Plan*
   - *Trophon® Environmental Probe Reprocessor (EPR)*
   - *Guidelines for Management of Health Care Providers with HEB, HEPC and/or HIV*
   - *Thrombolytic Therapy with Alteplace (tPA) for an Acute Ischemic Stroke (with attachments)*
   - *Suspicious Injury Reporting Policy*
   - *Elder and Dependent Adult Abuse*
   - *Use of Hospital-Issued Notice of Noncoverage HINN (with four attachments)*
   - *Surgery Scope of Service*
   - *Scope of Service - PACU*

2. **Temporary Staff Update (*information items*)**

   The following practitioners have been approved for temporary privileges through the expedited process as described in the Medical Staff bylaws to provide necessary coverage of patient care needs. The Service Chiefs, Chair of the Credentials Committee, Chief of Staff, and Administrator have reviewed and approved privileges for a maximum of 60 service days in the 2017 calendar year.

   - Amik Reen, MD (temporary hospitalist)
   - Naomi Lawrence-Reid, MD (temporary pediatrician)
   - Truong Quach, MD (temporary hospitalist)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient food from non-hospital sources	
Scope: Inpatient Services	Manual:
Source: Clinical Dietician	Effective Date:

PURPOSE: To identify the process for storing patient food brought in from non-hospital sources.

POLICY:

1. Patients diets requires a physician's order
2. ~~Special diets~~ Patients/residents may not have food brought in from non-hospital sources unless there is approval from the patient's physician via a "special diet order" and a detail note stating "foods from outside facility".
3. NIH shall consider patient's food preferences, and special food needs will be provided, if possible: by the Nutritional Services Department.
4. When special food requests can only be met by bringing "food from the outside", it should be handled in a safe and sanitary manner.

PROCEDURE:

1. Food and nutrition products brought in by patients and families shall be evaluated by the patient's nurse, shall be clearly labeled and dated, and shall be stored using proper sanitation, temperature, light, moisture, ventilation and security.
   a. ~~Any food brought in from the outside shall be labeled with patient's name, date and room number, and held in the refrigerator specifically designated for patient food, for 48 hours only.~~
   a. Nurses shall document external foods and %PO intake in note section of input/output.
2. Perishable food brought from the outside (i.e., not provided by NIH's Nutritional Services Department) should be consumed within two (2) hours of un-refrigerated time or thrown away at the 2 hour mark in effort to prevent food borne illness.
3. ~~Any perishable foods must be thrown away after two (2) hours of un-refrigerated time.~~ If there is any question of how long a food item has been un-refrigerated, it must be thrown away.
4. Exceptions to this rule are unopened individual containers of pudding, supplements, juices and fruit. After opening, they are perishable. Foods such as fresh fruit, crackers and cookies are generally regarded as safe.

Comment [LA1]: We do not have patient refrigerators. There for, we do not store patient food. All food needs to be thrown away after 2 hours.

REFERENCES:

1. TJC (March 2013) CAMCAH Provision of Care Standard PC 02.02.03 The CAH hospital makes food and nutrition products available to its patients EP 11 CAH stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

CROSS REFERENCE P&P:

1. Food Storage

Approval	**Date**
CCOC	6/5/17
Infection Control Committee	8/22/17
MEC	9/5/17
Board of Directors	
Last Board of Director review	

Developed: 5/17 la
Reviewed:
Revised:

1

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient food from non-hospital sources	
Scope: Inpatient Services	Manual:
Source: Clinical Dietician	Effective Date:

Supersedes: Patient Nourishment and Outside Food in the Hospital

Comment [LA2]: Needs to be archived

2

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

~~NORTHERN INYO HOSPITAL~~
~~EXPOSURE CONTROL PLAN~~

PURPOSE:

Title 8, California Code of Regulations, General Industry Safety Orders, Section 5199 (CCR, GSO, Title 8, 5199) requires that employers' procedures for complying with the regulation be documented in writing and made available to all employees for review and training.

PLAN:

Northern Inyo Healthcare District (NIHD) will provide a safe and healthy workplace environment by implementing an effective Aerosolized Transmissible Diseases (ATD) Exposure Control Plan. This ATD Exposure plan applies to the control of exposures to ATD's for high risk employees that may have a potential to an ATD exposure due to work environment and job tasks. This plan focuses on safe work practices, personal protective equipment (PPE), engineering and administrative controls, and vaccinations of employees.

OVERVIEW[nh1]**:**

The goal of the ~~respiratory protection program exposure control plan~~ for Aerosolized Transmissible Disease (ATD) is to eliminate or minimize health care worker (HCW) exposure to any respiratory aerosol transmissible ~~(RAT)~~[RC2] diseases, which are particles of respiratory secretions from the nose or mouth. Some diseases that are transmitted by respiratory aerosols may or may not manifest primarily with respiratory symptoms. Although there are many infectious diseases that may be transmitted by respiratory aerosols, this standard is meant to address diseases that cause significant morbidity and mortality and represent a significant threat to HCWs and to the health of the community. Examples of diseases in this category include:

- Pandemic Influenza
- Tuberculosis
- Pneumonic Plague
- Severe Acute Respiratory Syndrome (SARS)
- Middle East Respiratory Syndrome (MERS)
- Smallpox
- New diseases (novel) or syndromes not previously recognized

~~This plan focuses on safe work practices, personal protective equipment (PPE), engineering and administrative controls, and vaccinations of employees.~~

POLICY:

Northern Inyo Hospital will establish, implement, and maintain an effective, written ATD Exposure Control Plan[nh3] as specified by Cal/OSHA's State Standard, Title 8, and Chapter 4. This plan will be followed by all Northern Inyo Healthcare ~~District Hospital~~ HCWs and others working within this facility who may be potentially exposed to respiratory aerosol transmissible ~~RATs.~~

AEROSOLIZED TRANSMISSIBLE DISEASES EXPOSURE CONTROL PLAN:

The[nh4] Infection Preventionist will be responsible for administering this plan and maintenance of infection control procedures to control the risk of transmission of ATDs. The[nh5] Employee Health

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

Nurse and ~~Infection~~the Infection Preventionist will do this with the collaboration of Directors of Maintenance[nh6], Nursing-, Environmental Services, Cardiopulmonary, -and Safety. The plan will be reviewed annually by the program administrator, and by ~~employees~~employees ~~regarding the effectiveness of the program~~ in their respective work areas[nh7]. The changes and review will be documented.

EXPOSURE RISK ~~CATEGORIES~~PERSONNEL THAT REQUIRE FIT TESTING

1. Admission Services (Outpatient Clerks, e.g. ED, RHC) Exceptions: Admission Services Director; Insurance Verifier; Radiology Clerks	~~9~~8. Pharmacy (In case of a surge; pharmacy staff normally doesn't have direct patient care)
2. Nursing Department (RNs, LVNs, CNAs, Medical Office Assistants) Case Managers-RNs	~~10~~9. ~~Physical Therapists~~Rehabilitation Department
3. Environmental Services	~~11~~10. ~~Respiratory Cardio Pulomonary Therapy~~
4. ~~EKG Department~~Physicians	~~12~~11. Radiology Department
5. Laboratory Clinical Staff	~~13~~12. Security
6. Language Services- Director and Interpreters	~~14~~13. Social Services
7. Maintenance/Plant Operations	~~15.~~14. Students (if there is potential for patient contact)
~~8. Nursing Department (RNs, LVNs, CNAs, Medical Office Assistants)~~	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

DEFINITIONS:

Accredited laboratoryy. A laboratory that is licensed by the CDPH pursuant to Title 17 of the California Code of Regulations (CCR), or which has received a certification of competence based on participation in a quality assurance program administered by a governmental or private organization that tests and certifies laboratories.

Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP). A disease or pathogen for which droplet or airborne precautions are required, as listed in Appendix A.

Aerosol transmissible pathogen -- laboratory (ATP-L). A pathogen that meets one of the following criteria: (1) the pathogen appears on the list in Appendix D, (2) the Biosafety in Microbiological and Biomedical Laboratories (BMBL) recommends ~~biosafety~~Biosafety level 3 or above for the pathogen, (3) the biological safety officer recommends ~~biosafety~~Biosafety level 3 or above for the pathogen, or (4) the pathogen is a novel or unknown pathogen.

Airborne infection isolation (AII). Infection control procedures as described in Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. These procedures are designed to reduce the risk of transmission of airborne infectious pathogens, and apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

Airborne infection isolation room or area (AIIR). A room, area, booth, tent, or other enclosure that is maintained at negative pressure to adjacent areas in order to control the spread of aerosolized *M. tuberculosis* and other airborne infectious pathogens and that meets the requirements stated in subsection (e)(5)(D) of this standard.

Airborne infectious disease (AirID). Either: (1) an aerosol transmissible disease transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which AII is recommended by the CDC or CDPH, as listed in Appendix A, or (2) the disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Airborne infectious pathogen (AirIP). Either: (1) an aerosol transmissible pathogen transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the infectious agent, and for which the CDC or CDPH recommends Airborne Infection Isolation, as listed in Appendix A, or (2) a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that it is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Biological safety officer(s). A person who is qualified by training and/or experience to evaluate hazards associated with laboratory procedures involving **Aerosol transmissible pathogen -- laboratory**~~ATPs-L~~, who is knowledgeable about the facility ~~biosafety~~Biosafety plan, and who is authorized by the employer to establish and implement effective control measures for laboratory biological hazards.

Biosafety level 3. Compliance with the criteria for laboratory practices, safety equipment, and facility design and construction recommended by the CDC in Biosafety in Microbiological and Biomedical Laboratories for laboratories in which work is done with indigenous or exotic agents with a potential for aerosol transmission and which may cause serious or potentially lethal infection.

Biosafety in Microbiological and Biomedical Laboratories (BMBL). Biosafety in Microbiological and Biomedical Laboratories, Fifth Edition, CDC and National Institutes for Health, 2007, which is hereby incorporated by reference for the purpose of establishing ~~biosafety~~Biosafety requirements in laboratories.

CDC. United States Centers for Disease Control and Prevention.

CDPH. California Department of Public Health and its predecessor, the California Department of Health Services (CDHS).

Case. Either of the following:

(1) A person who has been diagnosed by a health care provider who is lawfully authorized to diagnose, using clinical judgment or laboratory evidence, to have a particular disease or condition.

(2) A person who is considered a case of a disease or condition that satisfies the most recent communicable disease surveillance case definitions established by the CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements.

Chief. The Chief of the Division of Occupational Safety and Health of the Department of Industrial Relations, or his or her designated representative.

CTCA. The California Tuberculosis Controllers Association.

Droplet precautions. Infection control procedures as described in Guideline for Isolation Precautions designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 mm ~~μ~~m in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.

Emergency medical services. Medical care provided pursuant to Title 22, Division 9, by employees who are certified EMT-1, certified EMT-II, or licensed paramedic personnel to the sick and injured at the scene of an emergency, during transport, or during ~~interfacility~~inter-facility transfer.

Epidemiology and Prevention of Vaccine-Preventable Diseases. Epidemiology and Prevention of Vaccine-Preventable Diseases. Centers for Disease Control and Prevention, Atkinson W, Hamborsky J, McIntyre L, Wolfe S, eds. 10th ed. 2nd printing, including chapters from the 9th edition on Anthrax and Smallpox, Washington DC: Public Health Foundation, 2008, which is hereby incorporated by reference.

Exposure incident. An event in which all of the following have occurred: (1) An employee has been exposed to an individual who is a case or suspected case of a reportable ATD, or to a work area or to equipment that is reasonably expected to contain ATPs associated with a reportable ATD; and (2) The exposure occurred without the benefit of applicable exposure controls required by this section, and (3) It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

Exposure incident (laboratory). A significant exposure to an aerosol containing an ATP-L, without the benefit of applicable exposure control measures required by this section.

Field operation: An operation conducted by employees that is outside of the employer's fixed establishment, such as paramedic and emergency medical services or transport, law enforcement, home health care, and public health.

Guideline for Isolation Precautions. The Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007, CDC, which is hereby incorporated by reference for the sole purpose of establishing requirements for droplet and contact precautions.

Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. The Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, December 2005, CDC, which is hereby incorporated by reference for the sole purpose of establishing requirements for airborne infection isolation.

Health care provider. A physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

Health care worker. A person who works in a health care facility, service or operation, or who has occupational exposure in a public health service described in subsection (a)(1)(D).

High hazard procedures. Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

Individually identifiable medical information. Medical information that includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Infection control PLHCP. A **Physician or other licensed health care professional** ~~PLHCP~~ who is knowledgeable about infection control practices, including routes of transmission, isolation precautions and the investigation of exposure incidents.

~~Influenza-like Illness (ILI)~~ **influenzaa- like illness (ILI).** sSigns and symptoms would include:

a. Fever > 100 F with cough and/or sore throat and headache;
b. Body aches, nasal congestion or discharge, chills and fatigue;
c. Nausea, vomiting, diarrhea or other GI symptoms may also be present

Initial treatment. Treatment provided at the time of the first contact a health care provider has with a person who is potentially an **Airborne infectious disease** ~~AirID~~ case or suspected case. Initial treatment does not include high hazard procedures.

Laboratory. A facility or operation in a facility where the manipulation of specimens or microorganisms is performed for the purpose of diagnosing disease or identifying disease agents, conducting research or experimentation on microorganisms, replicating microorganisms for distribution or related support activities for these processes.

Latent TB infection (LTBI). Infection with *M. tuberculosis* in which bacteria are present in the body, but are inactive. Persons who have **Latent TB infection**~~LTBI~~ but who do not have TB disease are asymptomatic, do not feel sick and cannot spread TB to other persons. They typically react positively to TB tests.

Local health officer. The health officer for the local jurisdiction responsible for receiving and/or sending reports of communicable diseases, as defined in Title 17, CCR.
NOTE: Title 17, Section 2500 requires that reports be made to the local health officer for the jurisdiction where the patient resides.
M. tuberculosis. *Mycobacterium tuberculosis* complex, which includes *M. tuberculosis, M. bovis, M. africanum*, and *M. microti*. M. tuberculosis is the scientific name of the group of bacteria that cause tuberculosis.
Negative pressure. A relative air pressure difference between two areas. The pressure in a containment room or area that is under negative pressure is lower than adjacent areas, which keeps air from flowing out of the containment facility and into adjacent rooms or areas.
NIOSH. The Director of the National Institute for Occupational Safety and Health, CDC, or his or her designated representative.
Non-medical transport. The transportation by employees other than health care providers or emergency medical personnel during which no medical services are reasonably anticipated to be provided.
Novel or unknown ~~A~~aerosol transmissible pathogen ~~ATP~~. A pathogen capable of causing serious human disease meeting the following criteria:

1. There is credible evidence that the pathogen is transmissible to humans by aerosols; and
2. The disease agent is:
   a. A newly recognized pathogen, or
   b. A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility, or
   c. A recognized pathogen that has been recently introduced into the human population, or
   d. A not yet identified pathogen.

NOTE: Variants of the human influenza virus that typically occur from season to season are not considered novel or unknown Aerosol transmissible pathogens ~~ATPs~~ if they do not differ significantly in virulence or transmissibility from existing seasonal variants. Pandemic influenza strains that have not been fully characterized are novel pathogens.

Occupational exposure. Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by Aerosol transmissible pathogen ~~ATPs~~ or Aerosol transmissible pathogen -laboratory ~~ATPs L~~ if protective measures are not in place. In this context, "elevated" means higher than what is considered ordinary for employees having direct contact with the general public outside of the facilities, service categories and operations listed in subsection (a)(1) of this standard. Occupational exposure is presumed to exist to some extent in each of the facilities, services and operations listed in subsection (a)(1)(A) through (a)(1)(I). Whether a particular employee has occupational exposure depends on the tasks, activities, and environment of the employee, and therefore, some employees of a covered employer may have no occupational exposure. For example, occupational exposure typically does not exist where a hospital employee works only in an office environment separated from patient care facilities, or works only in other areas separate from those where the risk ~~of A~~of Aerosolized Transmissible Disease transmission, whether from patients or contaminated items, would be elevated without protective measures. It is the task of employers covered by this standard to identify those employees who have occupational exposure so that appropriate protective measures can be implemented to

protect them as required. Employee activities that involve having contact with, or being within exposure range of cases or suspected cases of Aerosolized Transmissible Disease ~~ATD~~, are always considered to cause occupational exposure. Similarly, employee activities that involve contact with, or routinely being within exposure range of, populations served by facilities identified are considered to cause occupational exposure. Employees working in laboratory areas in which Aerosol transmissible pathogen -laboratory ~~ATPs-L~~ are handled or reasonably anticipated to be present are also considered to have occupational exposure.

Physician or other licensed health care professional (PLHCP) means an individual whose legally permitted scope or practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all of the health care services required by this section.

Public health guidelines. (1) In regards to tuberculosis, applicable guidelines published by the ~~CT~~Californian Tuberculosis Controllers Association and/or ~~C~~California Department Public Health. Refer to below reference number 3 ~~as follows, which are hereby incorporated by reference:~~

~~(A) Guidelines for Tuberculosis (TB) Screening and Treatment of Patients with Chronic Kidney Disease (CKD), Patients Receiving Hemodialysis (HD), Patients Receiving Peritoneal Dialysis (PD), Patients Undergoing Renal Transplantation and Employees of Dialysis Facilities, May 18, 2007.~~

~~(B) Guidelines for the Treatment of Active Tuberculosis Disease, April 15, 2003 including related material: Summary of Differences Between 2003 California and National Tuberculosis Treatment Guidelines, 2004, Amendment to Joint CDHS/CTCA Guidelines for the Treatment of Active Tuberculosis Disease, May 12, 2006, Appendix 3 – Algorithm for MDR-TB Cases and Hospital Discharge, May 12, 2006.~~

~~(C) Targeted Testing and Treatment of Latent Tuberculosis Infection in Adults and Children, May 12, 2006.~~

~~(D) California Tuberculosis Controllers Association Position Statement: The Utilization of QuantiFERON – TB Gold in California, May 18, 2007.~~

~~(E) Guidelines for Mycobacteriology Services in California, April 11, 1997.~~

~~(F) Guidelines for the Placement or Return of Tuberculosis Patients into High Risk Housing, Work, Correctional, or In-Patient Settings, April 11, 1997.~~

~~(G) Contact Investigation Guidelines, November 12, 1998.~~

~~(H) Source Case Investigation Guidelines, April 27, 2001.~~

~~(I) Guidelines on Prevention and Control of Tuberculosis in California Long-Term Health Care Facilities, October 2005.~~

~~(J) Guidelines for Reporting Tuberculosis Suspects and Cases in California, October 1997.~~

~~(K) CTCA recommendations for serial TB testing of Health Care Workers (CA Licensing and Certification), September 23, 2008.~~

~~(2) In regards to vaccine-preventable diseases, the publication cited in the definition of Epidemiology and Prevention of Vaccine-Preventable Diseases.~~

~~(3) In regards to any disease or condition not addressed by the above guidelines, recommendations made by the CDPH or the local health officer pursuant to authority granted under the Health and Safety Code and/or Title 17, California Code of Regulations.~~

Referral. The directing or transferring of a possible ATD case to another facility, service or operation for the purposes of transport, diagnosis, treatment, isolation, housing or care.

Referring employer. Any employer that operates a facility, service, or operation in which there is occupational exposure and which refers Airborne infectious disease ~~AirID~~ cases and suspected cases to other facilities. Referring facilities, services and operations do not provide diagnosis, treatment, transport, housing, isolation or management to persons requiring Airborne infection isolation~~AII~~. General acute care hospitals are not referring employers. Law enforcement, corrections, public health, and other operations that provide only non-medical transport for referred cases are considered referring employers if they do not provide diagnosis, treatment, housing, isolation or management of referred cases.

Reportable aerosol transmissible disease (RATD). A disease or condition which a health care provider is required to report to the local health officer, in accordance with Title 17 CCR, Division 1, Chapter 4, and which meets the definition of an aerosol transmissible disease (ATD).

Respirator. A device which has met the requirements of 42 CFR Part 84, has been designed to protect the wearer from inhalation of harmful atmospheres, and has been approved by National Institute for Occupational Safety and Health ~~NIOSH~~ for the purpose for which it is used.

Respirator user. An employee who in the scope of their current job may be assigned to tasks which may require the use of a respirator, in accordance with subsection (g).

Respiratory Hygiene/Cough Etiquette in Health Care Settings. To prevent the transmission of all respiratory infections in healthcare settings, including influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person. They should be incorporated into infection control practices as one component of Standard Precautions ~~Respiratory Hygiene/Cough Etiquette in Health Care Settings, CDC, November 4, 2004, which is hereby incorporated by reference for the sole purpose of establishing requirements for source control procedures.~~

Screening (health care provider). The initial assessment of persons who are potentially Airborne infectious disease ~~AirID~~ or Aerosolized Transmissible Disease cases by a health care provider in order to determine whether they need airborne infection isolation or need to be referred for further medical evaluation or treatment to make that determination. Screening does not include high hazard procedures.

Screening (non health care provider). The identification of potential Aerosolized Transmissible Disease ~~ATD~~ cases through readily observable signs and the self-report of patients or clients. Screening does not include high hazard procedures.

Significant exposure. An exposure to a source of Aerosol transmissible pathogen ~~ATPs~~ or Aerosol transmissible pathogen -- laboratory ~~ATPs-L~~ in which the circumstances of the exposure make the transmission of a disease sufficiently likely that the employee requires further evaluation by a Physician or other licensed health care professional ~~PLHCP.~~

Source control measures. The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an Aerosolized Transmissible Disease~~ATD,~~ such as persistent coughing.

Surge. A rapid expansion beyond normal services to meet the increased demand for qualified personnel, medical care, equipment, and public health services in the event of an epidemic, public health emergency, or disaster.

Susceptible person. A person who is at risk of acquiring an infection due to a lack of immunity as determined by a PLHCP in accordance with applicable public health guidelines.

Suspected case. Either of the following:

1. A person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence, to probably have a particular disease or condition listed in Appendix A.
2. A person who is considered a probable case, or an epidemiologically-linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements as applied to a particular disease or condition listed in Appendix A.

TB conversion. A change from negative to positive as indicated by TB test results, based upon current CDC or CDPH guidelines for interpretation of the TB test.

Test for tuberculosis infection (TB test). Any test, including the tuberculin skin test and blood assays for *M. Tuberculosis* (BAMT) such as interferon gamma release assays (IGRAs) which: (1) has been approved by the Food and Drug Administration for the purposes of detecting tuberculosis infection, and (2) is recommended by the CDC for testing for TB infection in the environment in which it is used, and (3) is administered, performed, analyzed and evaluated in accordance with those approvals and guidelines.

NOTE: Where surveillance for LTBI is required by Title 22, CCR, ~~the~~and the TB test must be approved for this use by the CDPH. The tool used to identify asymptomatic adults for Latent Tuberculosis Infection is the California Tuberculosis Risk Assessment Adults. http://www.cdph.ca.gov/programs/tb/Documents/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf

Tuberculosis (TB). A disease caused by *M. tuberculosis*.

UVGI. Ultraviolet germicidal irradiation.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

HIGH HAZARD PROCEDURES:

On patients suspected or known to be infected with an illness or pathogen requiring Airborne Precautions, t

~~T~~The following procedures are considered high hazard procedures for risk of exposure to ~~A~~Aerosolized Transmissible Disease, requiring the use of Personal Protective Equipment (PPE) ~~PPE~~ during the procedure.~~,~~ A ~~when the patient is a case or a suspected case of an~~ Aerosolized ~~Transmissible Disease ATD. At minimum,~~minimum ~~:~~ an N-95/Purified Air Powered Respirator (PAPR) and eye protection is indicated. Staff is expected to follow recommendations for additional PPE as indicated for specific disease processes under transmission-based precautions ~~. This~~this list includes, but is not limited to:

1. Sputum Induction/collection
2. Open suctioning of airways
3. Endotracheal intubation and extubation
4. Bronchoscopy
5. Aerosolized administration of medications when patient is in Droplet or Airborne Isolation
6. Cardiopulmonary resuscitation
7. Laboratory procedures that may aerosolize pathogens
8. Obtaining a nasal swab or throat culture

NOTE: NIH has PAPRs available ~~now~~ - see policy for use and maintenance.

Bronchoscopy and other similar high hazard procedures will be done in an AII room or area. Lesser procedures, like obtaining a nasal swab will be done with ~~an~~ minimally a surgical mask or N-95 mask if atypical respiratory illness such as ~~HIN1~~novel avian flu is suspected, face shield, gloves must be worn. A~~,~~ ~~and~~ gown is donned if patient unable has poor respiratory etiquette and/or poor hand hygiene. ~~.~~ Persons not performing the procedures are to be excluded from the area.

Exception: Where no airborne infection isolation ~~AII~~ room or area is available and the treating physician determines it would be detrimental to the patient's health to delay performing the procedure, high hazard procedures may be conducted in other areas with personnel using appropriate PPE.

EMPLOYEE IMMUNIZATIONS:

NIHD will comply with the "Mandatory Vaccination Recommendations for Susceptible Health Care Workers" as listed in Appendix below of the Cal/OSHA ATD Standard.

Employee Health, during the pre-employment physical process, obtains titers for the illnesses listed below- if the prospective employee does not have documented proof of the vaccinations. Vaccinations are provided free of charge when necessary for negative titers. Declinations must ~~may~~ be signed by the HCW in lieu of the vaccination after education on the vaccine and NIHD's commitment to safety for the patients, the employee, and his or her family.

Appendix: Aerosol Transmissible Disease Vaccination Recommendations for Susceptible Health Care Workers (Mandatory)

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	One dose
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses or lab evidence of immunity

Source: California Department of Public Health, Immunization ~~Branch.Immunity~~Branch. Immunity should be determined in consultation with *Epidemiology and Prevention of Vaccine-Preventable Diseases 13th edition or later by the Centers for Disease Control and Prevention.*~~.~~

WORK PRACTICE CONTROLS:

SOURCE CONTROL MEASURES: Measures to prevent patients, staff, or visitors from spreading illness inside of the hospital.

On Arrival ~~To~~to ~~The~~the Hospital:

1. Hand hygiene stations and Respiratory Hygiene/Cough Etiquette are at every entrance to the hospital with signs encouraging their use.

2. If indicated, warning/education signs may also be placed at entrances explaining any special concerns or limitations regarding entrance to the hospital e.g. with outbreak of influenza.
3. Patients, visitors, and caregivers will be instructed ~~on~~ on Respiratory Hygiene/ Cough Etiquette ~~source control~~ measures by the hospital staff, with easy access to all the necessary sanitation supplies.
    a. Cover mouth and nose for coughs and sneezes with Kleenex, linen, or elbow.
    b. To use the available surgical masks as soon as possible if actively coughing.
    c. To perform hand hygiene frequently and after handling their secretions.
    d. To dispose of contaminated tissues, napkins, linens into "no-touch" receptacles.
4. Entry may be denied to visitors if they already know they have suspected or confirmed influenza, another known serious respiratory illness, tuberculosis, and/or possibly others on a case by case basis.
5. Elective procedures may also be postponed for patients with suspected or confirmed influenza until they are no longer infectious.

On arrival to the Emergency Department (ED) Area:

1. Same entry procedures as above. Hand hygiene station is at the Emergency Department entrance.
2. The Emergency Department ~~ED clerks and nursing staff~~ personnel may have the patients mask immediately if the complaint is an Influenza- Like like-Illness (ILI) ~~illness~~ or cough.
3. A separate waiting room was developed so that those with Influenza-Like IllnessILI ~~ILI illness~~ can potentially be segregated from those without.
4. Influenza-Likelike IillnessILI ~~ILI~~ patients are isolated to an Emergency Department ~~ER~~ single room or kept masked and physically located ≥ ~~6~~ 3 feet from other patients. Friends and family are instructed in the use of surgical masks and any other necessary PPE being used. They are encouraged to follow instructions and to ask for clarification, so that they have the understanding of why the isolation procedures are used.
4.5. Appropriate isolation signngage will be posted outside the room visible to hospital staff and visitors

On Arrival ~~To~~to Another Hospital Unit:

1. Same entry procedures as above with access to hand hygiene stations and necessary sanitation supplies.
2. Notify the Infection Control Nurse, ~~or~~ via House Supervisor 12 hour shift report ~~designee, immediately~~ of all patients admitted with suspected airborne illnesses.
3. Sever Acute Respiratory Syndrome has its own assessment/screening form that is found on the hospital Intranet.
4. ~~-~~Source patients from any department, including the Emergency Department, are put into single rooms when available and the door is closed. Airborne precautions will be initiated,

when appropriate. ~~(See Airborne Policy- which does differentiate between novel influenza and TB-like illnesses in types of precautions required).~~ Visitors are instructed in the use of PPE and restricted to those most crucial to the patient's well-being.

4.

Room PPlacement:
Airborne infection isolation rooms ~~or the portable Hepa-Filter~~ units will be used for patients who are suspected of having airborne transmissible disease, e.g. TB, SARS, Smallpox, Avian Flu, and Pneumonic Plague.
Airborne isolation rooms are private rooms that have monitored negative air pressure in relation to the exterior surrounding areas, so that air does not come out from under the door because the pressure outside the door is > than inside the room. See the section under *Engineering Controls* related to Air Exchanges per hour and other specifics. Our current best options for any patient include:

- Option 1: Room 5 on the ~~Medical-Surgical-~~Acute/~~Subacute~~-Subacute ICU RM 1, and Infusion Room 6 unit is an Airborne Infection Isolation room ~~full negative pressure room~~, vented to the outside with filters and an antechamber.
- Option 2: If no Airborne Infection Isolation Room available put patient in surgical mask, keep door closed and staff to wear a N95 or PAPR ~~Room 1 in the ICU is a full negative pressure room, vented to the outside with filters and an antechamber.~~
- ~~Option 3: If unable to use either full negative pressure rooms or an additional room is needed we do have Hospi-Gard unit located on the 2nd floor. This can be used in any room as long as the door is kept closed and only opened for very short periods of time to allow staff to enter and exit. This unit is located in the closet of the Negative pressure room on the Medical Surgical unit.~~
- ~~Option 4: The Respiratory Department also has a Hospi-Gard unit that can be set up in any of the patient or exam rooms with the door kept closed.~~

Source Patient Control:

1. The patient will remain in the room, unless transport is necessary for a diagnostic procedure. The patient will be kept masked with a surgical mask and the transport team will wear a fit-tested N-95 mask.
2. Information about patients who have or may have an ATD is shared with appropriate personnel before transferring or transporting the patient ~~them~~ to other departments or other facilities using SBAR/Ticket to Ride or Handoff report.~~.~~
3. Personal Protective ~~equipment~~ Equipment and Isolation Precautions implemented ~~used~~ by staff may be discontinued based on documented, negative laboratory studies. This should be decided with input from any one or more of the following: ~~Infection~~ Infection Preventionist or designee, Infection Control Medical Staff Chairperson, ~~Control~~ and the unit's Nursing

Director ~~nurse~~ manager and the patient's physician, Inyo County Health Officer, or California State Health Department ~~official~~.

4. Visitors should be limited to only family or friends crucial to the patient's well-being.
5. Patient care equipment:
   a. Equipment (e.g. designated computer ~~WOWs~~, vital sign equipment~~thermometers, BP cuffs~~, stethoscopes, ~~commodes~~and commodes) should be kept in the patient's room. Use disposable equipment as much as possible.
   b. Any reusable equipment has to be cleaned per hospital protocol before re-use.
6. Linens, waste, and room cleaning as per policy under Contact Precautions.

~~Routine cleaning and disinfection strategies used during influenza season are found in the "Maintenance Policy on Cleaning Work Areas."~~

Precautions Required For SARS, Avian, And Other Serious Airborne Illnesses:

1. Standard
2. Airborne and Droplet
3. Contact

PPE Required When Entering An Airborne Isolation Room:

1. Fit-tested N-95 Mask or PAPR
2. Face shields or Eye Protectors
3. Disposable Gowns: For substantial contact with the patient or environmental surfaces.
4. Gloves

~~5. Dietary items should be disposable~~

Reporting the Illness:

Report all airborne illnesses to the county. The Confidential Morbidity Report form is on the NIH Intranet. The back of the form tells you by which method and how quickly to report each reportable illness. For example, with SARS you are to call the county health department immediately.

Procedure If NIH Has Insufficient Isolation Rooms:

If the patient needs an airborne isolation room and there is not one available, ~~there~~ the patient should be a transfer to another facility in a timely manner.

1. Transfers to other facilities: Transfer should occur within **5** hours of identification, unless the ~~**employer**~~ physician documents, at the end of the 5 hour period, and at least every 24 hours thereafter, one of the following:
   a. The ~~**employer**~~ Physician, Infection Preventionist or House ~~Supervisor has~~Supervisor has contacted the local health officer.
   b. There is no room or area available within that jurisdiction.
   c. Reasonable efforts have been made to contact establishments outside of that jurisdiction.

d. Applicable measures recommended by the local health officer and ~~or~~ the Physician or other licensed health care professional ~~PLHCP have been implemented.~~

Exception t~~T~~To a~~A~~above: The patient need not be transferred if the treating physician determines that the transfer would be detrimental to the patient's condition. In that case, the employees will use all necessary respiratory protection when entering the patient's room. The patient's condition has to be reviewed at least every 24 hours. Once transfer is safe, then it should still occur in the timeframe above.

Employee Control Measures:

1. Keeping personnel at home while they are ill to reduce the risk of spreading influenza or other airborne ~~illnesses is~~illnesses is essential ~~important.~~
2. Continuing monitoring of hand hygiene and PPE compliance.
3. Continue the yearly influenza vaccination policy. (Covered under Vaccination Section)
4. Monitor any employee with an airborne exposure. (Covered under Exposure Evaluation Section)
5. Annual education on Aerosolized Transmissible Disease for employees that have exposure risk.

PATIENT SCREENING: Patients will be screened during the triage period in the Emergency Department ~~Room and~~ during the admission assessment for inpatients, as appropriate, to evaluate for any symptoms of ~~A~~Aerosolized Transmissible Disease infections.

1. For **tuberculosis** this would include:
   a. Cough for more than 3 weeks not explained by non-infectious conditions~~;~~
   b. Hemoptysis~~;~~
   c. Unexplained significant weight loss~~;~~
   d. Fatigue~~;~~
   e. Night sweats~~;~~
   f. Known exposure to a TB patient

2. For **influenza-~~-~~like illness (ILI)** signs and symptoms would include:
   a. Fever > 100 F with cough and/or sore throat and headache;
   b. Body aches, nasal congestion or discharge, chills and fatigue;
   c. Nausea, vomiting, diarrhea or other GI symptoms may also be present

3. For **SARS: Screening form on Hospital Intranet>Forms> Infection Control**
4. ~~-~~Patient statement that they have a transmissible respiratory disease, excluding the common 5.4. ~~-~~ cold.

CLEANING AND DISINFECTION ~~DECONTAMINATION~~:

1. Routine cleaning and disinfection strategies used during influenza season can be applied to the environmental management of Influenza ~~H1N1. See *Maintenance Policy on Cleaning Work Areas.*~~
2. Dedicated d~~D~~isposable equipment is to be used whenever possible.
3. Non-disposable equipment is to be cleaned and disinfected ~~decontaminated~~ according to established agency policies. ~~—~~ "Infectious and Noninfectious Waste Disposal Procedure."
4. Management of laundry, utensils, and medical waste should also be performed in accordance with procedures followed for seasonal influenza.

PERSONAL PROTECTIVE EQUIPMENT/RESPIRATORY PROTECTION

1. Adherence to Standard Precautions and Transmission Based Precautions, as appropriate for the patient's disease status, is mandatory for all NIHD employees and departments.
2. Droplet Precautions: Permit the use of surgical masks rather than respiratory protection, i.e., use of respirators. Recognizing that surgical masks do not provide protection against inhalation of airborne infectious aerosols, NIHD will allow health care personnel to use N-95 masks for contact with influenza patients should they prefer that level of protection.
3. Clinical staff who are assigned to patients with suspected or confirmed infectious Pulmonary TB, or other aerosol transmissible disease requiring use of respirator will be provided and fitted with a ~~NIOSH~~National Institute for Occupational Safety and Health approved ~~-~~(at least N95) Respirator Mask for individual, personal protection prior to providing care. Trained personnel will instruct the clinical staff members on proper respirator use and fit-check, in accordance with the manufacturer's instructions and guidelines.
    a. Instructions on putting on and taking off N-95 masks is also available on the hospital Intranet. The staff has been instructed to watch this video. Hand-outs detailing re-use procedure have also been made available.
    b. Every attempt will be made to have an adequate supply of all types of N-95 masks we currently use for fit tests.
    c. The standard is to use a mask if needed and discard it after- *not to re-use*. They should be discarded after each patient encounter.
    d. The Purchasing Department Manager is responsible for monitoring mask numbers and will work in conjunction with the Infection Preventionist, if a disaster and surge make mask availability an issue.
4. Clinical staff that cannot be adequately fitted with the National Institute for Occupational Safety and Health ~~NIOSH~~ approved respirators will not be assigned to these patients, unless they have been trained to use the PAPR and a PAPR is available.
5. Personnel with histories of respiratory problems/compromise or those with known lack of immunity to the organism (ege.g.: chickenpox) should not be assigned to these patients.
6. Unprotected employees should be prevented from entering areas where aerosol generation procedures were performed until the required clearance time has elapsed.
~~7.~~ ~~When respirators are necessary to protect the HCW from other hazards, including the u~~
7. ~~u~~ncontrolled release of microbiological spores or exposure to chemical or radiologic agents, respirator selection shall be made in accordance with the anticipated risk.

8. In summary, NIHD provides, and ensures that employees use, a fit-tested N-95 respirator or PAPR when the employee:
   a. Enters an Airborne infection isolation room or area or an Airborne infection isolation ~~AII room or~~ area in use for ~~A~~Airborne ~~I~~Infection Isolation;
   b. P~~Is~~ present during the performance of procedures or services for an Airborne infectious disease ~~AirID~~ case or suspected case;
   c. Takes part in aerosol generating procedures on patient suspected or known to be infected with an illness or pathogen requiring airborne precautions such as sputum induction, bronchoscopy, open suctioning, CPR, intubation or extubation.~~? RT Treatments~~ Pulmonary function testing, collection of nasal pharyngeal lab specimens for RSV or Pertussis
   d. Repairs, replaces, or maintains air systems or equipment that may contain or generate aerosolized pathogens;
   e. Is working in an area occupied by an airborne infectious disease ~~AirID~~ case or suspected case, during decontamination procedures after the person has left the area and as required.
   f. Is performing a task for which the Biosafety Plan or Exposure Control Plan requires the use of respirators; or
   g. Transports an Airborne infectious disease ~~AirID~~ case or suspected case within the facility or in an enclosed vehicle (e.g., van, car, ambulance or Air transport ~~helicopter)~~ when the patient is not masked.
9. Medical Evaluation for Fit Testing:
   a. NIHD provides a medical evaluation by the Medical Director of the Respiratory Therapy Department. This is done to determine the employee's ability to use a respirator before the employee is fit tested or required to use the respirator. This form is the OSHA approved form for respirator fit testing.
   b. The employee's supervisor provides the employee a copy of the Medical Evaluation Questionnaire. The questionnaire is confidential. A sealable envelope must be provided to the employee, in which to return the questionnaire.
   c. After completion it is returned to the employee's supervisor who forwards it to the head of the Respiratory Therapy Department, who then has the Medical Director review it for any problems or concerns.
   d. The record is stored in the employee's confidential employee health records.
   e. After the medical evaluation, the employee can have the fit test scheduled.

10. Fit Testing: "*N95 Mask Fit Testing Using ~~The~~ the Portacount Pro Policy*"
    a. NIHD Cardiopulmonary RT staff ~~perfoms~~performs quantitative fit tests. The fit tests are performed on the same size, make, model and style of respirator as the employee will use. When fit testing single use respirators, a new respirator shall be used for each employee.
    b. The employer shall ensure that each employee who is assigned to use a filtering face piece or other tight-fitting respirator passes a fit test:
       i. At the time of initial fitting;
       ii. When a different size, make, model or style of respirator is used; and
       iii. At least annually thereafter.

c. NIHD requires an additional fit test when the employee reports, or the employer, **Pphysician or other licensed health care professional**~~PLHCP~~, supervisor, or program administrator makes visual observations of changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.
d. If, after passing a fit test, the employee subsequently notifies the employer, program administrator, supervisor, or Physician or other licensed health care professional ~~PLHCP~~ that the fit of the respirator is unacceptable, the employee shall be given a reasonable opportunity to select a different respirator face piece and to be retested.
e. NIHD will ensure that each respirator user is provided with initial and annual training in accordance with Section 5144, Respiratory Protection of these orders.

11. PAPR Orientation: Shall be provided for:
    a. Staff who ~~fail~~fails N-95 mask fit testing for whatever reason
    b. High hazard procedures where it is the safer option.

~~a.~~

MEDICAL SERVICES

1. NIHD provides any employee with *occupational exposure* medical services for tuberculosis and other ATDs, and infection with Aerosol transmissible pathogen ~~ATPs~~ and Aerosol transmissible pathogen -- laboratory~~ATPs-L~~, in accordance with applicable public health guidelines, for the type of work setting and disease. NIHD also acts as the evaluating health care professional through our Emergency Room. Following an exposure incident the employee may request follow-up medical care from another health care provider. When this occurs, NIH will ensure that a medical follow-up is arranged from a Physician or other licensed health care professional ~~PLHCP~~ other than through our Emergency Room.
2. Medical services, including vaccinations, tests, examinations, evaluations, determinations, procedures, and medical management and follow-up, shall be:
    a. Performed by or under the supervision of the Emergency Room Physician or designee.
    b. Provided according to applicable public health guidelines; and
    c. Provided in a manner that ensures the confidentiality of employees and patients. Test results and other information regarding exposure incidents and TB conversions shall be provided without providing the name of the source individual.
3. For questions related to Tuberculosis refer to NIHD's Tuberculosis policies ~~Policy~~ Tuberculosis Exposure Control Plan and the Employee Tuberculosis Surveillance Program.

~~3.~~4. ~~All assessment procedures are done in accordance with applicable public health guidelines.~~Unless it is determined that the TB test conversion is not occupational, the Infection Preventionist and the Employee Health nurse shall investigate the circumstances of the conversion, and correct any deficiencies found during the investigation.

Vaccinations:

1. Recommended vaccinations are made available to all employees who have occupational exposure during the pre-employment physical unless:

a. The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose; or
b. It is determined that the employee is immune in accordance with applicable public health guidelines;
c. The vaccine(s) is contraindicated for medical reasons.

2. Employee Health Nurse makes additional vaccine doses available to employees within 120 days of the issuance of new applicable public health guidelines recommending the additional dose as approved by NIHD in the vaccination policies.
3. Employee Health Nurse does not make participation in a prescreening serology program a prerequisite for receiving a vaccine, unless applicable public health guidelines recommend this prescreening prior to administration of the vaccine. However, titers are routinely tested at time of hire, with each new employee's consent, to determine eligibility for each indicated vaccine when the vaccination/immune status is not known.
4. If the employee initially declines a vaccination but at a later date, while still covered under the standard, decides to accept the vaccination, the employer shall make the vaccination available within 10 working days of receiving a written or verbal request from the employee.
5. Employee Health ~~-~~ensures that employees who decline to accept a recommended and offered vaccination sign the statement in ~~Appendix C~~1 for each declined vaccine.
6. Employee Health ~~-~~requests the responsible Physician or other licensed health care professional ~~PLHCP~~ or specific agency (when applicable, ~~e~~g.g.~~x~~; travelers) administering a vaccination or determining immunity to provide only the following information to the employer:
   a. The employee's name and employee identifier;
   b. The date of the vaccine dose or determination of immunity;
   c. Whether the employee is immune to the disease, and whether there are any specific restrictions on the employee's exposure or ability to receive vaccine;
   d. (D)Whether an additional vaccination dose is required, and if so, the date the additional vaccination dose should be provided.
7. Employee Health ~~-~~makes available seasonal influenza vaccine to all NIHD employees. In times of shortage it is offered first to those with the most occupational exposure. Each employee who declines to accept the seasonal influenza vaccine signs ~~the~~ a declination statement ~~in Appendix (C).~~
   - ~~—~~EXCEPTION 1: Seasonal influenza vaccine shall be provided during the period designated by the CDC (Oct 1 through March 30)
   - ~~for~~For administration, and need not be provided outside of those periods.
   - ~~—~~EXCEPTION 2: In lieu of the statement in ~~Appendix C2~~, the employer may utilize an influenza vaccine declination statement acceptable to the CDPH.

Exception for vaccine policies: When Employee Health cannot implement these procedures because of the lack of availability of vaccine, efforts made to obtain the vaccine in a timely manner and inform employees of the status of the vaccine availability, including when the vaccine is likely to become available will be documented. The employer shall check on the availability of the vaccine at least every 60 calendar days and inform employees when the vaccine becomes available.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

EXPOSURE EVALUATION AND FOLLOW-UP

1. A health care provider or the employer of a health care provider who determines that a person (patient or NIHD employee) is ~~an~~a Reportable aerosol transmissible disease ~~RATD~~ case or suspected case shall report, or ensure that the health care provider reports, the case to the local health officer, in accordance with Title 17.
   The official **CDPH Severe Influenza Case history Form (ICU and Fatal Cases Age 0-64 Years)** is located under NIHD Intranet> forms> Employee Health and Infection Prevention "Attachments" on the left sidebar and can be printed for use when appropriate.
2. Any Healthcare worker who has unprotected direct contact with an airborne illness must report the exposure to Employee Health, or Infection ~~Control~~Prevention Nurse ~~infection control~~ as soon as possible, either directly or with the assistance of the unit manager or ~~nursing~~ House supervisor. The Employee Health Nurse, Infection Preventionist, or House Supervisor will complete the form "HCW Contact with Case of an Aerosolized Transmissible Disease in conjunction with the exposed employee. It is critical it report exposures immediately when the source is a known life-threatening illness, such as SARS, Avian flu, Smallpox, etc.
3. An Exposure Incident: Significant exposure- exposure to a source of ~~A~~Aerosolized Transmissible Pathogens in which the circumstances make disease transmission sufficiently likely that the employee requires further evaluation by a physician or other Physician or other licensed health care provider~~PLHCP~~. The likelihood of transmission is determined by:
   a. Exposure scenario including distance, time, PPE used
   b. Specific pathogen
   c. Infectivity of the source
   d. Susceptibility of the host (vaccination status is one component)-

   Refer for a medical evaluation if the susceptibility is unknown.
4. In addition to the report required, NIH's Infection Preventionist and/or Employee Health Nurse shall, to the extent that the information is available:
   a. Decide what the affected employee needs to receive effective medical intervention to prevent disease or mitigate the disease course.
   b. Instruct the HCW to monitor their temperature in the morning and the evening for at least 10 days
   c. If a cough or fever ~~develops,~~develops; the HCW must seek medical evaluation immediately and notify the Infection Control nurse.
   d. Assess whether employees in other agencies may be affected. There is an ~~A~~Aerosolized Transmissible Disease notification form to be filled out in the Emergency Department to help track employees outside of NIHD who may have been exposed. ~~**See Appendix F**~~
   e. Initiate a prompt investigation to identify exposed employees. In no case, shall the notification be longer than 72 hours after the report to the local health officer and/or public health department. The notification shall include the date, time, and nature of the potential exposure, and provide any other information that is necessary for the other employer(s) to evaluate the potential exposure of his or her employees. The notifying NIHD provider ~~employer~~ shall not ~~provide~~ reveal the identity of the source patient to the other employers.

NOTE 1: These potentially exposed employees may include, but are not limited to, paramedics, emergency medical technicians, emergency responders, home health care personnel, homeless shelter personnel, personnel at referring health care facilities or agencies, and corrections personnel.
NOTE 2: Some diseases, such as meningococcal disease, require prompt prophylaxis of exposed individuals to prevent disease. Some diseases, such as varicella, have a limited window in which to administer vaccine to non-immune contacts. Exposure to some diseases may create a need to temporarily remove an employee from certain duties during a potential period of communicability as determined by the local health officer for that jurisdiction of the potentially exposed employees[nh8]. For other diseases such as tuberculosis there may not be a need for immediate medical intervention, however prompt follow up is important to the success of identifying exposed employees.

5. When NIHD becomes aware that employees may have been exposed to an ~~a~~ Rreportable aerosol transmissible disease ~~RATD~~ case or suspected case, or to an exposure incident involving an Aerosol transmissible pathogen ~~in~~ laboratory ~~ATP-L~~ shall do all of the following:
   a. Within a timeframe that is reasonable for the specific disease, but in no case later than 72 hours following, as applicable, conduct an analysis of the exposure scenario to determine which employees had significant exposures. This analysis shall be conducted by the Infection Preventionist with assistance from Inyo County Health Department when indicated. This analysis will include the employee names and shall also record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure or because Employee Health or a Physician or other licensed health care professional ~~PLHCP~~ determined that the employee is immune to the infection in accordance with applicable public health guidelines. The exposure analysis shall be made available to the local health officer upon request. The name of the person making the determination, and the identity of any Physician or other licensed health care professional ~~PLHCP~~ or local health officer consulted in making the determination shall be recorded.
   b. Within a timeframe that is reasonable for the specific disease, but in no case later than 96 hours of becoming aware of the potential exposure, notify employees who had significant exposures of the date, time, and nature of the exposure.
   c. ~~As soon as feasible, provide~~Provide post-exposure medical evaluation to all employees who had a significant exposure as soon as feasible. The evaluation shall be conducted by a Physician or other licensed health care professional ~~PLHCP~~ knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For *M. tuberculosis*, and for other pathogens where recommended by applicable public health guidelines, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless that it is not feasible.
   d. Obtain from the Physician or other licensed health care professional ~~PLHCP~~ or Inyo County Health Department ~~ICHD~~ a recommendation regarding precautionary removal as in a medical leave of absence following the exposure and a written opinion.
   e. Determine to the extent that the information is available ~~in the employer's records~~, whether employees of any other employers may have been exposed to the case or

material. ~~The employer~~ NIHD shall notify these other employers within a time frame that is reasonable for the specific disease, but in no case later than 72 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the local public health department.~~diagnosing PLHCP. The notifying employer~~ NIHD shall not provide the identity of the source patient to other employers.

6. Information provided to the Physician or Other Licensed Health Care Professional.
   a. NIH will ensure that all Physicians or other licensed health care professional ~~PLHCPs~~ responsible for making determinations and performing procedures as part of the medical services program are provided a copy of this standard and applicable public health guideline. For respirator medical evaluations, the employer shall provide information regarding the type of respiratory protection used, a description of the work effort required, any special environmental conditions that exist (e.g., heat, confined space entry), additional requirements for protective clothing and equipment, and the duration and frequency of respirator use.
   b. Each employer shall ensure that the Emergency Department ~~Room~~ physician or Pphysician or other licensed health care professional ~~PLHCP~~ who evaluates an employee after an exposure incident is provided the following information:
      i. A description of the exposed employee's duties as they relate to the exposure incident;
      ii. The circumstances under which the exposure incident occurred;
      iii. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management of the employee;
      iv. All of the employer's medical records for the employee that are relevant to the management of the employee, including tuberculin skin test results and other relevant tests for ATP infections, vaccination status, and determinations of immunity.
7. Precautionary removal recommendation from the emergency room physician, other Pphysician or other licensed health care professional ~~PLHCP,~~ Inyo County Health Department, or NIHD's Infection Control Committee Physician Director.
   a. NIHD, when necessary, shall request from the above an opinion regarding whether precautionary removal from the employee's regular assignment is necessary to prevent spread of the disease agent by the employee and what type of alternate work assignment may be provided. This recommendation will be documented in writing and provided to Human Resources and to the employee.
   b. Where precautionary removal is recommended, NIHD shall maintain until the employee is determined to be noninfectious, the employee's earnings, seniority, and all other employee rights and benefits, including the employee's right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited.

   EXCEPTION: Precautionary removal provisions do not extend to any period of time during which the employee is unable to work for reasons other than precautionary removal.
8. Written opinion from the physician or other licensed health care professional.

a. NIHD will obtain, and provide the employee with a copy of, the written opinion within 15 working days of the completion of all medical evaluations required by this section.
b. For TB conversions and all Reportable aerosol transmissible disease ~~RATD~~ and Aerosol transmissible pathogen ~~--~~ laboratory ~~ATP-L~~ exposure incidents, the written opinion shall be limited to the following information:
    i. The employee's TB test status or applicable Reportable aerosol transmissible disease ~~RATD~~ test status for the exposure of concern;
    i. The employee's infectivity status;
    ii. A statement that the employee has been informed of the results of the medical evaluation and has been offered any applicable vaccinations, prophylaxis, or treatment;
    iii. A statement that the employee has been told about any medical conditions resulting from exposure to TB, other Reportable aerosol transmissible disease ~~RATD~~, or Aerosol transmissible pathogen ~~--~~ laboratory ~~ATP-L~~ that require further evaluation or treatment and that the employee has been informed of treatment options; and
    iv. Any recommendations for precautionary removal from the employee's regular assignment.
c. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

TRAINING:

1. NIHD will provide that all employees, with occupational exposure, participate in ~~a~~ ~~trainingtraining~~ program.
2. The ~~A~~Aerosolized Transmissible Disease training will occur as stated below:
    a. At the time of initial assignment to tasks where occupational exposure may take place;
    b. At least annually thereafter, not to exceed 12 months from the previous training;
    c. For employees who have received training on aerosol transmissible diseases in the year preceding the effective date of the standard, only training with respect to the provisions of the standard that were not included previously need to be provided.
    d. When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.
3. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
4. The training program shall contain at a minimum the following elements:
    a. An accessible copy of the regulatory text of this standard and an explanation of its contents.
    b. A general explanation of Aerosolized Transmissible Diseases ~~ATDs~~ including the signs and symptoms of ~~ATDs~~ that require further medical evaluation.
    c. An explanation of the modes of transmission of Aerosol transmissible pathogen ~~--~~ ~~ATPs~~ or Aerosol transmissible pathogen ~~--~~ laboratory ~~ATPs-L~~ and applicable source control procedures.

d. An explanation of the employer's ATD Exposure Control Plan and/or Respiratory Protection Program and Biosafety Plan, and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.
e. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to Aerosol transmissible pathogen or Aerosol transmissible pathogen ~~--~~ laboratory ~~ATPs or ATPs-L.~~
f. An explanation of the use and limitations of methods that will prevent or reduce exposure to Aerosol transmissible pathogen or Aerosol transmissible pathogen laboratory ~~ATPs or ATPs-L~~ including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
g. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.
h. A description of the employer's TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for Latent TB infection ~~LTBI.~~
i. Training meeting the annual requirements for employees whose assignment includes the use of a respirator.
j. Information on the vaccines made available by Employee Health, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.
l. Information on the employer's surge plan as it pertains to the duties that employees will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

5. Every training program shall include an opportunity for interactive questions and answers with a person who is knowledgeable in the subject matter of the training as it relates to the workplace that the training addresses and who is also knowledgeable in the employer's ATD exposure control ~~or~~ Respiratory Protection Program and ~~biosafety~~Biosafety plan. Training not given in person fulfills all the subject matter required and allows for interactive questions to be answered within 24 hours by a knowledgeable person as described above.

ENGINEERING CONTROLS

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

1. Specific requirements for Airborne Infection Isolation Rooms ~~AII rooms~~ and areas. Hospital isolation rooms constructed in conformance with Title 24, California Code of Regulations, Section 417, et seq., and which are maintained to meet those requirements.
2. Negative pressure shall be maintained in Airborne Infection Isolation Rooms ~~AII rooms~~ or areas. The ventilation rate shall be 12 or more air changes per hour (ACH). The required ventilation rate may be achieved in part by using in-room high efficiency particulate air (HEPA) filtration or other air cleaning technologies, but in no case shall the outdoor air supply ventilation rate be less than six ACH. Hoods, booths, tents and other local exhaust control measures shall comply with Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings.

~~2.~~3. Negative pressure is demonstrated by smoke trails or equally effective means daily while a patient is in Infusion Room 6 Refer to Airborne Infection Isolation Rooms (AIIR) policy. ~~room or area is in use for AII. Refer to Airborne Infection Isolation Rooms (AIIR) policy.~~

Engineering controls shall be maintained, inspected and performance monitored for exhaust or

4. recirculation filter loading and leakage at least annually, whenever filters are changed, and more often if necessary to maintain effectiveness. NIHD's maintenance department does check at least quarterly. NIHD Plant Maintenance has an aggressive filter checking program that is managed with a software program for this purpose. If a problem(s) prevent the room from providing effective AII, then the room shall not be used for that purpose until the condition is corrected.

~~3.~~5. Ventilation systems for AII rooms or areas shall be constructed, installed, inspected, operated, tested, and maintained in accordance with Section 5143, General Requirements of Mechanical Ventilation Systems, of these orders. Inspections, testing and maintenance shall be documented in writing.

~~4.~~6. Air from Airborne Infection Isolation ~~rooms~~ Rooms or areas, and areas that are connected via plenums or other shared air spaces shall be exhausted directly outside, away from intake vents, employees, and the general public. Air that cannot be exhausted in such a manner or that must be recirculated must pass through HEPA filters before discharge or recirculation.

~~5.~~7. Ducts carrying air that may reasonably be anticipated to contain aerosolized *M. tuberculosis* or other Airborneairborne infectious pathogen ~~AirIP~~ shall be maintained under negative pressure for their entire length before in-duct HEPA filtration or until the ducts exit the building for discharge.

~~6.~~8. Doors and windows of Airborne Infection Isolation Rooms ~~AII rooms~~ or areas shall be kept closed while in use for airborne infection isolation, except when doors are opened for entering or exiting.

~~7.~~9. When a case or suspected case vacates an Airborne Infection Isolation Rooms~~AII room~~ or area, the room or area shall be ventilated according to Table 1 in the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings for a removal efficiency of 99.9 % before permitting employees to enter without respiratory protection.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

LABORATORIES

1. The biological safety officer at NIHD is the ~~director of the microbiology department~~Medical Director of Laboratory Services.
~~1.~~2. The biological safety officer performs a risk assessment in accordance with accepted methodology for each agent and procedure involving the handling of aerosolized transmissible disease pathogens in the lab Aerosol transmissible pathogen laboratory ~~(ATP-L).~~
~~2.~~3. Our laboratory has feasible engineering and work practice controls, in accordance with the risk assessment to minimize the employee exposures to Aerosol transmissible pathogen -- laboratory ~~ATPs-L~~. If exposure still remains after the institution of engineering and work practice controls, then the employees will use the appropriate PPE when and where necessary.
~~3.~~4. Biosafety Plan: Titled Chemical Hygiene Plan: ~~(BSP[mh9]).~~ The employer shall establish, implement, and maintain an effective written Biosafety Plan to minimize employee exposures to Aerosol transmissible pathogen -- laboratory ~~ATPs-L~~ that may be transmitted by laboratory aerosols. The Biosafety Plan ~~BSP~~ is kept in the laboratory's safety manual and includes the following:
   a. Identifies a biological safety officer(s) with the necessary knowledge, authority and responsibility for implementing the Biosafety Plan ~~BSP.~~
   b. Establishes safe handling procedures and prohibit practices, such as sniffing *in vitro* ~~cultures, that~~cultures that may increase employee exposure to infectious agents.
   c. ~~Identifies~~Identifies any operations or conditions in which respiratory protection will be required.
   d. Establishes emergency procedures for uncontrolled releases within the laboratory facility and untreated releases outside the laboratory facility. These procedures shall include effective means of reporting such incidents to the local health officer.
   e. Includes procedures for communication of hazards and employee training. This shall include training in the Biosafety Plan and emergency procedures.
   f. Includes an effective procedure for obtaining the active involvement of employees in reviewing and updating the Biosafety Plan with respect to the procedures performed by employees in their respective work areas or departments on an annual (or more frequent) basis.
   g. Includes procedures for the biological safety officer(s) to review plans for facility design and construction that will affect the control measures for Aerosol transmissible pathogen -- laboratory ~~ATPs-L~~.
   h. Includes procedures for inspection of laboratory facilities, including an audit of ~~biosafety~~Biosafety procedures. These inspections shall be performed at least annually. Hazards found during the inspection, and actions taken to correct hazards, shall be recorded.
5. Recordkeeping will be done by the biological safety officer._____

SURGE PROCEDURES

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

1. In the event of a surge of patients due to infectious disease, NIHD staff will follow established policies for Disaster Preparedness.
2. NIHD will participate in a multi-agency management plan, and will be directed by the Incident Command System and the county Emergency Operations Center.
3. Respiratory and personal protective equipment may be ~~is~~ stockpiled and distributed by the Inyo County Health Department for use during a public health surge.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

RECORDKEEPING

1. Medical records.
   a. Employers are responsible for recording cases of Aerosolized Transmissible Diseases for occupational exposures, ~~2009 H1N1 illness if the case is a confirmed case of 2009 H1N1 as defined by the CDC and the case is work-related~~ and if it involves days away from work and/or medical treatment. This record may not be combined with non-medical personnel records.
   b. This record shall include:
      i. The employee's name and any other employee identifier used in the workplace;
      ii. The employee's vaccination status for all vaccines required by this standard, including the information provided by Employee Health, any vaccine record provided by the employee, and any signed declination forms;

      ~~EXCEPTION :~~EXCEPTION: As to seasonal influenza vaccine, the medical record need only contain a
      declination form for the most recent seasonal influenza vaccine.
      iii. A copy of all written opinions provided by a Physician or other licensed health care professional ~~PLHCP~~ in accordance with this standard, and the~~-~~ results of all TB assessments; and
      iv. A copy of the information regarding an exposure incident that was provided to the Physician or other licensed health care~~PLHCP~~.
   c. Confidentiality. The employer shall ensure that all employee medical records required by this section are:
      i. Kept confidential; and
      ii. Not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

      NOTE: These provisions do not apply to records that do not contain individually identifiable medical information, or from which individually identifiable medical information has been removed.
   d. The employer shall maintain the medical records required by this section for at least the duration of employment plus 30 years in accordance with Section 3204, Access to Employee Exposure and Medical Records, of these orders.
2. Training records.
   a. Training records shall include the following information:
      i. ~~i. The~~i. The date(s) of the training session(s);
      ii. ii~~. The~~. The contents or a summary of the training session(s);
      iii. The names and qualifications of persons conducting the training or who are designated to respond to interactive questions; and
      iv. The names and job titles of all persons attending the training sessions.
   b. Training records shall be maintained for 3 years from the date on which the training occurred.
3. Records of implementation of Aerosolized Transmissible Disease Plan and/or Biosafety Plan.

a. Records of annual review of the ATD Plan and Respiratory Protection Program ~~Biosafety~~ Plan shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of employees involved, and a summary of the conclusions. The record shall be retained for three years.
b. Records of exposure incidents shall be retained and made available as employee exposure records in accordance with Section 3204. These records shall include:
    i. The date of the exposure incident;
    ii. The names, and any other employee identifiers used in the workplace, of employees who were included in the exposure evaluation;
    iii. The disease or pathogen to which employees may have been exposed;
    iv. The name and job title of the person performing the evaluation;
    v. The identity of any local health officer and/or Physician or other licensed health care ~~PLHCP~~ consulted;
    vi. The date of the evaluation; and
    vii. vii The date of contact and contact information for any other employer notified by NIHD regarding potential employee exposure.
c. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.
d. Records of the unavailability of Airborne Infection Isolation R~~r~~ooms or areas shall include the name of the person who determined that an Airborne Infection Isolation Room ~~AII room~~ or area was not available, the names and the affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer providing assistance, and the times and dates of these contacts. This record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.
e. Records of decisions not to transfer a patient to another facility ~~for~~ for Airborne Infection Isolation Room ~~AII~~ for medical reasons shall be documented in the patient's chart, and a summary shall be provided to the Plan administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision and the date, time and identity of the person(s) who performed each daily review. The summary record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.
f. Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems shall be maintained for a minimum of five years and shall include the name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance, the date, and any significant findings and actions that were taken. Plant operation ~~s~~ uses a computer-based work system for documentation of records.
g. Records of the respiratory protection program shall be established and maintained. Fit-test screenings will be retained for two years.

4. Availability.
   a. The employer shall ensure that all records, other than the employee medical records more specifically dealt with in this subsection, required to be maintained by this section shall be made available upon request to the Chief Operations Officer and National Institute for Occupational Safety and Health ~~NIOSH~~ and the local health officer for examination and copying.
   b. Employee training records, the exposure control plan and/or ~~biosafety~~Biosafety plan, and records of implementation of the ~~A~~Aerosolized Transmissible Disease exposure control plan and Respiratory Protection Program and the ~~biosafety~~Biosafety plan (Chemical Hygiene Plan), other than medical records containing individually identifiable medical information, shall be made available as employee exposure records in accordance to employees and/or employee representatives.
   c. Employee medical records required by this subsection shall be provided upon request to the subject employee, anyone having the written consent of the subject employee, the local health officer, and to the Chief Operations Officer and National Institute for Occupational Safety and Health ~~NIOSH~~ for examination and copying.
5. Transfer of Records.
   a. NIHD will comply with the requirements involving the transfer of employee medical and exposure records.
   b. If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Chief Operations Officer and National Institute for Occupational Safety and Health ~~NIOSH~~, at least three months prior to the disposal of the records and shall transmit them to National Institute for Occupational Safety and Health~~NIOSH~~, if required by National Institute for Occupational Safety and Health ~~NIOSH~~ to do so, within that three-month period.
   NOTE: Authority cited: Sections 142.3 and 6308; Labor Code. Reference: Sections 142.3 and 6308, Labor Code, and 8 CCR 332.3.

~~**Policy References:**~~**REFERENCES:**

1. 2009, California Occupational Safety & Health Standards Board (OSHSB), General Industry Safety Orders, Aerosolized Transmissible Diseases, Title 8, Chapter 4, Subchapter 7, Article 109, Section 5199 *http://www.dir.ca.gov/title8/5199.HTML* ~~*(http://www.dir.ca.gov/OSHSB/atd0.html); http://www.dir.ca.gov/OSHSB/atdapprvdtxt.pdf*~~
~~1.~~2. California Department of Public Health. (2017). ATD Standard Appendix D: Aerosol Transmissible Pathogens-Laboratory. Retrieved from https://www.dir.ca.gov/title8/5199d.html
3. Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings,~~,~~ (2005) CDC page last updated 2012 and page last reviewed 2016.~~.~~, published by the Centers for Disease Control.
~~2.~~4. California Department of Public Health. (2017). Respiratory Protection in the Workplace: Cal?OSGA Respiratory Protection Standard. Retrieved from https://www.cdph.ca.gov/programs/ohb/Pages/RespStd.aspx

~~3.~~5. California Tuberculosis Controllers Association. (2015). Current CDPH-CTCA Joint Guidelines. Retrieved from http://www.ctca.org/menus/cdph-ctca-joint-guidelines.html http://www.ctca.org/filelibrary/Scrning_Trtmnt-Patients_with_ChronicKidneyDisease..._.pdf http://www.ctca.org/filelibrary/CTCA_CDPH_Actions_and_Best_Practices_For_TB_Approved.pdf August 2016. http://www.cdph.ca.gov/programs/tb/Documents/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf (Oct 2016)~~2006, California Department of Health Services/California Tuberculosis Controllers Association Joint Guidelines; http://www.ctca.org/guidelines/index.htmsl~~

4.6. California Health & Safety Code, Title 22, Division 5, Chapter 6, Article 4, §74723 (c)(4), http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/index.cfm *(go to the Official CCR via link from this site)*

~~5.~~7. *Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-preventable Diseases*, Hamborsky J, Kroger A, Wolfe S, eds. 13th ed..~~2009~~, Washington D.C. Public Health Foundation, 2015. ~~published by the Centers for Disease Control. http://www.cdc.gov/vaccines/pubs/pinkbook/default.htm~~

~~6. http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Enviro_guide_03.pdf~~

8. Centers for Disease Control and Prevention. (2012) Respiratory Hygiene/Cough Etiquette in Healthcare Settings. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm

9. Centers for Disease Control and Prevention. (2016). The National Personal Protective Technology Laboratory (NPPTL). Retrieved from https://www.cdc.gov/niosh/npptl/hospresptoolkit/default.html

10. APIC Position Paper" Recommendations for Extending Use and/or Reusing Respirators" December 2009 (Placed at the end of this policy for referencing).

11. *Implementing Respiratory Protection Programs in Hospitals A Guide for Respirator Program Administrators*, California ~~Departmnet~~Department of Public Health, Occupational Health Branch, August 2015

~~7.~~12. California Department of Public Health (CDPH). (2012). Respirator Use in Health Care Workplaces: Cal/OSHA Aerosol Transmissible Disease Standard. Retrieved from https://www.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx

CROSS REFERENCE POLICIES:

1. Airborne Infection Isolation Room (AIIR)
2. N95 Mask Fit Testing Using Porta Count Pro
3. Employee Health Surveillance Program
4. Adult Immunization in the Healthcare Worker
5. Work Related Accidents/Exposures
6. Initial Evaluation of Exposure Incident
7. Lippincott Procedures: Airborne Precautions , Contact Precautions, Droplet Precautions, Standard Precautions, Respiratory Hygiene and Cough Etiquette ambulatory care.
8. Admission of a Patient with a Communicable Disease
9. Avian Influenza-H5N1 Flu Hospitalized Patients Infection Control

NORTHERN INYO HOSPITAL
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Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

10. Infectious/Non Infectious Waste Disposal Procedure
11. Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) Middle East Respiratory Syndrome (MERS-CoV) Infection Control Recommendations Hospitalized Patients
12. PAPR Respirator Inspection Record
13. Care and Donning of a Powered Air Purifying Respirator
14. Northern Inyo Healthcare District Surge Plan
15. Chemical Hygiene Plan

Approval	**Date**
CCOC	7/17/17
Infection Control Committee	8/22/17
MEC	9/5/17
Board of Directors	01/26/2010
Last Board of Directors Review	

Developed: 11/09/10 LA
Reviewed:
Revised: 8/11LA; 12/15NH, 1/17 NH, 6/17RC
Supersedes:
Index Listings: ATD, Aerosolized, TB, Respiratory, Airborne Isolation,
~~This is the link to the CAL/OSHA site for the ATD Standard~~

~~**Responsibility for review and maintenance:** Infection Control Practitioner~~
~~**Index Listings:** Exposure Control Plan~~
~~**Revised/Reviewed:** 11/09/10; 8/11LA; 12/15NH; 1/17 NH~~

~~**Date**~~

NORTHERN INYO HOSPITAL
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Title: Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program	
Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

~~1/26/10~~

Appendix A – Aerosol Transmissible Diseases/Pathogens (Mandatory)

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

Diseases/Pathogens Requiring Airborne Infection Isolation
Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/*Bacillus anthracis.*
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in ~~immunocompromised~~immuncompromised patient until disseminated infection ruled out
Measles (rubeola)/Measles virus
Monkeypox/Monkeypox virus
Novel or unknown pathogens
Severe acute respiratory syndrome (SARS)
Smallpox (variola)/Varioloa virus
Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
Any other disease for which public health guidelines recommend airborne infection isolation

Diseases/Pathogens Requiring Droplet Precautions
Diphtheria pharyngeal
Epiglottitis, due to *Haemophilus influenzae* type b
Haemophilus influenzae Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children
Influenza, human (typical seasonal variations)/influenza viruses
Meningitis
Haemophilus influenzae, type b known or suspected
Neisseria meningitidis (meningococcal) known or suspected
Meningococcal disease sepsis, pneumonia (see also meningitis)
Mumps (infectious parotitis)/Mumps virus
Mycoplasmal pneumonia
Parvovirus B19 infection (erythema infectiosum)
Pertussis (whooping cough)
Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
Pneumonia
Adenovirus
Haemophilus influenzae Serotype b, infants and children
Meningococcal
Mycoplasma, primary atypical

Streptococcus Type A
Pneumonic plague/*Yersinia pestis*
Rubella virus infection (German measles)/Rubella virus
Severe acute respiratory syndrome (SARS)
Streptococcal disease (group A streptococcus)
Skin, wound or burn, Major
Pharyngitis in infants and young children; Scarlet fever in infants and young children
Pneumonia
Serious invasive disease
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures)
Any other disease for which public health guidelines recommend droplet precautions

Note: The ~~biosafety~~Biosafety officer reviewed all of the pathogens listed above and listed the few that may pertain to our laboratory.
Airborne: All bioterrorism bacteria- sent to the state lab immediately, without work here
Droplet: Streptococcus Type A
~~Hemophilus~~Haemophilus influenza, type b known or suspected- Do not type it here, but may work with it
Neisseria ~~meningitidis~~meningitis, known or suspected- Any work with this is done under the hood.

~~**Appendix B—Alternate Respirator Medical Evaluation Questionnaire (This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C)**~~

~~**To the PLHCP:** Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employees must be provided with a confidential means of contacting the health care professional who will review this questionnaire.~~
~~**To the employee:** Can you read and understand this questionnaire (circle one): Yes No~~

~~**Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.Appendix D: N-95 Questionnaire- for Employees Required to Have Every 2 Year Re-Fit Testing**~~

~~Date:~~ _____

~~Name:~~ _____ ~~Dept:~~
_____
_____

~~Respirators are an important means of reducing your exposure to infectious aerosols. Air purifying respirators provide a barrier to prevent health care workers from inhaling *Mycobacterium*~~

~~*tuberculosis* and other pathogens. The level of protection a respirator provides is determined by the efficiency of the filter material and how well the facepiece fits or seals to your face.~~
~~Cal/OSHA regulations require that you be provided with a fit-test at the time of initial fitting, whenever a different size, make, model or style of respirator is used, and whenever you report a change in physical characteristics that may affect fit, such as major dental work, facial surgery or injury, or a change in weight.~~
~~Fit tests must also be repeated periodically, because people are not always aware of facial changes that may have affected the fit of the respirator. Generally, Cal/OSHA regulations require that fit-tests be repeated annually. The aerosol transmissible disease regulation permits employers to lengthen this interval to every two years for employees who are not exposed to high hazard procedures, such as bronchoscopies. However, if you believe that you need another fit-test to ensure that the respirator is fitting you correctly, you may request an additional fit-test, and your employer will provide it.~~
~~A respirator will not protect you if it does not fit, and if it is not worn properly. In addition to fit-testing, it is important for you to be aware of the size, make, model and style of respirator that fits you, and to understand and practice how to put the respirator on and take it off. It is particularly important to properly place the straps, and in some models, to adjust the straps and adjust the nose piece, so that it forms a snug seal on your face. During your annual training, you will be shown how to use a respirator.~~

~~Screening Questions (Answer Yes/No)~~

~~Have you had recent major dental work, facial injury or facial surgery since your last fit-test?~~
~~Have you had a significant weight gain or loss since your last fit-test?~~
~~Do you want to be provided with an additional fit-test for your current respirator?~~
~~Date: _____~~

~~Printed Signature _____~~
~~_____ Print legibly~~

~~Signature _____~~

~~Date of fit-test (if provided): _____~~

~~Please Return to Human Resources~~

~~Appendix E~~
~~HCW Contact with Case of an Aerosolized Transmissible Disease~~
~~Date of Investigation: _____; Date(s) of possible exposure: _____~~
~~HCW Name: _____ Dept: _____~~
~~Occupation(s): _____~~
~~Area where HCW typically works: _____~~

NORTHERN INYO HOSPITAL
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Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

~~Area where exposure occurred:~~ _____
~~Nature of exposure:~~ ☐ ~~patient care~~ ☐ ~~examined patient~~ ☐ ~~CPR~~
☐ ~~obtained respiratory specimens~~ ☐ ~~within 6 feet,~~
~~Other,specify:~~ _____

~~Number of times/hours HCW had contact with case:~~ _____

~~Influenza A/B Swab done:~~ ☐ ~~Yes~~ ☐ ~~No, Date:~~ _____; ~~H1N1 don~~ ☐ ~~Y~~ ☐ ~~No, Date:~~ _____

~~Case confirmed?~~ ☐ ~~Yes~~ ☐ ~~No; Date of confirmation:~~ _____
~~Did HCW use PPE?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If yes, check all that apply:~~ ☐ ~~gloves~~ ☐ ~~N-95 mask~~ ☐ ~~surgical mask~~ ☐ ~~gown~~
☐ ~~face shield~~ ☐ ~~goggles~~

~~Did HCW get vaccinated this season?~~ ☐ ~~H1N1~~ ☐ ~~Seasonal~~
~~HCW Medical Conditions/Family Considerations:~~ _____

~~HCW Illness Form, Check all symptoms that apply:~~
~~Conjunctivitis~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~N~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Coughing~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Diarrhea~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~N~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Shortness of Breat~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Fever~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Headache~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Muscle Aches~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~N~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Runny nose~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Sore throat~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~N~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Vomiting~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~
~~Other symptoms~~ ☐ ~~Yes (Date___/___/___)~~ ☐ ~~No~~ ☐ ~~Unk~~ ~~Predates initial exposure~~

~~Was exposure likely significant?☐ Ye☐ No~~
~~PEP offered per Anti-viral Policy? If so, name of medication:~~
~~_____~~
~~HCW advised to monitor themselves for ILI symptoms and report to immediate supervisor if he or she has any symptoms?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~HCW seen by ER Physician or other provider?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~Was HCW placed on home isolation?~~ ☐ ~~Yes~~ ☐ ~~No~~ ~~If yes, date:~~
~~_____~~
~~Were laboratory specimens obtained?~~ ☐~~Yes~~ ☐ ~~No~~ ~~If yes, date:~~
~~_____~~
~~Was ICHD involved in case investigation~~☐ ~~Yes~~☐ ~~No~~ ~~Other Comments (may also use back of page):~~
~~_____~~
~~_____~~
~~_____~~

~~**Appendix F**~~

~~**Date of ED Visit** _____ **MRN#** _____~~

~~**Reportable Disease**~~

- ☐ ~~**Novel flu under airborne and Seasonal flu.**~~
- ☐ ~~Chickenpox and Disseminated Herpes Zoster~~
- ☐ ~~Rubeola/Rubella~~
- ☐ ~~TB~~
- ☐ ~~Diphtheria~~
- ☐ ~~Epiglottis due to H. Influenza Type B~~
- ☐ ~~Meningitis, due to Meningococcal or H. Influenza Type B~~
- ☐ ~~Meningococcal pneumonia~~
- ☐ ~~Mumps~~
- ☐ ~~Pertussis~~

~~**Arrival**~~

- ☐ ~~Ambulance~~ _____ ~~(Ambulance Service)~~
- ☐ ~~Law Enforcement Custody~~ _____ ~~(Agency Name)~~
- ☐ ~~Ambulatory~~
- ☐ ~~Transfer~~ _____ ~~(Facility and Ambulance)~~
- ☐ ~~Outside Agency Involved with patient's care prior to ED admit (PHHC, ICMH, 02)~~

NORTHERN INYO HOSPITAL
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Scope: NIHD	Manual: CPM- Infection Control Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist	Effective Date:

~~**Please complete form and send to Barbara Smith, Infection Control Nurse.**~~

~~**REMOVE APPENDIX G**~~[RC10]

Patient Sticker

~~**Appendix G – Reference**~~
~~**Recommendations for Extending Use and/or Reusin**~~
~~(Taken directly from the APIC Position Paper, including referenc~~

~~*Assumptions*~~
~~*These recommendations are based on the premise that existing recommendations and guidelines are followed when supplies are adequate. It is also assumed that healthcare facilities will implement all hierarchy of controls as outlined by the CDC, including eliminating potential exposures and using engineering and administrative controls. This document only addresses extending the use and/or reusing respiratory protection; other documents should be consulted for information on other control measures needed to prevent disease spread during infectious disease disasters.*~~[1,3]

~~II. Recommendations for extending the use and/or reusing respirators~~
~~Disposable N-95 respirators, when used solely to prevent occupational exposure to Mycobacterium tuberculosis, can be safely reused until contaminated, damaged, or no longer form a good seal.~~[5] ~~Unlike Mycobacterium tuberculosis, which is transmitted exclusively via airborne droplet nuclei, most other respiratory pathogens are transmitted primarily via direct and indirect (droplet) contact with respiratory secretions. Therefore the exterior of respiratory protection used in caring for patients with respiratory pathogens other than tuberculosis can become contaminated and serve as a reservoir for infectious agents. Special precautions must be taken when extending the use or reusing disposable respiratory protection to prevent healthcare personnel exposure.~~

~~Extended use of respiratory protection is defined as the wearing of a disposable respirator during serial patient encounters without the removal or re-donning of the device between encounters.~~[3] ~~Reuse of respiratory protection consists of removing and re-donning the device between encounters.~~[3] ~~Both of these actions pose a transmission risk to healthcare personnel due to potential respirator contamination. This transmission risk can be minimized if healthcare personnel adhere stringently to hand hygiene before and after handling the respiratory protection device.~~

If supplies are likely to be limited, healthcare organizations should conserve supplies as follows, considering vaccine availability for the specific pathogen:

1. **Strongly encourage healthcare personnel to be vaccinated against the agent involved in the infectious disease disaster (such as influenza vaccine during an influenza pandemic), when such vaccine is available.** This will create an immunized cadre of healthcare personnel for whom respiratory protection will be less critical.
2. **Extending the use or reusing respiratory protection is preferred over prioritizing the allocation of N95 respirators and surgical/procedure masks based on exposure risk**
3. **Extended use is preferred over reuse**[3]

Practices for extending the use and/or reusing a respirator:

- The respirator should only be worn and/or reused by a single wearer
- The respirator should not be removed, adjusted, or touched during patient care activities
- Avoid contamination during use by not touching the outside of the respirator
- Care should be taken to prevent touching the inside of the respirator
- The respirator should be discarded after being used during an aerosol-generating procedure
- The respirator should be discarded if it becomes grossly contaminated with the patient's body fluids, including blood or respiratory secretions. Note: this may be difficult for the wearer to discern. Healthcare personnel should be aware that even if not visibly soiled, the external surface of the respirator is considered to be contaminated
- The respirator must be discarded if it becomes obviously soiled or damaged (e.g., creased, torn, or saturated) or if breathing through the device becomes difficult
- Consider using a surgical/procedure mask[7] or face shield[3] over the respirator to reduce/prevent contamination of the device. If masks are also in short supply, face shield use should be encouraged to help conserve masks
- Care should be taken during removal of the mask or face shield to ensure the respirator is not contaminated
- The surgical/procedure mask must be discarded after a single use. If reusable, the face shield must be decontaminated between uses
- Hand hygiene should be performed after removing the face shield or mask and before removing the respirator
- Perform hand hygiene before and after handling/touching the respirator

The following are examples of situations/locations in which extended use may be both practical and feasible when supplies are limited: triage clinics/areas, in-patient units that house large numbers of infected patients, or isolation units dedicated to patients with known or suspected infections. Each facility should conduct a risk assessment and

develop a contingency plan that includes examination of its patient population, healthcare personnel immune/vaccination status, and physical structure in terms of the feasibility of implementing an extended and/or reuse protocol.

In addition to the above, the following recommendations should also be followed when reusing a respirator:

- The respirator should be removed carefully to avoid cross-contamination
- Personnel should be instructed to use hand hygiene after putting the respirator on and following removal/placement in a storage location
- The respirator should be stored in a clean, dry location that prevents it from becoming contaminated and maintains its physical and functional integrity[8]
- Store the respirator in a breathable container, such as a paper bag, or hang the respirator in a designated area[3,8]
- If the respirator is to be stored in a container, the container/bag should be labeled with the user's name
- The container/bag is a single use item because the inside can become contaminated due to storing a used respirator; therefore, the container/bag should be discarded after the respirator is re-donned[9]
- Consider labeling the respirator with the user's name to prevent staff from reusing another's respirator; labeling should be written on the straps whenever feasible to prevent damage to the respirator[8]
- The respirator should be inspected before each use to ensure its physical integrity is intact and a seal check should be performed by the healthcare personnel to ensure an adequate fit
- Respirators that are damaged or cannot achieve an adequate fit during the seal check should be discarded

III. Prioritize allocation of N95 respirators and masks based on exposure risk

If respirator/mask supplies are scarce or insufficient even after the facility has obtained additional supplies from local, regional, or national sources, examined the feasibility of reusable respirators (PAPRs, elastomeric respirators, etc.), and implemented extended use and/or reuse procedures, protocols should be followed to prioritize healthcare personnel to receive respirators/masks based on their exposure risk; exposure risk should be determined based on the healthcare facility's exposure risk analysis that is part of emergency management planning, including personnel's immune status.

Healthcare organizations should develop prioritized respirator use protocols as follows:

1. Facilities should maintain a reserve stock of respirators/masks that will be used during aerosol-generating procedures and/or with patients who are known

or suspected of being infected with an airborne microorganism, such as Mycobacterium tuberculosis.
Consider a contingency plan wherein reusable respiratory protection, such as PAPRs, is available for personnel who need to care for those with suspected or active TB disease.

2. Airborne-transmitted diseases: Priority for respirator use should be given to healthcare workers providing care for patients with obligate and preferential airborne-transmitted diseases, such as active tuberculosis disease.

- Laboratory studies indicate that surgical and procedure masks do not offer appropriate respiratory protection against small particle aerosols (i.e. in a size similar to airborne droplet nuclei) and should not be used unless particulate respirators are not available when dealing with diseases transmitted by the airborne route;[10-12] if a particulaterespirator is not available, use a tightly fitting surgical/procedure mask.[13]

3. Aerosol-generating procedures: Priority for respirator use should be given to healthcare personnel performing aerosol-generating procedures.[1,3,9,14]

- During disasters involving an airborne spread disease, aerosol generating procedures should only be performed by staff wearing an N95 respirator or other respiratory protection that is at least as protective as an N95 respirator[1,9]
- If the healthcare facility is completely out of respirators (disposable or reusable) and aerosol-generating procedures must be performed on a patient with an airborne spread disease, the healthcare personnel involved in the procedure should wear a surgical/procedure mask. Use of a surgical/procedure mask in this type of dire situation is preferable to using no facial protection at all. **It is important to note that this scenario should not occur;** healthcare facilities should use contingency planning to ensure they have adequate respiratory protection supplies for staff by obtaining additional respirators, utilizing reusable respirators, extending the use and/or reusing disposable respirators, and implementing control measures (such as vaccinating personnel) to decrease the need for respirators. In addition, healthcare personnel in this situation should follow infection prevention strategies to decrease their risk of infection, including following Standard Precautions and performing hand hygiene.

Aerosol-generating procedures that pose a higher risk of exposure than routine patient care activities consist of the following:

- Intubation, extubation, bronchoscopy, sputum induction, cardiopulmonary resuscitation, open suction of airways, and autopsy[1,9,15]

Other medical procedures have been identified as having the potential to generate limited amounts of aerosols, although the risk of infection transmission associated with these procedures varies, depending on the disease involved.[1,16] Disease-specific guidelines should be consulted when determining if the following aerosol-generating medical procedures should be considered high risk for infection transmission and thus receive priority for respirator usage:

- Administering nebulizer treatments, collecting nasopharyngeal samples, use of highflow oxygen, positive pressure ventilation via face mask (e.g., BiPAP, CPAP), and high-frequency oscillatory ventilation[1,16]
- When feasible, it is preferred that staff who have not been immunized against the specific agent be given priority for respirators over immunized staff when conducting aerosolizing procedures on patients who are known to be infected with the agent involved in the infectious disease disaster during times of limited supplies (i.e., nonimmunized personnel should be provided a respirator; immunized personnel would be provided a surgical/procedure mask). In most situations, healthcare personnel's immune status will need to be evaluated contextually because it will not be feasible to draw titers or conduct other tests to ensure immunity quantitatively. Immunogenicity should be based on the date of vaccination and the vaccine-specific time needed to develop an immune response.

4. **Healthcare personnel at risk of infectious complications**: Allocating limited supplies of respirators should be prioritized for healthcare staff who are at greatest risk from complications of infections.[3]

- The risk analysis will vary from event to event, depending on the infectious agent involved, but should include assessing the task being performed in terms of the duration and intensity of the encounter (i.e., personnel exposure risk), personnel immune/vaccination status, and personnel health status that may affect their risk of infection (such as being immunocompromised, pregnant, etc.)

5. Healthcare staff who are not in the high-exposure/priority groups (i.e., those who are not assigned to care for patients who are known or suspected of being infected with an airborne transmissible disease, involved in routine patient care that does not involve aerosol-generating procedures, and/or those who do not meet the criteria for being at high risk of complicated infection) should be provided with FDA-cleared surgical/procedure masks.[3]

- Switching to an FDA-cleared surgical/procedure mask for healthcare staff who are not in the high-exposure/priority groups during prioritized respirator use mode is considered a temporary measure only. Every effort should be made to obtain additional respirators as soon as possible.

6. If the facility is unable to obtain or conserve N95 respirators per the prioritized respirator use protocols above and/or supplies of N95 respirators are depleted despite conservation efforts:

- **Surgical/procedure masks can provide benefits against large droplet exposure, and should be worn by healthcare personnel when providing care to patients who have signs/symptoms of a respiratory illness.**[17] In time of such dire shortages, they should be used in order to reduce exposure potential.
    - Select surgical/procedure masks that can be tied tightly or have elastic straps (no tear loop masks that do not form a seal)
    - Disposable surgical/procedure masks should fit the user's face tightly and be discarded immediately after use. If the mask gets wet or dirty with secretions, it must be changed immediately[14]
    - Perform hand hygiene before and after touching/handling the mask

7. If supplies of surgical/procedure masks are insufficient or unavailable:

- If supplies of FDA-cleared healthcare surgical/procedure masks become depleted:
    - Consider the use of full face shields that protect the wearer's eyes and mouth for staff who have been immunized against the specific agent involved in the infectious disease disaster rather than having them use a respiratory protective device when caring for a patient who is known to be infected with the agent involved in the infectious disease disaster. This will help conserve the supply of respirators/masks for personnel at high risk from complications of infection (i.e.,non-immunized personnel).
- Respirators that are FDA-cleared for general public use during public health emergencies can be used in healthcare settings, but do not provide the same level of protection as N95 or higher level respirators; it is not known if FDA cleared respirators are more protective than FDA-cleared surgical/procedure masks.[17] Respirators that are FDA-cleared for general public use during public health emergencies should only be used in healthcare settings in dire circumstances. All other efforts at conserving and obtaining NIOSH-certified respirators or FDA-cleared surgical/procedure masks should be made before proceeding with this type of respirator in healthcare settings.
- Controversies exist regarding how to proceed when supplies of disposable N95 or higher level respirators, FDA-cleared healthcare surgical/procedure masks, and masks/respirators that are FDA-cleared for general public use during public health emergencies are depleted/unavailable.[18]
- Review of the scientific literature identified a published letter detailing construction of a handmade, reusable cotton mask. This type of mask is currently available in Asia and may be constructed quickly during a pandemic if all other resources have been exhausted. Cloth/woven masks may provide some

~~level of protection based on anecdotal and/or limited evidence.[19-21] APIC hesitates to discourage their use if all other mask/respirator options have been exhausted by the healthcare facility, but cautions that these masks are not as protective as NIOSH-certified respirators or FDA-cleared surgical/procedure masks.~~

- ~~Dust masks, such as those commonly sold at home improvement stores, have been shown to be less protective than NIOSH-certified N95 respirators[22] and therefore should not be used in healthcare settings to prevent the transmission of infectious agents. There is no evidence regarding dust mask performance versus an FDA-cleared surgical/procedure mask in preventing infection transmission; therefore, no recommendation can be made regarding their use in healthcare facilities.~~

~~IV. Regardless of the availability of respirators or surgical/procedure masks, environmental control measures, respiratory hygiene/cough etiquette, and extreme vigilance with proper hand hygiene are critical in minimizing the likelihood of exposure.~~

~~This is the link to the CAL/OSHA site for the ATD Standard~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Trophon® Environmental Probe Reprocessor (EPR)	
Scope: Diagnostic Imaging, RHC Women's	Manual:
Source: Infection Preventionist	Effective Date:

PURPOSE:
Provide guidance for achieving high level disinfection (HLD) using the Trophon® EPR in accordance with the manufacturer's recommendations and infection control guidelines.
The sole purpose of the Trophon® EPR is to provide high level disinfect on all ultrasound transducers.

POLICY:
1. High Level Disinfection of the ultrasound probes will be preformed after each patient use to ensure it is properly sanitized for the next patient.
2. Trophon EPR system will be used only by trained healthcare professionals.
3. The Trophon EPR system will be used according to manufacturer's safe operation
4. Trophon EPR system and user training will be completed upon hire and annually
5. Personal Protective Equipment (PPE) required: gloves and standard precautions
6. The Chemical indicator chart and Trophon EPR user chart must be posted where the Trophon is being utilized.
7. The Trophon® EPR must be left connected to power and switched ON at all times.

DEFINTION:
High-Level Disinfection: Destruction/removal of all microorganisms except bacterial spores

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

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

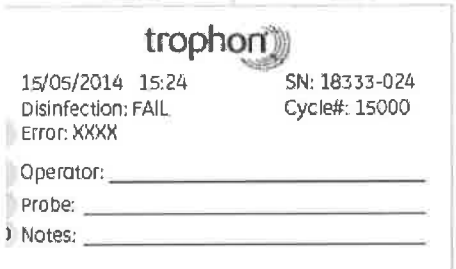
PROCEDURE:
1. PREPARING AND POSITIONING THE PROBE:
   - Don gloves
   - The probe must be pre-cleaned and dried BEFORE the HLD process can commence in the Trophon® EPR. Use a hospital approved alcohol-free cleaning disinfecting wipe, following directions of cleaning and disinfecting product being used, and ensure the cleaner being used is approved by the probe manufacturer.

Title: Trophon® Environmental Probe Reprocessor (EPR)	
Scope: Diagnostic Imaging, RHC Women's	Manual:
Source: Infection Preventionist	Effective Date:

- A chemical indicator must be used for each disinfection cycle and can only be used one time. A chemical indicator shall be placed into the holder on the floor of the device chamber.
- *Load Probe and Indicator* screen message will be displayed when Trophon EPR system is ready.
- Open chamber door, and use the two clamps to hold the probe securely to the chamber
- After correctly loading the probe into the chamber the door will automatically lock at the start of the HLD cycle. Note: If door not properly closed a "Close Chamber Door" message will be displayed.

2. DISINFECTING THE PROBE SCREEN MESSAGE
   - If the probe has been pre-cleaned and dried press YES and then Press Start
   - If the probe has not been pre-cleaned and dried press NO, remove probe, clean and dry with approved alcohol-free cleaning disinfecting wipe. Reload probe into chamber
   - High Level Disinfection process will take 7 minutes to complete.
3. REMOVING THE PROBE:
   - When the cycle has been completed, the trophon will sound an audible alarm. Put on gloves and follow the screen instruction message
     - Message 1 Cycle complete, remove and wipe probe
     - Message 2: Attention wear gloves and wipe probe. (This message indicates that some hydrogen peroxide may not be broken down and extra care should be taken when removing the probe.
     - Immediately remove the used Chemical Indicator from the trophon and verify the color change against the chart on the Chemical Indicator carton. Discard Indicator. Record the result using the printer and label.

Sample label:



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

- Remove the probe carefully using minimal contact after the cycle is complete. Avoid touching the probe against the chamber's hot surface.

Title: Trophon® Environmental Probe Reprocessor (EPR)	
Scope: Diagnostic Imaging, RHC Women's	Manual:
Source: Infection Preventionist	Effective Date:

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

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

4. REMOVING AND DISPOSING OF USED DISINFECTANT CARTRIDGES

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

1. Removing the Cartridge
   - Wear gloves

Screen message: REPLACE THE CARTRIDGE AND CLOSE CARTRIDGE DOOR

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

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

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

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

Title: Trophon® Environmental Probe Reprocessor (EPR)	
Scope: Diagnostic Imaging, RHC Women's	Manual:
Source: Infection Preventionist	Effective Date:

5. SLEEP MODE AND SHUTDOWN PROCEDURES

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

6. WARM-UP CYCLE:

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

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

7. PURGE CYCLE:

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

8. INCOMPLETE OR FAILED CYCLES

- Refer to manual page 19 titled Part D- Troubleshooting

9. ROUTINE CARE AND MAINTENANCE

- Wipe all accessible surfaces of the trophon with a hospital approved Quat disinfectant.

REFERENCES:

1. American Institute of Ultrasound in Medicine. (2017). Guidelines for Cleaning and Preparing External-and Internal-Sue Ultrasound Probes Between Patients, Safe Handling,

and use of Ultrasound Coupling Gel. Retrieved from http://www.aium.org/officialStatements/57

2. Centers for Disease Control and Prevention. (2016). Disinfection and Sterilization, https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf (2008)
3. General Electric Healthcare. (2017). Trophon EPR for High Level Disinfection for Ultrasound Probes. Retrieved from http://www3.gehealthcare.com/en/products/categories/ultrasound/trophon_epr
4. Infection Control Today. (2015) Human Papilloma Virus the New Challenge For Infection Prevention. Retrieved from https://www.infectioncontroltoday.com/immersion-centers/2015/05/~/media/DF602B3687504B6E8A9FF975329C739F.ashx
5. Joint Commission E-dition. (2017). Infection Prevention and Control (IC.02.02.01 EP 2) The Critical Access hospital reduces the risk of infections associated with the medical equipment, devices and supplies. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

CROSS REFERENCE P&P:

1. Endovgainal Ultrasound Probe Storage Transportation and Disinfection
2. Gluteraldehyde Use Station GUS – STATION HIGH-LEVEL DISINFECTION DEVICE

Approval	Date
CCOC	7/17/17
Infection Control Committee	8/22/17
MEC	9/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 5/2017 KA/RC
Reviewed:
Revised:
Supersedes:
Index Listings: Trophon, endovaginal probes, High Level Disinfection, Ultrasound Probes

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **GUIDELINES FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIV** ~~**GUIDELINES FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIV**~~	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

PURPOSE:
To provide a guideline so the hospital can appropriately guide and manage health care workers (HCWs) who are infected with one or more of the above pathogens.

General Guidelines:

1. Northern Inyo Healthcare District (NIHD) through the Infection Control Department and committee, is dedicated to preventing provider to patient transmission through exposure risk management; training; needleless systems and other devices to decrease percutaneous exposures; personal protective equipment; and numerous other measures.

2. NIHD stresses the importance of patient safety, as well as provider privacy and medical confidentiality.

3. Accordingly, HCWs have an obligation to follow the accepted standards of practice to prevent the transmission of blood borne pathogens to patients. These standards include knowledge about and utilization of infection control procedures. All HCWs need to comply with policies and procedures designed to protect patients.

4. HBV, HCV, and HIV are known to be most readily transmitted either parenterally or across mucous membranes. Therefore, SHEA guidelines state "that the risk of these viruses from an infected provider to a patient during the provision of routine healthcare that does not involve invasive procedures is negligible." Even exposure prone activities have very low likelihood of transmission, but it is elevated when compared to routine activities.

5. Because of a potential risk of provider to patient transmission, however low, it is considered that HCWs are ethically bound to report their disease status, when known, to Infection Control Because of the overall low transmission risk of the 3 viruses, mandatory screening of HCWs is not warranted and not recommended. (Both SHEA and the CDC agree on this)

6. Infection with a bloodborne pathogen does not justify restriction on the practice of an otherwise competent HCW. However, there are some high risk procedures where restriction may be necessary if the HCW is infected and has a high viral load of the pathogen. In addition, practice restrictions may be considered if the HCW has a physical or mental impairment that affects his or her judgment and/or jeopardizes patient safety. Examples include exudative lesions; a history of poor infection control techniques or adherence; mental confusion; or a prior incident of transmitting a bloodborne pathogen to a patient.

7. Society for Healthcare Epidemiology of America (SHEA) has published recommendations that can be considered on a case by case basis when the HCWs viral load is known. These can be viewed by

Title: GUIDELINES FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIVGUIDELINES ~~FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIV~~	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

accessing the article through the link below. However, SHEA continues to recommend that HCWs who are known to positive for HBV "e" antigen use double-gloving for all invasive procedures.

8. SHEA's guidelines also list 3 different categories of procedural risks. The procedures associated to each of these categories can be located in Table 2 through the link below. ~~These can also be viewed through the link below.~~
    1. Category 1: Procedures with de minimis risk of bloodborne virus transmission
    2. Category II: Procedures for which bloodborne virus transmission is theoretically possible but unlikely
    3. Category III: Procedures for which there is definite risk of bloodborne virus transmission or that have been classified previously as "exposure-prone." ~~Shea~~ SHEA recommends that Healthcare healthcare workers when performing category III maintain HBV blood levels 10^4 GE/ml, i.e. depending on the assay used, approximately 2,000 IU/ml
9. NIHD's policy for provider to patient exposure can be found in the Patient Exposure policy.

10. The HCW who knows that he or she is the source of a patient exposure is ethically obligated to undergo testing for HBV (if immune status is unknown), HCV, and HIV. Testing may not be done without consent.

REFERENCES:

Centers for Disease Control and Prevention (CDC). (2012). *Updated CDC Recommendations for the Management of Hepatitis B Virus-Infected Healthcare Providers and Students*, Morbidity and Mortality Weekly Report, July 6, 2012 ~~*https://www.cdc.gov/Mmwr/preview/mmwrhtml/rr6103a1.htm*~~ *https://www.cdc.gov/mmwr/pdf/rr/rr6103.pdf*

The Society for Healthcare Epidemiology of America (SHEA). (2017). Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus **(2010).** Link to the entire SHEA document: ~~https://www.shea-online.org/images/guidelines/BBPathogen_GL.pdf~~ https://www.shea-online.org/index.php/practice-resources/2015-04-25-18-30-42/guidelines-under-review/412-guideline-for-management-of-healthcare-workers-who-are-infected-with-hepatitis-b-virus-hepatitis-c-virus-and-or-human-immunodeficiency-virus

Resource Material:
Infection Control and Hospital Epidemiology March 2010, Vol 31, No.3

CROSS REFERNCEES:
1. Patient Exposure
2. Adult Immunization in the Healthcare Worker

~~Committee approval needed: No~~
~~Responsibility for review and maintenance: Infection Control Nurse~~
~~Index Listing: Infected Providers~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **GUIDELINES FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIV**~~**GUIDELINES FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIV**~~	
Scope: NIHD	Manual: CPM - Infection Control- Patient Care (ICP)
Source: Quality Nurse/Infection Control Preventionist	Effective Date:

~~Reviewed/Revised: 12/97; 06/03;9/05;5/10;1/11; 9/12 BS; 5/15 NH, 1/2017 RC,~~

Approval	**Date**
CCOC	6/5/17
Infection Control	8/22/17
MEC	9/5/17
Board of Directors	
Last Board of Directors Review	

Developed: 12/97
Reviewed:
Revised:; 06/03; 9/05;5/10;1/11; 9/12 BS; 5/15 NH, 1/2017 RC,
Supersedes:
Index: Infected Providers, Hepatitis B, Hepatitis C, HIV

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Thrombolytic Therapy with Alteplase (tPA) for an Acute Ischemic Stroke	
Scope: ED, ICU, Acute/Subacute	Manual: CPM - Medication (MED)
Source: ED Manager/Director	Effective Date: 2/18/16

PURPOSE:
Ensure the timely, safe and appropriate administration of thrombolytic therapy for the treatment of an acute ischemic stroke.

POLICY:
1. ~~Emergency~~ dDepartment ~~physicians,~~ iInternal mMedicine pPhysicians, ~~and~~ fFamily pPractice ~~physicians~~ Physicians trained in the diagnosis of ischemic strokes and also in the administration of thrombolytic therapy for an ischemic stroke~~,~~ may initiate the use of Alteplase therapy.
2. Alteplase (tPA) is currently the only thrombolytic approved for the treatment of acute ischemic strokes.
3. The pharmacist will prepare the Alteplase and deliver it to the treating~~Emergency~~ dDepartment for use if a pharmacist is on duty in the hospital.
4. If the pharmacist is unavailable or untimely, the nurse will obtain the Alteplase from the automated dispensing Cabinet~~unitomnicell~~ and will reconstitute it in accordance with the package insert directions or by using the standard mix calculator.
5. The thrombolytic administration packet shall consists of:
    a. Acute Ischemic Stroke Orders and Transport Protocol~~.~~
    b. Checklist for Acute Stroke~~.~~
    c. ED National Institute of Health (NIH) Stroke Scale~~.~~
    d. Consent for Use of Thrombolytic Therapy~~.~~
    e. Neurological flow sheet~~.~~

CROSS REFERENCES:
1.

REFERENCES:
1. **National ~~Institue~~Institute of Health Stroke Scale**
~~1.~~2.

Committee Approval	**Date**
Clinical Consistency Oversight Committee (CCOC)	4/24/17
Emergency Room Services Committee	5/17/17
Med/ICU	7/27/17
Pharmacy and Therapeutics Committee	8/17/17
Medical Executive Committee	9/5/17
Board of Directors	
Last Board of Directors Review	

Developed:
Revised: 11/15 SB 3/17 kp
Reviewed
Index Listings: Alteplase, ischemic stroke

PATIENT SELECTION CRITERIA

Yes	No	PATIENT SELECTION CRITERIA
☐	☐	1. Age 18 or over
☐	☐	2. Clinical diagnosis of ischemic stroke with a measureable neurological deficit. (NIHSS score _____).
☐	☐	3. Time of "last known well" established to be less than 3 hours before treatment would begin. **Last known well Date/Time:** _____ / ____:____

(FOR PATIENTS WITHIN **3 - 4.5 HOUR RANGE** OF TIME LAST KNOWN WELL, COMPLETE **ADDITIONAL WARNINGS)**

Yes	No	ABSOLUTE CONTRAINDICATIONS
☐	☐	1. Evidence of intracranial hemorrhage or major early infarct signs (e.g., substantial edema, mass effect, or midline shift) on pretreatment CT.
☐	☐	2. Clinical presentation suggestive of subarachnoid hemorrhage
☐	☐	3. Internal bleeding (e.g., GI/GU, hemoptysis, etc) actively or within the last 3 weeks.
☐	☐	4. Known bleeding diathesis, including but not limited to: • Platelet count < 100,000 • Patient has received heparin within 48 hours and has an elevated aPTT at presentation • An elevated PT > 15 seconds or INR > 1.4 • Currently taking Dabigatran (Pradaxa) • Currently taking Xarelto (Rivaroxaban) • Currently taking Eliquis (Apixaban)
☐	☐	5. Stroke, serious head trauma, intracranial or intraspinal surgery **within 3 months**
☐	☐	6. SBP > 185 or DBP > 110 despite aggressive treatment
☐	☐	7. Known intracranial neoplasm, arteriovenous malformation, or aneurysm
☐	☐	8. History of intracranial hemorrhage. (intra-parenchymal or subarachnoid)

Yes	No	WARNINGS (May proceed, but weigh against anticipated benefits)
☐	☐	1. Only minor or rapidly improving stroke symptoms (e.g., TIA)
☐	☐	2. Patients with severe neurological deficit (e.g., NIHSS >20) at presentation.
☐	☐	3. Currently receiving oral anticoagulants (e.g., warfarin sodium.)
☐	☐	4. Major surgery within past 14 days
☐	☐	5. Arterial puncture at non-compressible site or Lumbar puncture within past week.
☐	☐	6. Abnormal blood glucose (<50 or > 400 mg/dL).
☐	☐	7. Acute pericarditis
☐	☐	8. Known subacute bacterial endocarditis
☐	☐	9. Significant hepatic or renal dysfunction
☐	☐	10. Female patient of child-bearing age with positive pregnancy test
☐	☐	11. Childbirth within last 30 days.
☐	☐	12. Diabetic hemorrhagic retinopathy, or other hemorrhagic ophthalmic conditions
☐	☐	13. High likelihood of left heart thrombus (e.g., mitral stenosis with atrial fibrillation).
☐	☐	14. AMI within last 3 months
☐	☐	15. Seizure (may proceed if residual symptoms are stroke and not a postictal phenomenon)

3 – 4.5 HOUR Yes	3 – 4.5 HOUR No	ADDITIONAL WARNINGS 3- 4.5 HOUR WINDOW – NEEDS RECOMMENDATION FROM NEUROLOGIST
☐	☐	1. Age > 80
☐	☐	2. History of prior stroke AND diabetes
☐	☐	3. Any anticoagulant use prior to admission (even if INR < 1.7)
☐	☐	4. NIHSS >25
☐	☐	5. CT findings involve > 1/3 of the MCA territory (as evidenced by hypodensity, sulcal effacement or mass effect estimated by visual inspection or ABC/2>100cc).

PATIENT IDENTIFICATION

Nursing signature / RAV _____ Date _____ Time _____

Physician signature _____ Date _____ Time _____

Barcode 3 of 9

CHECKLIST FOR ACUTE STROKE

STROKE WORKUP

- ☐ Date / Time patient last known well: _____
- ☐ Vital Signs: Minimum of every 15 minutes (with continuous O2 and cardiac monitoring)
- ☐ O2 at 2 liters per nasal cannula
- ☐ Two peripheral IV's (18 guage preferable)
- ☐ Labs: CBC, CMP, PT/INR, PTT, Type and Screen, Blood Glucose, Troponin, and pregnancy test if applicable
- ☐ Diagnostic: CT Head Without Contrast (notify radiologist for STAT read); CXR; EKG
- ☐ Strict NPO
- ☐ NIH Stroke Scale Score by MD: _____ At (Time): _____
- ☐ Complete tPA Checklist :
  - ☐ Patient meets tPA criteria, proceed with tPA orders below. Neuro consult Dr: _____ at (time) _____
  - ☐ TPA contraindicated due to _____ (cross through tPA orders)
- ☐ Notify Dispatch / Transport Team

PRE TPA

- ☐ Insert Foley catheter
- ☐ Monitor BP every 15 minutes. **Keep BP < 185/110mmHg**
  - Labetolol 10 mg IVP (may repeat x 1). (Hold for HR < 60)
  - Hydralazine 10 mg IVP. (May repeat x 1). (Hold if SBP < 140 or DBP < 80)
  - Nicardipine gtt. 5 mg/hr to max of 15 mg/hr
- ☐ Start Normal Saline IVF drip at 75 mL per hour
- ☐ Obtain signed informed consent.
- ☐ Weight in kilograms _____ (if unable to weigh, obtain from patient/family or average 2 estimated weights)

TPA PREP / ADMINISTRATION

Calculations Checked by: (2 initials)_____ & _____

- ☐ Mix tPA with sterile water as provided by manufacturer to a concentration of 1 mg/mL
- ☐ Calculate Total Dose (will be the bolus + infusion):
  - **Total Dose**: (0.9mg/kg) =_____ **(max of 90 mg)**
- ☐ Waste unneeded tPA portion.
  - **Waste**: (100mg – total dose) = _____ mg.
- ☐ Administer Bolus over 1 minute IV push
  - **Bolus Dose:** 10% of total dose (total dose x 0.1) = _____mg. / **Time Given**: _____
- ☐ Administer Infusion Dose as a secondary infusion over 1 hour.
  - **Infusion Dose**: 90% of total dose (total dose x 0.9) = _____mg. / **Time Started:** _____

POST TPA / TRANSPORT PREPARATION:

- ☐ Monitor Vital Signs every 15 minutes.
  - Keep **SBP <180mmHg, DBP <105 mmHg,**
    - Labetolol 10 mg IVP (may repeat x 1). (Hold for HR < 60)
    - Hydralazine 10 mg IVP. (May repeat x 1). (Hold if SBP < 140 or DBP < 80)
    - Nicardipine gtt. 5 mg/hr to max of 15 mg/hr
  - Keep SBP > 100: NS 500ml IVF bolus
- ☐ Monitor Neuro Checks every 15 minutes.
  - If sudden change in mental status or severe headache, STOP t-PA infusion.
- ☐ Monitor for Adverse Reactions:
  - Gingival oozing, ecchymoses, abdominal and/or flank pain, hemoptysis, hematemesis, shortness of breath/rales/rhonchi, STOP t-PA infusion.

CAUTIONS

- NO Anticoagulation or Antiplatelet Therapy for 24 hours
- No foley insertion/re-insertion, central venous line placement or arterial puncture for at least 24 hours after tPA
- Avoid insertion of nasogastric tube for 6-8 hours after tPA administration

- ☐ Send copy of CT Head Scan
- ☐ Send patient records with documentation of allergies, current medications, past medical history

Nursing signature/RAV: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

PATIENT LABEL

Barcode 3 of 9

CONSENT FOR USE OF THROMBOLYTIC THERAPY FOR
BRAIN INFARCT (*ACUTE ISCHEMIC STROKE*)

NAME OF PATIENT: _____

ATTENDING PHYSICIAN: _____

DRUG THERAPY: ALTEPLASE (tPA)

PURPOSE: To dissolve a clot in the cerebral artery that is causing your stroke symptoms.

POSSIBLE KNOWN SIDE EFFECTS – Internal bleeding, or other excessive bleeding may include bleeding in the brain, worsening stroke symptoms, allergic reactions or death.

ALTERNATIVE TREATMENT – Conservative medical management.
Conservative medical treatment may include medicine for blood pressure control, oxygen, aspirin or other anti-platelet medicine.

I have been informed of the above therapy, side effects, and alternative treatment by my physician and hereby consent to this treatment. I understand that I must be transferred for neurological follow-up immediately with this treatment.

_____ _____
Date and Time Patient

_____ _____
Witness Legal Representative

Barcode 3 of 9

Neurological Flow Sheet

DATE	TIME	BLOOD PRESSURE	PULSE	RESPIRATION R / R	TEMPERATURE						COMA SCALE: EYES	COMA SCALE: BEST MOTOR RESPONSE	COMA SCALE: BEST VERBAL RESPONSE	COMA SCALE: TOTAL	EXTREMITIES: UPPER R / L	EXTREMITIES: LOWER R / L	PUPILS: RIGHT mm / REACT	PUPILS: LEFT mm / REACT	INITIALS

GLASGOW COMA SCALE

EYES OPEN	Spontaneously	4	Best Motor Response	
	To verbal command	3		
	To pain	2		
	No response	1		
	Untestable	0		

To verbal command	Obeys	6
To painful stimulus	Localizes pain	5
	Flexion withdrawal	4
	Flexion- abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)	2
	No response	1
	Untestable	0

Best Verbal Response	Oriented and converses	5
	Disoriented and converses	4
	Inappropriate words	3
	Incomprehensible sounds	2
	No response	1
	Untestable	0

Respiration

R = regular

I = Irregular

C = Cheyne-Stokes

Extremities - Strength

6 = Normal

5 = Mild Weakness

4 = Severe Weakness

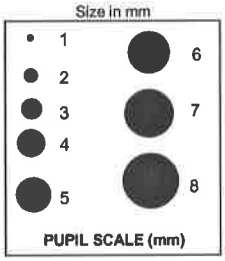
3 = Spastic Flexion

2 = Extension

1 = Flaccid

Pupils

Size in mm



PUPIL SCALE (mm)

Reaction

N = Normal

S = Sluggish

F = Fixed

Patient Label

Barcode 3 of 9

ED NIH Stroke Scale

Today's Date: _____ **DATE/TIME LAST KNOWN WELL** _____

Category	Description Time:	Score	Score	Score	Score	Score	Score
Level of Consciousness	**0**=Alert **1**=Not Alert but arousable by mild stimulation **2**=Not alert; Requires repeated stimulation to attend **3**=Responds only with reflex motor/or autonomic reflex or unresponsive						
Level of Consciousness Questions	**0**= Answers both month and age correctly **1**=Answers one question correctly **2**=Answers neither question correctly						
LOC-Commands	**0**= Performs both tasks correctly **1**= Performs one task correctly **2**=Performs neither task correctly						
Gaze	**0**= Normal **1**= Partial Gaze Palsy **2**= Forced Deviation						
Visual Fields	**0**= No visual loss **1**= Partial Hemianopia **2**= Complete Hemianopia **3**= Bilateral Hemianopia						
Facial Movement (Facial Paresis)	**0**= Normal symmetrical movements **1**= Minor paralysis **2**= Partial paralysis **3**= Complete paralysis of one or both						
Motor Function-Arms (Right and Left)	**0**= No drift **1**= Drift **2**= Some effort against gravity **3**= No effort against gravity **4**= No movement **UN**= Amputation or joint fusion	R / L	R / L	R / L	R / L	R / L	R / L
Motor Function-Legs (Right and Left)	**0**= No drift **1**= Drift **2**= Some effort against gravity **3**= No effort against gravity **4**= No movement **UN** = Amputation or joint fusion	R / L	R / L	R / L	R / L	R / L	R / L
Limb Ataxia	**0**= Absent **1**= Present in one limb **2**= Present in two limbs **UN**= Amputation or joint fusion, explain						
Sensory	**0**= Normal: no sensory loss **1**= Mild to moderate sensory loss **2**= Severe to total sensory loss						
Best Language	**0**= No aphasia **1**= Mild to moderate aphasia **2**=Severe Aphasia **3**= Mute						
Dysarthria	**0**= Normal **1**= Mild to moderate dysarthria **2**= Severe dysarthria **UN**=Intubated or other physical barrier, explain						
Extinction & Inattention (formerly Neglect)	**0**= No abnormality **1**= Visual, tactile, auditory, spatial, or personal inattention **2**= Profound hemi-inattention/extinction						
	Total Score						

_____ **Nursing signature / RAV**	_____ **Date**	_____ **Time**	PATIENT LABEL
_____ **Physician signature**	_____ **Date**	_____ **Time**	

Barcode 3 of 9

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Suspicious Injury Reporting	
Scope: ~~All Health Care Professionals Providing Direct Patient Care~~NIHD	Manual: Clinical Practice Manual: Patient Safety
Source: Social Worker	Effective Date: TBD

PURPOSE:
The purpose of this policy is to establish guidelines for complying with California Penal Codes, which require the reporting of assaultive or abusive acts.

POLICY:
The Emergency Department will report all wounds and injuries from firearms or assaultive/ abusive conduct to police, sheriff, or highway patrol, depending on jurisdiction where incident occurred.

The report will be made even if the person with the injury expires.

In accordance with California Penal Code Section 11160 requiring any health care practitioner employed by NIHD to make reports to local law enforcement agency when they treat persons with specified injuries. Additionally, under Penal Code Section 11161, every physician treating such persons also has a duty to make a report. A single report may be made where the reporting falls upon two or more persons.

A report must be made when a health care practitioner, in their professional capacity or within the scope of their employment, provides medical services for a physical condition to a patient whom they know or reasonably suspect is a person described as follows:

1. A person suffering from a wound or other physical injury where the injury is by means of a firearm, whether inflicted by the patient him/herself or by another person.

2. A person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct.

The duty to report arises where the health practitioner provides medical services to a patient for any physical condition, not just the condition or injury arising from the assault, battery or firearm incident.

A report must also be made by every physician who has such a person under his or her charge or care [Penal Code Section 11161 (a)].

DEFINITIONS: (See attached supplement)

PROCEDURE:
REPORTING:

1. Both the physician and the licensed hospital staff are required by law to report to the local law enforcement agency, but the reports may be consolidated to one telephone report and one written report, provided that either the doctor or nurse sign the written report.

Title: Suspicious Injury Reporting	
Scope: ~~All Health Care Professionals Providing Direct Patient Care~~NIHD	Manual: Clinical Practice Manual: Patient Safety
Source: Social Worker	Effective Date: TBD

2. A report by telephone must be made immediately or as soon as practically possible to the local law enforcement agency. The person making the telephone report should note the date/time of the telephone report, agency and agency representative spoken to on the written report. The telephone report shall include: (A) The name of the injured person, if known. (B) The injured person's whereabouts. (C) The character and extent of the person's injuries. (D) The identity of any person the injured person alleges inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person.

3. A written report using the State form "Suspicious Injury Report (CalEMA 2-920)" must be prepared and sent to a local law enforcement agency within two working days.

4. A report must be made even if the person who suffered the injury has died, regardless of whether or not the injury or assaultive or abusive conduct was a factor contributing to the death.

5. The nurse will forward the report in a "Confidential" envelope to Medical Records for mailing to law enforcement.

6. If the wound or injury requires a Sexual Assault/Rape, Child Abuse, or Elder/Dependent Adult Abuse Report, the report should be made on specific forms for each purpose. (Refer to the specific policy for reporting Sexual Assault/Rape, Child Abuse or Elder/Dependent Adult Abuse for additional guidelines and requirements.)

7. If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient (or their representative, if the patient is not capable) must be promptly informed that the report has been or will be made, unless:

    1. The health care provider believes, in the exercise of professional judgment, that informing the patient would place him or her at risk for serious harm; or

    2. The health care provider reasonably suspects that the personal representative is responsible for the abuse and informing the personal representative would not be in the patient's best interests. Verbal notification is sufficient. The report must be made, even if the patient objects.

8. If a victim wishes to press charges and requests that the medical record be released to law enforcement, the patient must sign an Authorization to Use or Disclose PHI (HIPAA-12), prior to the release of the records.

9. The Medical Records Director will be responsible for establishing a policy for sending the original report to the same law enforcement agency that received the telephone report (as indicated on the report), within two working days of the initial findings. A copy of the report will be maintained in the "Confidential" file of the patient's medical record. The release of PHI will be tracked as required by HIPAA regulations, per hospital policy.

Title: Suspicious Injury Reporting	
Scope: ~~All Health Care Professionals Providing Direct Patient Care~~NIHD	Manual: Clinical Practice Manual: Patient Safety
Source: Social Worker	Effective Date: TBD

10. Any licensed hospital staff aware of the injury and with knowledge that the designated person failed to report, should complete the reporting duties as soon as possible.

MEDICAL RECORD DOCUMENTATION:

1. Record any comments by the patient regarding past domestic violence or regarding the name of any persons suspected of inflicting the wound, other physical injury, or assaultive or abusive conduct upon the patient.

2. A map of the patient's body showing and identifying injuries and bruises at the time of the health care encounter.

3. Include a copy of the law enforcement reporting form.

4. Check appropriate box for Suspicious Injury Report under the Mandated Reporting tab in the Ambulatory Assessment, which will trigger a social services referral.

~~**REFERENCES:**~~

~~1. The Joint Commission E-dition PC.01.02.09: The critical access hospital assesses the patient be a victim of possible abuse and neglect.~~

~~2. CHA Consent Manual 2016 Edition, Chapter 19 (page 19.2) Assault and Abuse Reporting Requirements: III Reporting injuries by firearm or assaultive or abusive conduct ("Suspicious Injuries).~~

~~**CROSS REFERENCE P&P:**~~

~~1. Nursing Administration Manual~~

~~2. Case Management Manual~~

DEFINITIONS:

"Assaultive or abusive conduct" includes any of the following offenses as they are defined in their respective provisions of the Penal Code 11160(d):

1. Murder
2. Manslaughter
3. Mayhem
4. Aggregative mayhem
5. Torture
6. Assault with intent to commit mayhem, rape, sodomy, or oral copulation
7. Administering controlled substances or anesthetic to aid the commission of a felony
8. Battery
9. Sexual battery
10. Incest

11. Throwing any vitriol, corrosive acid or caustic chemical with intent to injure or disfigure
12. Assault with a stun gun or taser
13. Assault with a deadly weapon, firearm, assault weapon or machine gun, or by means likely to produce great bodily injury
14. Rape
15. Spousal rape
16. Procuring any female to have sex with another man
17. Child abuse or endangerment
18. Abuse of spouse or cohabitant
19. Sodomy
20. Lewd and lascivious acts with a child
21. Oral copulation
22. Sexual penetration by a foreign object
23. Elder abuse
24. An attempt to commit any crime specified in the offenses listed above.

[Penal Code Section 11160(d)]

"Health Practitioner" is defined in the law to include:

1. A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage and family therapist, clinical social worker, or any other person who is currently licensed under Business and Professions Code Section et seq.;

2. An emergency medical technician I or II, paramedic or other person certified pursuant to Health and Safety Code Section 1797 et seq.;

3. A psychological assistant registered pursuant to Business and Professions Code Section 2913;

4. A marriage and family therapist trainee, as defined in Business and Professions Code Section 4980.03(c);

5. An unlicensed marriage and family therapist intern registered under Business and Professions Code section 4980.44;

6. A state or county public health employee who treats a minor for venereal disease or any other condition;

7. A coroner; or

8. A medical examiner or any person who performs autopsies.

[Penal Code Section 11162.5(a) and 11165.7]

Title: Suspicious Injury Reporting	
Scope: ~~All Health Care Professionals Providing Direct Patient Care~~NIHD	Manual: Clinical Practice Manual: Patient Safety
Source: Social Worker	Effective Date: TBD

"Injury" does not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restrictive dangerous drug [Penal Code Section 11160(c)].

"Reasonably suspects" means that it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate from his or her training and experience, to suspect [Penal Code Section 11162.5(d)].

REFERENCES:

1. The Joint Commission E-dition PC.01.02.09: The critical access hospital assesses the patient be a victim of possible abuse and neglect. Retrieved from https://e-dition.jcrinc.com/MainContent.aspx

2. California Hospital Association (CHA) Consent Manual 2016 Edition, Chapter 19 (page 19.2) Assault and Abuse Reporting Requirements: III Reporting injuries by firearm or assaultive or abusive conduct ("Suspicious Injuries).

CROSS REFERENCE P&P:

1. ~~.5(d)~~].Ombudsman
2. Wild Iris
3. Elder Abuse from Licensed Facility
4. Sexual Assualt Exam Policy
5. Sexual Assalut Response Team
6. Spousal and Domestic Abuse Guideline for Victims of
7. Recognizing and Reporting Swing Bed Resident Abuse/Neglect
8. Child Abuse or Suspected or Sexual Assault Guidelines for Victim of
9. Dependent Adult/Elder Abuse
10. Community Resources

Approval	Date
CCOC	4/24/2017
UR/Medical Records Committee	8/24/17
MEC	9/5/17
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Elder and Dependent Adult Abuse	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

I. PURPOSE:

A. To define the policy and procedure for reporting victims of suspected dependent adult/elder abuse, neglect, and exploitation who present as an outpatient or inpatient to Northern Inyo Healthcare District.
B. To identify and protect the dependent adult/elderly from further abuse, neglect, and exploitation.
C. To comply with the Elder Abuse and Dependent Adult Civil Protection Act [Welfare and Institutions Code Sections 15600-15659] mandatory reporting requirements for abuse of elders and dependent adults.
D. To ensure system wide recognition of dependent adult/elder abuse, neglect and exploitation, including specific reporting procedures.

II. DEFINITIONS:

A. **Abandonment** means the desertion or willful forsaking of and elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody [Welfare and Institutions Code Section 15610.05].
B. **Abuse of an elder or a dependent adult** means physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. Abuse of an elder or dependent adult includes financial abuse as defined below. [Welfare and Institutions Code Section 15610.07].
C. **Adult Protective Services Agency** means a county welfare department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff [Welfare and Institutions Code Section 15610.13].
D. **Dependent Adult** means a person between the ages of 18 and 64 who resides in California and who has physical or mental limitations that restrict their ability to carry out normal activities or to protect their rights, including (but not limited to) persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. Dependent adult also expressly includes any person between the ages of 18 and 64 who is admitted as an inpatient in an acute care hospital or other 24-hour health facility as defined in Health and Safety Code Sections 1250, 1250.2 and 1250.3 [Welfare and Institutions Code Section 15610.23].
E. **Elder** means a person 65 years of ages or older [Welfare and Institutions Code Sections 15610.27].
F. **Financial Abuse** occurs when a person or entity takes, secretes, appropriates, obtains, or retains (or assists another to do so) real or personal property of and elder or dependent adult for a wrongful use or with intent to defraud or both, or by undue influence. [Welfare and Institutions Code Section 15610.30].
G. **Health Practitioner** includes a physician; surgeon; psychiatrist; resident; intern; registered nurse; licensed clinical social worker or associate clinical social worker; or any other person who is currently licensed under Business and Professions Code Section 500 [Welfare and Institutions Code Section 15610.37].
H. **Isolation** means any of the following [Welfare and Institutions Code Section 15610.43]:

Acts intentionally committed for the purpose of preventing an elder or dependent adult from receiving mail or telephone calls.

1. Telling a caller or prospective visitor that an elder or dependent adult is not present, does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is:
   a. False;
   b. Contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not; and
   c. Made for the purpose of preventing the elder or dependent adult from having contact with family, friends or concerned persons.
2. False imprisonment, as defined by the Penal Code Section 236.
3. Physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with visitors.

These acts are subject to a rebuttable presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician licensed to practice medicine in California, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care.

Also, these acts shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

I. **Local law enforcement agency** means a city police or county sheriff's department or a county probation department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff [Welfare and InstitutionsSection15610.45].

J. **Mental suffering** means:
   1. Fear, agitation, confusion, severe depression or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment or by deceptive acts performed; or
   2. False or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult.

   [Welfare and Institutions Code Section 15610.53]

K. **Neglect** means:
   1. The negligent failure of a person having the care custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or
   2. The negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.

Neglect includes, but is not limited to, all of the following:

1. Failure to assist in personal hygiene, or in the provision of food, clothing or shelter.
2. Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that her or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.
3. Failure to protect from health and safety hazards.
4. Failure to prevent malnutrition or dehydration.

If a person cannot provide the above for themselves due to poor cognitive functions, mental limitation, substance abuse or chronic poor health, this also constitutes neglect.

[Welfare and Institutions Code Sections 15610.57]

L. **Physical abuse** means all of the following, as these terms are defined in the Penal Code [Welfare and Institutions Code Section 15610.63]:
   1. Assault
   2. Battery
   3. Assault with a deadly weapon or force likely to produce great bodily injury
   4. Unreasonable physical constraint, or prolonged or continual deprivation of food or water
   5. Sexual assault, which means any of the following:
      a. Sexual battery
      b. Rape
      c. Rape in concert
      d. Spousal rape
      e. Incest
      f. Sodomy
      g. Oral copulation
      h. Sexual penetration
      i. Lewd or lascivious act
   6. Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
      a. For punishment
      b. For a period significantly beyond that for which the restraint or medication is authorized by a physician licensed in California who is providing medical care to the elder or dependent adult at the time the instructions are given
      c. For any purpose not authorized by the physician

M. **Reasonable suspicion** means an objectively reasonable suspicion that a person would entertain, based upon facts drawing when appropriate training and experience, to suspect abuse [Welfare and Institutions Code Section 15610.65].

III. POLICY:

A. Any employee who is engaged in patient care activities shall sign a statement acknowledging he/her awareness of the child abuse, neglect and/or exploitation reporting

requirements and his/her agreement to comply with the law , as a prerequisite to employment. This statement shall be retained in the employee's personnel file. Every employee will sign this statement during the new hiring process before New Employee Orientation.

B. Health practitioners have **Mandatory** reporting responsibilities: when a dependent adult/elder presents in the Northern Inyo Healthcare District as an inpatient or outpatient, when the health practitioner has either observed and incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, its location on the body, or repetition of injuries, clearly indicates that physical abuse has occurred. The health practitioner is also mandated to report and verbal accounts by the dependent adult/elder that they have experienced behavior constituting physical abuse.
C. Any physician who has knowledge of abuse, or any health practitioner who observes in their professional capacity, or in the scope of their employment, a patient whom they reasonably suspects is a victim of dependent adult/elder abuse, neglect, and/or exploitation, shall immediately, or a soon as practically possible report to the appropriate authorities (Inyo County Adult Protective Services or the local Law Enforcement Agency; or Ombudsman Services of Inyo County, and California Department of Public Health. See IV below).
D. Reasonably suspected dependent adult/elder abuse, neglect and exploitation examples are listed in definitions. (See II above).
E. The identity of all persons who make child abuse reports is confidential and may be disclosed only among the agencies receiving or investigating mandated reports
F. A health practitioner who makes a required report does not incur civil or criminal liability, and may not be discharged or disciplined for making the report.
G. Any health practitioner who knowingly fails to report an instance of dependent adult/elder abuse, neglect and/or exploitation is guilty of a misdemeanor and punishable by imprisonment, fine or both [Welfare and Institutions Code Section 15630(h)].
H. In the hospital or clinic, when two or more mandated reporters may become jointly aware of the same instance of reportable elder or dependent adult abuse. The law allows them to select, by mutual agreement, a single person who will be responsible for making the report. However, if one of these persons knows that the designated person has failed to report, that person must thereafter make the report [Welfare and Institutions Code Section 15630(d)].
I. The statute allows the hospital to create internal procedures to facilitate reporting, endure confidentiality and apprise supervisors and administrators of reports. These procedures must make clear that reporting duties are individual, that no supervisor or administrator may impede or inhibit such reporting, and that a person is not subject to sanctions for making a report [Welfare and Institutions Code Section 15630(f)]. Any administrative procedures implemented must also maintain the confidentiality of the report.
J. Each department manager is responsible for the education of appropriate medical office and hospital staff regarding criteria for handling patients whose injuries or illnesses are suspected attributable to dependent adult/elder abuse, neglect, and/or exploitation.

IV. PROCEDURE

A. The health practitioner shall: (See attachment I – Indicators of Dependent Adult/Elder Abuse).
   1. Provide a private, safe, non-judgmental environmental for assessment.
   2. REPORT:
      a. If the suspected or alleged abuse/and or neglect occurred **outside a licensed facility,** immediately, or as soon as practically possible, telephone:
         1) Monday thru Friday 8:00 to 5:00 - **Inyo County Adult Protective Services** at **760-872-1727.** After hours, weekends, and holidays - **Inyo County Sheriff's Department** at **760-873-7887.**
         2) Complete a **Report of Suspected Dependent Adult/Elder Abuse** form (SOC 341) (located on the Intranet under Forms; Suspected Dependent/Adult/Elder Abuse Report).
         3) Once completed; print copy, and fax a written report (form SOC 341) to **Inyo County Adult Protective Services** at **760-873-5103**. Written reports should be faxed within two working days of receiving the information concerning the incident [Welfare and Institutions Code Section 15630(b)].
         4) The original Form (SOC 341) is to be sealed in a manila envelope marked confidential for delivery to Medical Records.
         5) For Inpatient and Emergency Department, a copy of the form (SOC 341) is to be given to the social worker; second floor **Clinical Coordinators Office H2096**. After hours, weekends, and holidays place in mail box outside of clinical coordinators office.
         6) For Outpatient, a copy of the form (SOC 341) is to be given to case management for follow up.
      b. If the suspected or alleged **physical abuse** occurred while in a **licensed care facility** and resulted in **serious bodily injury, immediately** telephone:
         1) **Inyo County Sherriff's Department** at **760-873-7887**.
         2) Complete a Report of Suspected Dependent Adult/Elder Abuse form (SOC 341) (located on the Intranet under Forms; Suspected Dependent Adult/Elder Abuse Report).
         3) Once completed; print copy and fax the written report (Form SOC 341) to **Ombudsman Advocacy Services of Inyo** at **760-873-4250,** to **Inyo County Sheriff's Department** at **760-873-6515, and** to **California Department of Public Health (CDPH)** at **909-800-2315 within two hours** of receiving the information concerning the incident [Welfare and Institutions Code Section 15630(b)].
         4) The original Form SOC 341 is to be sealed in a manila envelope marked confidential for delivery to Medical Records.
         5) For Inpatient and Emergency Department, a copy of the form is to be given to the social worker; second floor **Clinical Coordinators Office H2096**. After hours, weekends, and holidays place in mail box outside of clinical coordinators office.
         6) For Outpatient, a copy of the form is to be given to case management for follow up.

c. If the suspected or alleged **physical abuse** occurred while in a **licensed care facility** and resulted in **no serious bodily injury, within 24 hours** telephone:
   1) **Inyo County Sherriff's Department** at **760-873-7887.**
   2) Complete a Report of Suspected Dependent Adult/Elder Abuse form (SOC 341) (located on the Intranet under Forms; Suspected Dependent Adult/Elder Abuse Report).
   3) Once completed; print copy and fax the written report (Form SOC 341) to **Ombudsman Advocacy Services of Inyo** at **760-873-4250,** to **Inyo County Sheriff's Department** at **760-873-6515, and** to **California Department of Public Health (CDPH)** at **909-800-2315 within twenty four hours** of receiving the information concerning the incident [Welfare and Institutions Code Section 15630(b)].
   4) The original Form SOC 341 is to be sealed in a manila envelope marked confidential for delivery to Medical Records.
   5) For Inpatient and Emergency Department, a copy of the form is to be given to the social worker; second floor **Clinical Coordinators Office H2096**. After hours, weekends, and holidays place in mail box outside of clinical coordinators office.
   6) For Outpatient, a copy of the form is to be given to case management for follow up.

d. If the suspected or alleged **physical abuse** occurred in a **licensed care facility** and was **caused by a resident diagnosed with dementia by a physician and resulted in no serious bodily injury, within 24 hours** telephone:
   1) **Ombudsman Advocacy Services of Inyo** at **760-873-4128 or Inyo County Sheriff's Department** at **760-873-7887.**
   2) Complete a Report of Suspected Dependent Adult/Elder Abuse form (SOC 341) (located on the Intranet under Forms; Suspected Dependent Adult/Elder Abuse Report).
   3) Once completed; print copy and fax the written report (Form SOC 341) to **Inyo County Sheriff's Department** at **760-873-6515 within twenty four hours** of receiving the information concerning the incident [Welfare and Institutions Code Section 15630(b)].
   4) The original Form SOC 341 is to be sealed in a manila envelope marked confidential for delivery to Medical Records.
   5) For Inpatient and Emergency Department, a copy of the form is to be given to the social worker; second floor **Clinical Coordinators Office H2096**. After hours, weekends, and holidays place in mail box outside of clinical coordinators office.
   6) For Outpatient, a copy of the form is to be given to case management for follow up.

e. If the suspected or alleged **non-physical abuse** (abandonment, abduction, deprivation, financial abuse, isolation, mental suffering, or neglect occurred in a **licensed care facility, immediately, or as soon as practically possible** telephone:

1) **Ombudsman Advocacy Services of Inyo** at **760-873-4128 or Inyo County Sheriff's Department** at **760-873-6515.**
2) Complete a Report of Suspected Dependent Adult/Elder Abuse form (SOC 341) (located on the Intranet under Forms; Suspected Dependent Adult/Elder Abuse Report).
3) Once completed; print copy and fax the written report (Form SOC 341) to **Ombudsman Advocacy Services of Inyo** at **760-873-4250, Inyo County Sheriff's Department** at **760-873-6515, and** to **California Department of Public Health (CDPH)** at **909-800-2315 within two working days** of receiving the information concerning the incident [Welfare and Institutions Code Section 15630(b)].
4) The original Form SOC 341 is to be sealed in a manila envelope marked confidential for delivery to Medical Records.
5) For Inpatient and Emergency Department, a copy of the form is to be given to the social worker; second floor **Clinical Coordinators Office H2096.** After hours, weekends, and holidays place in mail box outside of clinical coordinators office.
6) For Outpatient, a copy of the form is to be given to case management for follow up.

3. A report made by **telephone** must include, if known:
   a. The name of the person making the report.
   b. The name and age of elder or dependent adult.
   c. The present location of the elder or dependent adult.
   d. The names and addresses of family members or any other adult responsible for the elder's or dependent adult's care.
   e. The nature and extent of the elder's or dependent adult's condition.
   f. The date of the incident.
   g. Any other information requested by the agency receiving the report, including information that led the person to suspect elder or dependent adult abuse. [Welfare and Institutions Code Section 15630(e)]
4. Written reports should be submitted on forms adopted by the California Department Social Services. The current form is "Report of Suspected Dependent Adult/Elder Abuse" (SOC 341). This form can be obtained from county adult protective services agencies, long-term care ombudsman coordinators or at www.ccfmtc.org.

   The SOC 341 form shall include the following information:
   a. Name of individual completing the report who has also observed the wound or injury.
   b. Name of the victim.
   c. Victim's address and phone number.
   d. Nature of the incident.
   e. Character and extent of victim's injuries.
   f. Identity of any person the victim alleges inflicted the wound, other injury or assaultive conduct upon the victim.

5. Document in the medical record the patient's injuries or illnesses suspected attributable to dependent adult/elder abuse, neglect and/or exploitation:
   a. Comments by the victim regarding past abuse.
   b. A map of the victim's body showing and identifying injuries and bruises at the time the care is provided.
   c. Photographs may be taken of the injuries by the healthcare practitioner without consent.
6. The patient may be informed that a report has been or will be made, unless:
   a. The health care provider believes, in the exercise of professional judgment, that informing the patient would place him or her at risk of serious harm; or
   b. The health care provider would be informing a personal representative, and the provider reasonably believes the personal representation is responsible for the abuse, neglect or other injury, and that informing the personal representative would not be in the best interest of the patient as determined by the provider in the exercise of professional judgment [45 C.F.R. Section 164.512(c)].

   *NOTE: Verbal notification to the patient is sufficient. A report must be made even if patient objects.

7. For suspected abuse where there is **evidence of sexual abuse** see Emergency Department Sexual Assault Exam policy. For sexual assault victims and suspect exams, a SART (Sexual Assault Response Team) nurse will be contacted by the examining nurse.
8. IN SUMMARY – **Failure to report is a crime and there are strong penalties for anyone who fails to report** [Welfare and Institutions Code Section 15630(h)].

REFERENCES:

1. CHA Consent Manual 2016 Edition, Chapter 19 Assault and Abuse Reporting Requirements; Abuse of Elders and Dependent Adults (19.19 – 19.28).
2. CA.GOV. California Department Pubic Health CDPH Health Facilities Consumer Information System http://hfcis.cdph.ca.gov/LongTermCare/ConsumerComplaint.aspx
3. North Bay Healthcare Administrative Manual. Elder and Dependent Adult Abuse, Neglect and Exploitation; Policy #309.

CROSS REFERENCE P&P:

1. Child Abuse Neglect Policy
2.

Approval	Date
CCOC	7/17/17
UR Committee	8/24/17
Med Services/ICU	7/27/17
MEC	9/5/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Elder and Dependent Adult Abuse	
Scope: NIHD	Manual: Social Services
Source: Social Worker	Effective Date:

Board of Directors	
Last Board of Director Review	

Developed:
Reviewed:
Revised:
Supersedes: Elder Abuse from Licensed Facility
Index Listings:

Attachment I: Indicators of Dependent Adult/Elder Abuse/Neglect/Exploitation

The following are symptoms that may indicate dependent adult/elder abuse, neglect and exploitation. Patients who present with these symptoms require further evaluations, even if an acute problem is not apparent. Evaluation may be provided by the healthcare worker for physical abuse or social worker for psychological abuse.

CIRCUMSTANCES WHICH ESTABLISH OR AROUSE REASONABLE SUSPICION OF DEPENDENT ADULT/ELDER ABUSE/NEGLECT/EXPLOITATION

Patient discloses physical abuse.

Unexplained injury or vague or evasive explanation, i.e., "I'm clumsy."

Discrepant history:

- Patient and caregiver histories are contradictory
- Changing histories
- Minor accident, yet major injuries
- Injuries on different dates

Alleged self-inflicted injury

Delay in seeking medical care

History of repeated suspicious injuries

High risk factors for populations experiencing dependent adult/elder abuse include:

- Alcohol and/or drug abuse
- Total dependence on caregiver
- Mentally challenged caregiver

Common injuries of populations experiencing dependent adult/elder abuse include:

- Contusions, abrasions, fractures and/or sprains
- Bruises on extremities from pulling or pushing
- Physical neglect

Commonly observed behavioral symptoms of populations experiencing dependent adult/elder abuse, neglect and/or exploitation include:

- Depression

Panic attacks and other anxiety symptoms

Alcohol and/or drug abuse

Fright, shame, evasiveness, embarrassment

Feelings of isolation and inability to cope

Frequent emergency room visits or "911" calls with vague symptoms

An abusive caregiver's use of control in an abusive relationship may result in:

Limited access to medical or emergency care

Non-compliance with treatment regimens

Not being allowed to obtain or take medication

Missed appointments

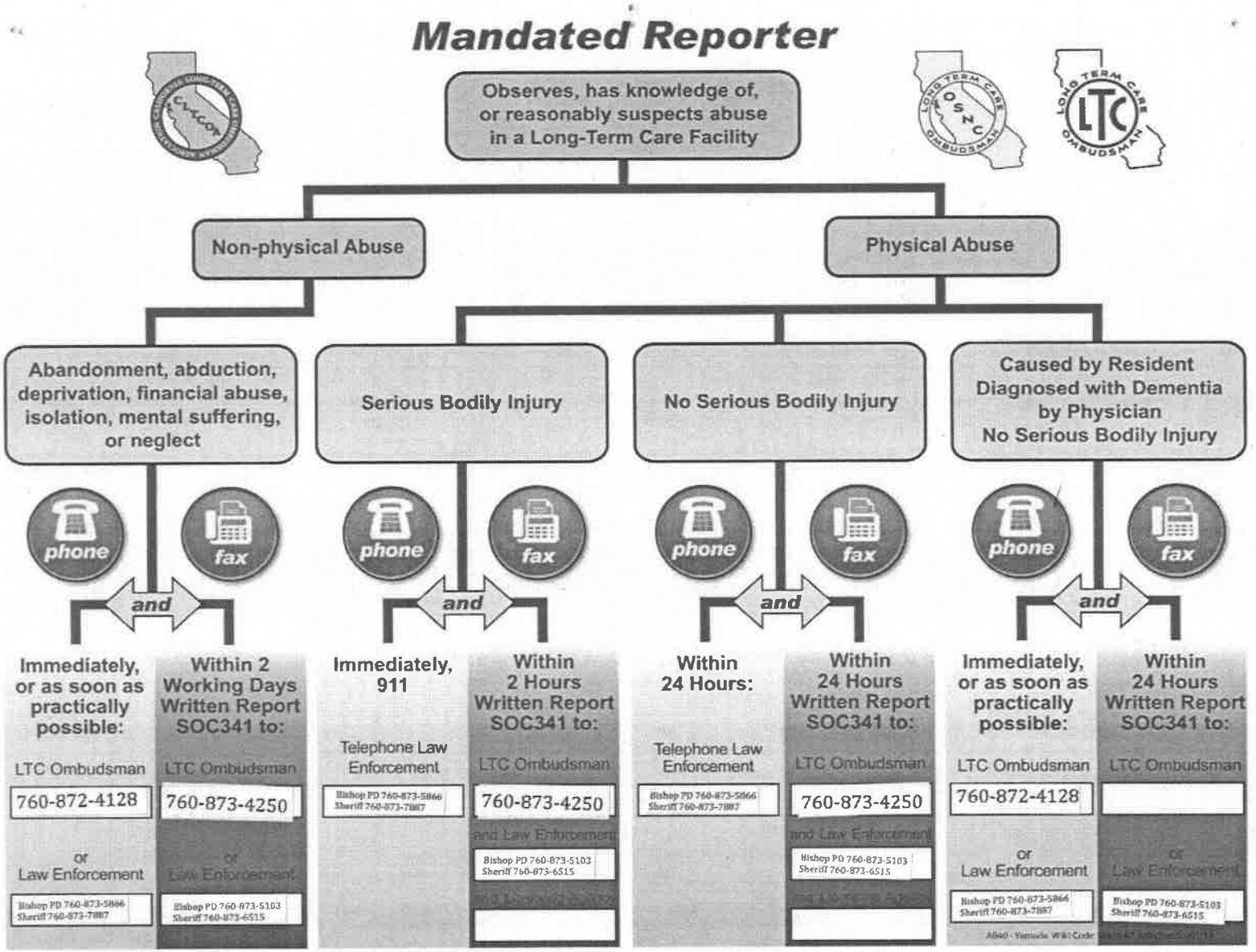
Lack of transportation, access to finances, and ability to communicate by telephone

Other findings may include:

Caregiver accompanies patient, insists on staying close and answers all questions directed at patient.

Absence of caregiver when needed and not easily located

Reluctance of patient to speak or disagree in front of caregiver


Mandated Reporter
Observes, has knowledge of, or reasonably suspects abuse in a Long-Term Care Facility
Non-physical Abuse
Physical Abuse
Abandonment, abduction, deprivation, financial abuse, isolation, mental suffering, or neglect
Serious Bodily Injury
No Serious Bodily Injury
Caused by Resident Diagnosed with Dementia by Physician No Serious Bodily Injury
phone
fax
and
Immediately, or as soon as practically possible:
LTC Ombudsman
760-872-4128
or
Law Enforcement
Bishop PD 760-873-5866
Sheriff 760-873-7887
Within 2 Working Days Written Report SOC341 to:
LTC Ombudsman
760-873-4250
or
Law Enforcement
Bishop PD 760-873-5103
Sheriff 760-873-6515
Immediately, 911
Telephone Law Enforcement
Bishop PD 760-873-5866
Sheriff 760-873-7887
Within 2 Hours Written Report SOC341 to:
LTC Ombudsman
760-873-4250
and Law Enforcement
Bishop PD 760-873-5103
Sheriff 760-873-6515
Within 24 Hours:
Telephone Law Enforcement
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Bishop PD 760-873-5866
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LTC Ombudsman
or
Law Enforcement
Bishop PD 760-873-5103
Sheriff 760-873-6515

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Use of Hospital Iissued Notice of Nnoncoverage (HINN)	
Scope: Case Manager and Supervisors	Manual: Case Management
Source: Case Manager	Effective Date:

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

~~1.~~ **POLICY:**

~~2.~~1. Hospitals may issue HINNs to Medicare fee-for service inpatients if they plan to hold the patient financially liable. HINNs may be issued prior to admission~~,~~, at admission, or at any point during an inpatient stay if it is determined that the care the patient is receiving, or is about to receive, is not covered because it is:

a. Not medically necessary

b. Not delivered in the most appropriate setting; or
~~b.~~
~~c.~~—Is custodial in nature~~.~~
c.

~~3.~~2. Prior to issuing a HINN, hospitals may contact the ordering physician for additional information regarding the patient's case.

~~4.~~3. If there is ambiguity as to whether the requirements of a Medicare National or local Coverage Determination (NCD or LCD, respectively) have been met, hospitals should proceed with obtaining a HINN in order to allow the Medicare Contractor to adjudicate the claim.

~~5.~~4. HINNs must not be issued to patients who are unable to comprehend the HINN, under duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Active labor Act (EMTALA) applies.

~~6.~~5. When notifying patients of Medicare non-coverage services, hospitals must use the form that best represents the scenario of non-coverage. The hospital must adhere to the general guidelines and the specific guidelines applicable to the form being issued.

~~7.~~6. Services for which HINNs are issued must be billed in accordance with the requirements within this policy.

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

PROCEDURE:

Issuing a HINN Form

1.
1. When the decision has been made to issue a HINN, the hospital must use the HINN that is appropriate to the situation as described above. The hospital must also adhere to the following guidelines for issuing a HINN.

2. A. Use exact language as specified in CMS model forms

a.

b. B. Only use CMS model forms

3.

c. C. Deliver in-person to patient representative*

4. *

d. D. Ensure comprehension by patient or representative

5. ive

e. E. Obtain patient or representative signature along with the date and time

f. Annotate if patient or representative refuses to sign

g. Provide a copy to the patient,

6.h. Retain a copy on file in the patient's medical record and provide a copy to the Medicare Contractor or QIO upon request.
(and date)

7. F. Annotate if patient or representative refuses to sign

8. Provide a copy to the patient, retain a copy on file in medical record and provide a copy to Medicare Contractor or QIO upon request.

9.1. *If the patient's representative is not physically present, the hospital should communicate financial information by telephone and receive the representative's agreement for financial liability. The hospital must maintain documentation that this was communicated, understood and agreed upon by the patient's representative.

Preadmission/ Admission HINN

1. When issuing the HINN prior to the inpatients admission, the hospital must:

1.

2. Complete and deliver the form as described above.

a.

3. Inform the patient that they will be liable for all services, except those services eligible for payment under Part B

b.

c. Inform the patient they have a right to a QIO review, but they should do so immediately or no later than 3 days post receipt of the HINN.

4.

2. When issuing the HINN at 3pm or earlier on the day of admission, the hospital must:

5.

Complete and deliver the form as described above.

a.

Inform the patient that they will be liable for all services rendered after the receipt of notice, except those services eligible for payment under Part B

b.

c. Inform the patent that they have right to a QIO review, but they should do so immediately or at any point during their stay after the HINN has been issued.

6. When issuing the HINN after 3 pm on the day of admission the hospital must:

3.

7. Complete the form as described above.

a.

Inform the patient that they will be liable for all services rendered on the day following

8. receipt of notice, except those services eligible for payment under Part B.

b.

9. c. Inform the patient they have a right to a QIO review, but should do so immediately or at any point during their stay after the HINN have been issued.

HINN 10- Notice of Hospital Requested Review (HRR)

a. When the hospital requests a QIO review, it must supply any pertinent information to the QIO by close of business on the first full day immediately following the day the request was submitted.

1. The QIO must:

b.

a. Notify the hospital of receipt of request and if it has not received pertinent records

e. ;

b. Make determination within 2 days of request; and notify the beneficiary, hospital and physician by telephone and subsequently in writing decision

d. ;

c. The hospital should follow-up with the QIO if the above-specified items are not executed by the QIO.

Title: Use of Hospital Iissued Notice of Nnoncoverage (HINN)	
Scope: Case Manager and Supervisors	Manual: Case Management
Source: Case Manager	Effective Date:

~~e.~~
~~f.~~d. If the QIO concurs with the hospital, the hospital must issue a HINN 12.

~~————————~~HINN 11:

1. ~~————————~~When issuing the HINN, the hospital must:

   a. ~~————————~~Complete and deliver the form as described above

   ~~——~~;
   ~~————————~~ Inform the patient that he/she will be liable for all non-covered services.
   ~~——~~
   b.

~~————————~~HINN 12:

~~——~~
~~————————~~When the physician concurs that inpatient care is no longer necessary and the patient did ~~not~~t
~~————————~~ rRequest a QIO review by midnight of the proposed discharge and chose to remain in the
1. ~~————————~~Hospital, the hospital must:

   ~~————————~~Complete and deliver the form as described above; and inform the patient that he/she e
   a. ~~————————~~will be liable for charges incurred as of midnight on the day of the proposed discharge.

REFERENCES:

~~1. National Coverage Determinations can be found at the Centers for Medicare and Medicaid Services (CMS) coverage website at: http://www.cms.gov/center/coverage.asp. Occasionally, national Medicare coverage policy is issued through service-specific regulations. This policy applies to either situation.~~
~~2. LCD's are formulated by MAC's, which should be contacted for further information.~~
~~3.~~ http://www.cms.hhs.gov/Medicare/Coverage/CoverageGenInfo/index.html
1.
2. https://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html

~~ATTACHMENTS~~FORMS found on the intranet>Forms>Departmental>Case Management:
HINN – Preadmission Admission Form
HINN 10 Notice of Hospital Requested Review (HRR)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Use of Hospital Iissued Notice of Nnoncoverage (HINN)	
Scope: Case Manager and Supervisors	Manual: Case Management
Source: Case Manager	Effective Date:

HINN 11 - Noncovered Service(s) during Covered Stay
HINN 12- Medicare Non-Covered Continued Stay Form
[LA1]

Approval	Date
NEC	6/7/17
Utilization Review Committee	8/24/17
MEC	9/5/17
Board of Directors	

Developed: 5/17mf
Reviewed:
Revised:
Supersedes:
Index Listings:

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

HINN - Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN)

Name of Patient: _____ *Name of Physician:* _____
Patient ID Number: _____ *Date Issued:* _____

We believe that Medicare is not likely to pay for your admission for (specify service or condition) _____ *because:*

____ *it is not considered to be medically necessary*
____ *it could be furnished safely in another setting*
____ *other* _____

However, this notice is not an official Medicare decision.

If you disagree with our finding:

- *You should talk to your doctor about this notice and any further health care you may need.*
- *You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to make a formal decision about whether your admission is covered by Medicare.* ***See page 2 for instructions on how to request a review and contact the QIO.***
- ***If you decide to go ahead with the hospitalization, you will have to pay for:***

_____[1]

CONTINUED ON PAGE 2

[1] *For preadmission notices, insert: "customary charges for all services furnished during the stay, except for those services for which you are eligible under Part B."*

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

Barcode 3 of 9

Developed: 5/30/17

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

HINN - Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN)

If you want an immediate review of your case: *(insert one of the following as appropriate)*

_____

_____

Preadmission:

- *Call the QIO immediately at the number listed below, but no later than 3 calendar days after you receive this notice. If you are admitted, you may call the QIO at any point in the stay.*

Admission:

Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.
You may also call the QIO for quality of care issues.

QIO Contact Name: _____

QIO Contact phone number: _____

If you do not want an immediate review:

You may still request a review within 30 calendar days from the date of receipt of this notice by calling the QIO at the number below.

Results of the QIO Review:

- *The QIO will send you a formal decision about whether your hospitalization is appropriate according to Medicare's rules, and will tell you about your reconsideration and appeal rights.*
  - *IF THE QIO FINDS YOUR HOSPITAL CARE IS COVERED, you will be refunded any money you may have paid the hospital except for any applicable copays, deductibles, and convenience items or services normally not covered by Medicare.*
  - *IF THE QIO FINDS THAT YOUR HOSPITAL CARE IS NOT COVERED, you are responsible for payment for all services beginning on (specify date) _____. (see footnote[1] on page 1).*

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

_____

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

_____ _____ _____

Signature of Patient or Representative *Date* *Time*

Barcode 3 of 9

Developed: 5/30/17

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

HINN 10 - Notice of Hospital Requested Review (HRR)

Name of Patient: _____ Name of Physician: _____

Patient ID Number: _____ Date Issued: _____

We believe that Medicare will not continue to cover your hospital care because these services are no longer considered medically necessary in your case. Because your doctor disagreed with our finding, the hospital is asking the quality improvement organization (QIO) to review your case. The QIO is an outside reviewer hired by Medicare to look at your case to decide if you are ready to leave the hospital. The name of the QIO is _____

- The QIO will contact you to solicit your views about your case and the care you need.
- You do not need to take any action until you hear from the QIO.

For more information about this notice, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

_____ _____ _____

Signature of Patient or Representative Date Time

BARCODE 3 of 9

Revised: 5/23/17

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

HINN 11 - Noncovered Service(s) during Covered Stay

Name of Patient or Representative _____ *Date of Notice* _____

Street Address _____ *Admission Date* _____

City, State, Zip Code _____ *Attending Physician* _____

Health Insurance Claim (HIC) Number _____

YOUR IMMEDIATE ATTENTION IS REQUIRED

The purpose of this notice is to inform you that: _____

is/are not covered under Medicare because: _____

_____

Our opinion was based upon the following Medicare policy we and our Medicare intermediary follow:

_____

_____

If you decide to receive the service(s) listed above, based on our customary charges for this/these service(s), you will have payment responsibility for: _____

Your attending physician has been advised of our opinion. You should talk with your physician about your health care needs, including the service(s) listed above.

RECEIPT OF THIS NOTICE

This notice is not an official Medicare decision. Your signature below only shows you have received the notice and understand what you may have to pay for. On the next page is information to use if you get the service(s) and you want to ask Medicare if it agrees with our opinion. Note we will also give a copy of this notice to your physician listed above.

Signature of Beneficiary or Representative _____ Date _____ Time _____

BARCODE 3 of 9

Revised: 5/23/17

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

HINN 11 - Noncovered Service(s) during Covered Stay

YOUR RIGHT TO A MEDICARE REVIEW (APPEAL):

You can ask us to file a Medicare claim for the service(s) listed on this notice. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this/these service(s), and how to ask for an appeal of that decision if Medicare does not pay.

- If Medicare has covered your hospital stay, it reviews any individual service it does not cover during that stay, only after you file a claim.
- If you appeal and Medicare decides to pay despite our opinion, any charges we collected will be refunded to you.
- You can ask your physician among others to represent you in filing an appeal.

Your Medicare intermediary does the formal review and makes the payment decision on the service(s) listed on this notice when processing the related claim. If you have questions on that claim or the MSN for the service(s) listed on this notice, you can contact your intermediary. **Your intermediary contact information:** _____

_____

Quality Improvement Organizations (QIOs) in each State do certain types of reviews for Medicare, including judging the need for certain medical services and quality of care. You can ask your QIO in your State to review the service(s) listed on this notice after you have received them. **Your QIO contact information:** _____

_____

Sincerely,

_____

BARCODE 3 of 9

Revised: 5/23/17

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

HINN 12 – Medicare Non-covered Continued Stay

Name of Patient or Representative _____ Identification Number _____

The purpose of this notice is to inform you that we believe your continued hospital stay will not be paid for by Medicare because:

Based on our understanding of Medicare policy, we believe that beginning on _____ you will be responsible for payment of your continued stay. **Beginning on this date, you or your other insurance may have to pay for your continued stay. We estimate the cost of your continued stay to be:**

You should talk with your physician about your health care needs, including your continued stay.

You can ask us to file a Medicare claim for your continued stay. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this claim, and how to ask for an appeal of that decision if Medicare does not pay. If you appeal and Medicare decides to pay despite our opinion, any charges we collected (minus co-pays and deductibles) will be refunded to you. If you have questions you can call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

This notice is not an official Medicare decision. Your signature below only shows that you have received this notice and understand what you may have to pay for. You will receive a copy of this notice.

Signature of Beneficiary or Representative _____ Date _____ Time _____

BARCODE 3 of 9

Revised: 5/30/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Scope of Service**	
Scope: Surgery	Manual: Surgery
Source:	Effective Date:

I. Department Description:

The Surgery unit is located in the new hospital by the staff elevators, across the hall from the PACU. The unit can be accessed eight ways:

- from the ED corridor into the Surgery corridor
- from Sterile Processing into each of the 3 surgery suites
- through the double doors adjacent to the staff elevators
- through the Perioperative Staff Office door
- through the staff elevators (back door of the elevator opens into the Surgery corridor)
- through the door adjacent to the Perioperative Staff Lounge

The Surgery Unit has 3 surgical suites, an anesthesia medication room, a decontamination room, Sterile Processing, two offices, a patient bathroom, and a storage room.

ADC – Surgical cases/ year: 1365. Monthly caseload range: 309-378. Average cases/ day: 5.3

II. Mission:

To provide care / assist and support the members of our community undergoing operative or other invasive procedures in meeting projected outcomes.

III. Vision: The goals are to provide safe, cost effective surgical care locally through:

- Patient/family and peer education
- Support and reassurance
- Control of the environment/ maintenance of asepsis
- Monitoring of physiologic and psychologic patient needs
- Integration / coordination of care including collaboration and consultation

IV. Scope:

The purpose of the Surgery Unit is to provide competent staff and a pleasant, safe facility in which elective and emergency surgery and procedures can be performed. Service is provided to the public 5 days a week Monday through Friday from 0700-1730. Patients are scheduled by the Surgery/PACU Clerk once orders have been received, authorization for treatment obtained. A surgical team (RN, technician, surgeon, and anesthesiologist) are on call during evening, night, weekend, and holiday hours to provide care for urgent and emergency surgeries and procedures. Surgical services covered at NIH include: general surgery, obstetric and gynecologic surgery, orthopedic surgery, ophthalmologic surgery, and podiatric surgery. Other services may be added depending on the availability of qualified surgical practitioners (physicians?).

V. Staffing:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Scope of Service**	
Scope: Surgery	Manual: Surgery
Source:	Effective Date:

The Surgery Unit is staffed daily by one or more RNs, one or more Surgical Technicians, one or more Sterile Processing Technicians, an inventory control analyst, and a manager. Medical staff includes the surgeon and an anesthesiologist (unless the procedure is performed under procedural sedation administered by a qualified RN). The number of RNs and Surgical Technicians is based on the number of patients scheduled. A number of the RNs are CNOR (Certified Nurse in the Operating Room), and RNFA (Registered Nurse First Assistants).

VI. Customers

Internal customers include nursing staff, other hospital department staff, medical staff practitioners, and administration. External customers include patients, families, visitors, and suppliers.
The Surgery Unit works in partnership with all services provided by NIH for lab, diagnostic imaging, physical therapy, surgery, or inpatient needs.
The Surgery Unit works in partnership with community resources provided by Pioneer Home Health, Hospice, Toiyabe Indian Health Clinic and Dialysis Unit, Inyo county department of public health, Bishop Care Center, and Sterling Heights.

VII. Ages Serviced:

Surgical care provided across the life span
Pediatrics: 28 days to <13 years
Adult: 13 to 65 years
Geriatric: > 65 years

VIII. QA/PI:

The Perioperative DON integrates all nursing quality improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares a yearly Pillar of Excellence report concerning nursing quality improvement programs for the Nurse Performance Improvement Committee. Activities of the Surgery Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the NEC and QA/PI Department.
The Surgery Unit is State licensed and Joint Commission accredited.

XI. Budgeted Staff :

Refer to Master staffing plan

Committee Approval	**Date**
CCOC	**6/13/16**
Surgery Tissue	**7/27/16**
MEC	**9/5/17**
Board	

Developed: 1/86
Reviewed:
Revised: 5/11BS, 3/16 AW

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Scope of Service**	
Scope: Surgery	Manual: Surgery
Source:	Effective Date:

Supercedes: Scope of Perioperative Nursing Practice

Responsibility for review and maintenance:
Index Listings: Scope of Service, Surgery; Surgery Scope of Service

Dev. 7/14

NORTHERN INYO HOSPITAL
SCOPE OF SERVICE

Title: Scope of Service	
Scope: PACU	Manual: PACU Manual
Source: Perioperative DON	Effective Date:

I. Department Description:

The Post Anesthesia Care Unit is an 11 bay unit located in the new hospital on the first floor. There are 2 locked entrances. The entrance to the west of the unit is for ambulatory patients or visitors. The north entrance is for approved employees and patient flow to and from surgery or to inpatient care.

The department has 11 bays, 2 of which are closed rooms for isolation use, one of those currently is used as a draw room or for confidential interviews.

ADC is based on Monday – Friday Surgeries: 5-6 / OP Procedures: 7-9

II. Mission:

Provide perianesthesia nursing care that involves cultural, developmental, and age-specific assessment, diagnosis, intervention, and evaluation of individuals within the perianesthesia continuum. This includes care for patients in Preanesthesia Care (preadmission, day of surgery/procedure), Postanesthesia care (Phase I & II, and extended care) and procedural areas such as Interventional and Diagnostic Imaging.

III. Vision:

- Preadmission: To prepare patients for surgery / procedures. Interview and assess; identify potential or actual problems, educate and intervene to optimize positive outcomes.
- Day of Surgery / Procedure Preparation: Reinforce preoperative teaching, review discharge instructions, and complete preparation for the surgery / procedure.
- Postanesthesia Phase I: Provide postanesthesia care for patients and transition to Phase II, an inpatient setting, or ICU for continued care.
- Postanesthesia Phase II: Preparation for the home setting.
- Care of the Procedure patients in Interventional and Diagnostic Imaging: (incorporating care from all spectrums of Perianesthesia Nursing Care): Interview, assess, teach, prepare, and provide post-sedation recovery for the patients identified as needing nursing care.

IV. Scope:

The PACU unit provides elective and 24 hour emergency post anesthesia care; both ambulatory and inpatient patient care is provided. The Outpatient department is open during the day Monday through Friday and provides patient preparation for AM admit and outpatient surgeries. The outpatient department nursing staff assists with outpatient procedures, transfusions, chemotherapy etc., and provides recovery and discharge of local anesthesia and analgesia sedation patients, as well as, post recovery observation

and discharge of patients who have met PACU discharge criteria and have been discharged by a physician

Patients whose acuity exceeds the criteria for discharge are transferred to the appropriate inpatient unit per MD orders.

V. Staffing:

The PACU patient is under the care of the Surgeon and Anesthesiologist. They may consult with the hospitalist for admission to inpatient care.

The PACU is open M-F from 6am-6pm excluding holidays. There are 2 RNs on call for all after hours 24/7, 365 days a year.

Nursing staff includes:
Perioperative DON
Manager (Infusion and PACU)
RN
Unit Clerk/LVN

VI. Customers

The PACU/Outpatient management is a joint function of the Medical Staff and Nursing Department and the nursing staff work in close cooperation with physician staff of the Medical Services Committee, Anesthesia Department, Surgical physicians and nursing staff, Pharmacy, Laboratory, Respiratory Therapy and Radiology departments.

VII. Ages Serviced:

PACU provides care across the life span
Pediatrics: 28 days to <13 years
Adult: 13 to 65 years
Geriatric: > 65 years

VIII. QA/PI:

The Perioperative DON integrates all nursing quality improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares a yearly Pillar of Excellence report concerning nursing quality improvement programs for the Nurse Performance Improvement Committee. Activities of the PACU Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the NEC and QA/PI Department.

XI. Budgeted Staff :

Refer to Master staffing plan

Committee Approval	Date
CCOC	6/13/16
Surgery Tissue	7/27/16
MEC	9/5/17
Board	

Developed: 7/14
Reviewed:
Revised:
Supercedes:

Responsibility for review and maintenance:
Index Listings: