Northern Inyo Hospital

November 14 2018 Regular Meeting

November 14 2018 Regular Meeting - November 14 2018 Reg

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

November 14, 2018 at 5:30 p.m.

682 Spruce 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. Strategic Plan update, Finance Committee report (*information item*).
   B. Chief Executive Officer report (*information item*).
   C. Receipt and approval of NIHD Annual Audit for 2017/2018 fiscal year tabled to December regular meeting (*information item*).
   D. Determination of dates for January Board education (*action item*).
   E. Newspaper article report on addiction services (*information item*).
   F. Chief Operating Officer report (*information item*).
   G. Chief Financial Officer report (*information item*).
   H. Primary Banking Institution RFP results review and approval of Board Resolution 18-06 (*action item*).
   I. Fiscal 2020 Budget Process and Calendar (*action item*).
   J. Identity Theft Red Flag Rules Policy (*action item*).
   K. Small Balance Write Off Policy (*action item*).
   L. Credit Balance Refund Policy (*action item*).
   M. Chief Nursing Officer report (*information item*).
   N. CDPH Survey findings and response (*information item*).
   O. Chief Human Resources Officer report (*information item*).
   P. Compliance Officer quarterly report (*action item*).
4. Old Business

A. Approval of real estate purchase (376 West Yaney Street, Bishop, California) and Board Resolution 18-07 (*action item*).

Consent Agenda

5. Approval of minutes of the October 17 2018 regular meeting
6. 2013 CMS Survey Validation Monitoring, November 2018
7. Financial and Statistical reports for September 2018
8. Policy and Procedure annual approvals

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9. Chief of Staff Report; Allison Robinson MD:
   A. Policies/Procedures/Protocols/Order Sets (*action items*):
      1. *Cardiac Monitoring*
      2. *Malignant Hyperthermia*
      3. *Pediatric and Newborn Consultation Requirements*
   B. Medical Staff Appointment/Privileges (*action item*):
      1. Laura Sullivan, MD (*cardiology, Renown*) – telemedicine staff
   C. Allied Health Professional Appointments/Privileges (*action items*):
      1. Nancy Fong, FNP (*Rural Health Clinic*)
      2. Alissa Dell, FNP (*Rural Health Clinic/Internal Medicine Clinic*)
   D. Telemedicine Staff Appointment/Privileges – credentialing by proxy (*action item*)
      As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42 CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Quality Nighthawk's credentialing and privileging decisions:
      1. Benjamin Ge, MED (*diagnostic radiology, Quality Nighthawk*)
   E. Additional privileges (*action item*):
      1. Erik Maki, MD (*interventional radiology*) – new privileges in Radiofrequency Ablation
      2. Tammy O'Neill, PA-C (*Rural Health Clinic*) – new privileges as generalist Physician Assistant in the Rural Health Clinic
   F. Medical Staff Resignations (*action items*):
      1. Sheldon Kop, MD (*radiology*) – effective 10/30/18

2. David Landis, MD (*radiology*) – effective 10/30/18
3. Arsen Mkrtchyan, MD (*internal medicine*) – effective 12/31/2018

G. Core Privilege Forms (*action items*):

1. Pathology (new)
2. Psychiatry (new)
3. Pediatrics (revised)
4. Obstetrics and Gynecology (revised)
5. Family Medicine (revised)

10. Reports from Board members (*information items*).
11. Adjournment to closed session to/for:
    A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
12. Return to open session and report of any action taken in closed session.
13. 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.

RESOLUTION NO. 18-06
OF THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS

WHEREAS, the Northern Inyo Healthcare District has conducted a Request for Proposal in compliance with its policy for general banking services; and

WHEREAS, the proposals from the respondents have been analyzed using the Districts banking activity for the first quarter of 2018 as a basis for analysis; and

WHEREAS, the Board has discussed the historical costs information and the merits of each of the respondents proposals;

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 14th day of November, 2018 that based upon the discussions and agreement of a majority of the Board, _____ has been designated as the primary provider of banking services for Northern Inyo Healthcare District.

BE IT FURTHER RESOLVED that Management is instructed to transfer funds and/or execute any and all agreements necessary to make the primary banking relationship functional for the District.

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

_____
President

Attest: _____
Secretary

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

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District

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November 1, 2018

Memo To: Governing Board of Northern Inyo Healthcare District

From: John Tremble, Chief Financial Officer

Subject: RFP Responses for Primary Banking Services

It was identified in 2017 that the bank transaction fees that Northern Inyo Healthcare District was incurring were quite substantial. During 2018, a number of actions were taken with Board permission to close and consolidate accounts and to otherwise improve efficiencies in order to reduce monthly bank transaction costs. In mid-September, all of the financial institutions in Bishop were sent a letter and asked to contact myself in order to receive information from which a bid could be developed to become NIHDs primary banking services provider.

Four financial institutions responded. One was a letter of declination due to the size of our account and another withdrew due to the services the District needed being beyond their ability to provide. This left the District with two competitors; Union Bank and Eastern Sierra Community Bank. Both banks were provided the exact same data which was based on NIHD's transaction volumes from June 1, 2018 to September, 30, 2018. During this period of time, the District had an average ledger balance of $6,035,000. The Accounting department has found an average ledger balance of $3,000,000 to $5,000,000 minimizes the quantity of transfers to and from LAIF (California State Controller's Fund) in the normal course of business. The biweekly payroll for NIHD requires $1,400,000 to be available to pay employees, taxes and benefits.

During this time, conversations were held with the Treasurer of Inyo County to compare their costs today (they pay substantially less than NIHD does) and to discuss what their future plans may be. They too are concerned with their costs and looking at alternatives.

Union Bank has been the primary provider of general financial products to the District for over a decade. Annual fees were steady from 2010 to 2014 varying from $27,000 to $34,000 for a calendar year. Starting in 2015 the fees jumped substantially to $56,000, then to $63,000 and jumped again to $72,000 in 2017. The above fees do not include the transaction costs NIHD incurs for the payment of services where patients use Visa, MasterCard, American Express or Discover to pay their bills. After actions taken in 2018, net fees for the latest quarter dropped to $4,752 a month, $57,024 annualized.

Proposals Received:

The Union Bank proposal is one which continues the current rate structure for fees but reduces most fees substantially and changes the per item fee to $0.00 on a number of services. If the new fee structure was in place for the first quarter of 2019; bank fees would have been $8,552.94 instead of the $14,770.37 we were actually charged, a (42.1%) reduction. More substantially, Union Bank is proposing raising the Net Earnings Allowance from .04% on 90% of the average collected balance to .75% on 90% of the average collected balance. This would mean the $511.90 in Net Earnings Allowance for the first quarter of 2019 would have been $10,095.03. In this case the Net Earnings Allowance of $10,095.03 would have eliminated the $8,552.94 in fees charged. On an annualized basis if we maintain an average collected balance of $5,100,000 our new projected annual fees of $34,212 would be covered by Net Earning Allowance credits. Overall, the net change in expenditures is projected to be $57,024 less than current state/contract.

The Eastern Sierra Community Bank proposal is structured similarly to that of Union Bank. Eastern Sierra Community Bank is proposing banking fees which would approximate $5,700 for the first quarter of 2019 activity, which would be covered with a compensating balance of approximately $3,040,000, given the quoted Earnings Credit Rate, resulting in no monthly service charges. All remaining balances would be invested in a sweep account with a monthly adjusted yield of LAIF less a quoted spread. If we maintain an average collected balance of $5,100,000; we would earn interest of approximately $27,048 for a fiscal year, assuming rates remain flat, as this is an adjustable rate. The Overall net change in expenditures is projected to be $81,950 less than our current state/contract.

In summary both offers put NIHD's banking services cost in a place competitive with the best results reported by the CFOS who attended the September, CCAHN (California Critical Access Hospital Network) meeting. There were a couple of the hospitals who reported they had arrangements that allowed them to have no fees if they met certain conditions.

Northern Inyo Healthcare District has a need for general checking and deposit features, cash change features, remote image deposit functionality, credit card purchase capability, cashed check image features, ACH web capabilities, Wire web capabilities, Branch deposit availability, intra-bank transfer capability and purchase card rebate income. It is believed that both Banks meet all these requirements and the California collateralization requirements we have as a government unit.

I look forward to discussing these two very positive proposals at the November Regular Board Meeting. The accounting staff will be preparing a table of tasks required to switch primary banking providers and estimated associated costs from the one-time set-up for your reference at the Board meeting.

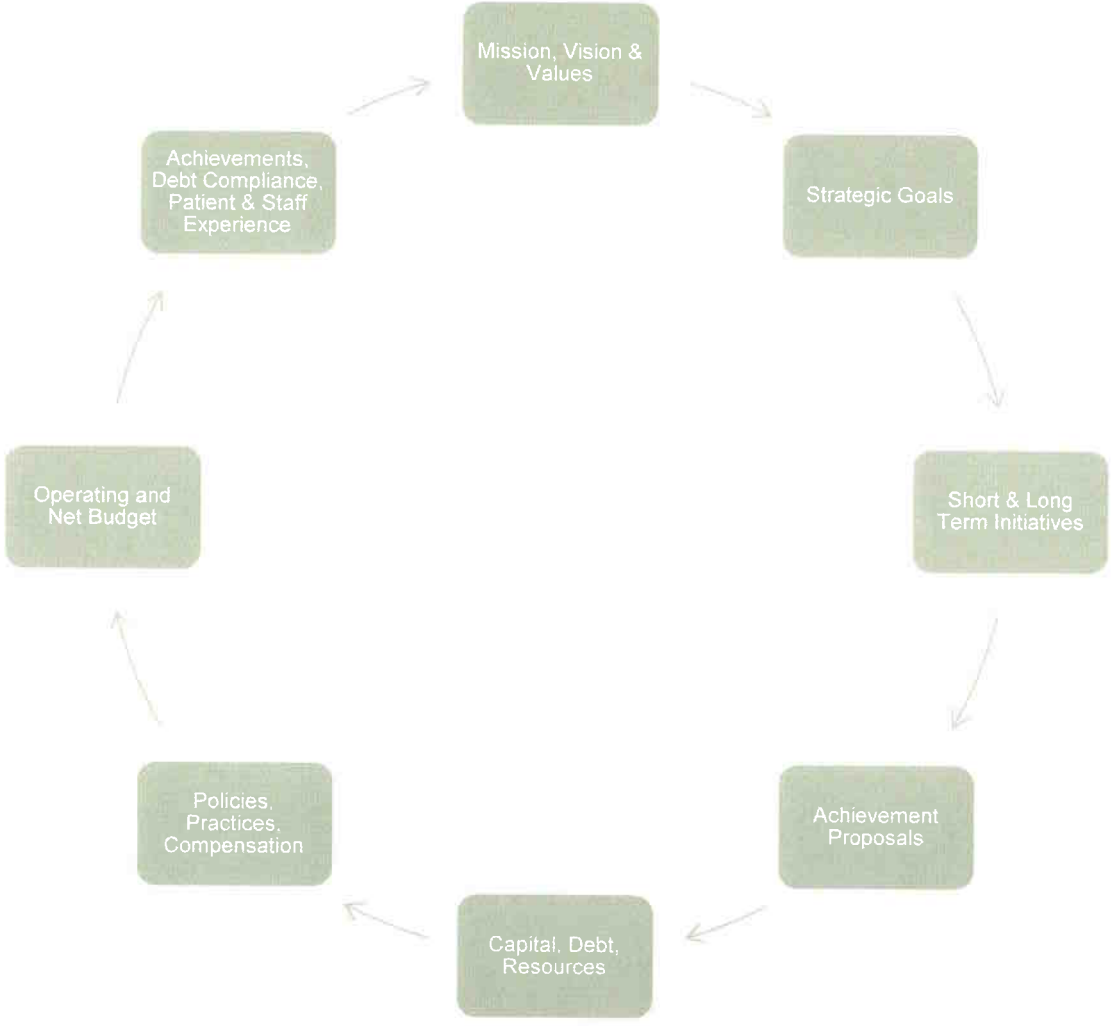
FISCAL 2020 BUDGET PROCESS

November, 2018

The Budget Process

- The role of Finance (money, time, resources) in the success of an organization is a critical one.
- By our adding an annual process whereby the Mission and Vision of the Organization is confirmed (or perhaps modified), then proper attention to the Finance Resources required for the Organization to meet its Mission, Vision and Values which are supported by the Strategic Goals can increase staff knowledge of the Goals and increase the level of success in obtaining the Goals.
- The Strategic Goals being both short and long term will have an impact on both Finance Resources and development of the operating and net margin targets for the organization.

Annual Budget Process



Proposed Budget Process

- Proposed Fiscal 2020 Calendar – January
- Confirm the Mission, Vision and Values and long and short term Strategic goals via the budget process
- Discuss and approve NIHD's compensation and benefit objectives for fiscal 2020 using the recommendations of the Compensation and Benefits Task Force
- Approve high level budget objectives…margin, capital and strategic achievements
- Role out to NIHD management the budget forms with the direction and goals for fiscal 2020
- Bring first Capital and then Operations to the Board of Directors for approval with a list of expected achievements

Sample Achievement Proposals

- Complete transition to new primary bank
- Implementation of 2nd 340B Contract Pharmacy
- Implementation of Compensation and Benefit Changes approved for Fiscal 2020

Budget Calendar

- November, 2018 review budget process proposal and receive Board approval to implement
- December, 2018 Review and approve supplemental capital budget for second half of Fiscal 2019
- February, 2019 Mission, Vision, Values and Strategic Objectives review
- February, 2019 approve high level goals for Capital, Policies/Practices and Achievements
- April, 2019 approve overall Capital budget
- May, 2019 approve Operating Budget, funded Achievements and price changes
- June, 2019 (extra time)
- October, 2019 Audit Results Presented
- November, 2019 Proposed Budget Calendar for 2021

NORTHERN INYO HEALTHCARE
DISTRICTHEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Identity Theft Red Flags Rule Policy	
Scope: Northern Inyo HealthCare District-which includes the hospital campus, the Rural Health Clinic and the Northern Inyo Associates Clinics	**Department:** Business Office
Source: FTC's Identity Theft Prevention Red Flag Rules-16 C.F.R. Section 681.2 (2008)	**Effective Date:** 11/2018

PURPOSE:

As an issuer of credit to recipients of its healthcare services, Northern Inyo HealthCare District adopts an Identify Theft Prevention Program to assist in identifying, detecting, and mitigating risks of identity theft affecting patients of the Healthcare District and clinics. This policy is intended to comply with requirements of Federal Trade Commission's Identity Theft Prevention Red Flag Rules - 16 C.F.R. Section 681.2 (2008) which is a result of the Fair and Accurate Credit Transactions (FACT) Act of2003.

POLICY:

It is Northern Inyo HealthCare District's intent to provide safeguards to protect patients by detecting Red Flags and preventing or mitigating Identity Theft without impacting appropriate care of patients or compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

DEFINITIONS:

l. Identity theft - fraudulently using the identifying information of another person.

ll. Medical Identity Theft - When an individual assumes or attempts to assume the identity of another person through fraudulent means or false pretenses and obtains or attempts to obtain medical service or goods, or to make false claims for medical services or goods.

III. Red Flag - a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

PROCEDURE:

I. IDENTIFICATION OF RED FLAGS

Activities involving Identity Theft generally fall within one of the following general types of red flags:

A. Suspicious documents
B. Suspicious personal identifying information, such as a suspicious address
C. Unusual use of – or suspicious activity relating to – a covered account
D. Alerts from others (e.g. customer, identity theft victim, or law enforcement)

II. DECTECTION OF RED FLAGS

A. Northern Inyo HealthCare District has adopted the following procedures to aid in the detection of red flags for identity theft:

1. New Patient Accounts
Obtain appropriate identifying information and insurance information. This should include the following:
a. Full legal name
b. Date of Birth
c. Address
d. Make copy of Government issued or other valid picture ID, e.g. Driver's License
e. When applicable, make copy of patient's insurance card
f. Verify eligibility and insurance company's information
f. Have patient sign Conditions of Admission

2. Existing Patient Account
Verify and update the personal and insurance information listed
a. During each return patient visit have patient show valid picture ID
b. Make copy of insurance card, including existing insurance listed
c. Verify eligibility and insurance company's information
d. Verify validity of requests for changes of billing addresses
e. Have patient sign Conditions of Admission with each patient visit
f. Verify identification of patients before releasing any personal information.

3. Emergency Care – No Delay
Providing identification is not a condition for obtaining emergency care. The process of confirming a patient's identity must **never** delay the provision of an appropriate medical screening examination or necessary stabilizing treatment for emergency medical conditions.

III. PREVENTION AND MITIGATION OF IDENTITY THEFT

A. If a patient notifies Northern Inyo HealthCare District of possible identity theft in regard to their medical record or bill, an investigation will be coordinated with the appropriate department(s) (e.g., Patient Financial Services and Medical Records) pursuant to bill, an investigation will be coordinated with the appropriate department(s) (e.g., Patient Financial Services and Medical Records) pursuant to Northern Inyo HealthCare District established departmental procedures.

B. In determining an appropriate response to a red flag or other threat of identity theft, Northern Inyo HealthCare District will consider aggravating factors that may heighten the risk of identity theft, such as a data security incident that results in unauthorized access to a patient's account records, or notice that a patient has become aware of someone fraudulently claiming to obtain medical services in the name of the patient.

C. Appropriate responses may include:
1. Monitoring a covered account for evidence of identity theft;
2. Contacting the patient;
3. Placing Billing Hold on account;
4. Reopening a covered account with a new account number;
5. Not opening a new covered account;
6. Closing an existing covered account;
7. Notifying law enforcement; or
8. Determining that no response is warranted under the particular circumstances.

D. Internal Notifications:
Any Northern Inyo HealthCare District employee who becomes aware of a potential or actual breach of personal information should report it to their manager for follow-up. The Compliance Office should be notified of all breaches and resolutions.

E. External Notification:
The Compliance Office will work with the appropriate department(s) to determine if any reports to outside agencies are required.

IV. UPDATING THE PROGRAM

Northern Inyo HealthCare District will evaluate and update policies and procedures as necessary to reflect changes in risks to patients or to the organization from identity theft.

V. PROGRAM OVERSIGHT

The Compliance Office shall report to the Board, at least annually, on Northern Inyo HealthCare District's compliance with the identity theft program.

Committee Approval	**Date**
Fiscal Services Meeting	10/30/18

Revised
Reviewed
Supercedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Small Balance Write Off Policy	
Scope: Business Office	Department: Business Office
Source: Revenue Cycle Director	Effective Date: 11/15/2018

PURPOSE:

Maximize efforts of the Revenue Cycle collection resources by minimizing activities with least cost effective return.

POLICY:

Any self-Pay patient account balance not totaling more than $4.99, will be written off and not be submitted to the patient, or the patient's guarantor for payment.

PROCEDURE:

Within the HIS (Health Information System), parameters will be set to automatically adjust the self pay patient account balances of $4.99 or less, off to Small Balance Adjustment.

"Self-Pay Patient Account Balance" is defined as the patient account balance owed following insurance adjudication, i.e., balance owed after any insurance payment(s).

"Self-Pay Patient Account Balance" is defined as the patient account balance ***prior*** to any "Prompt Pay" Discounts. Balance after applying discount will not be written off to small balance.

"Submitted" is defined as mailing a patient statement indicating amount due/owed by the patient.

"Submitted" is not defined as patient presenting with payment for any patient balance they become aware of by means of their insurance company which may be totally less than $4.99, such as explanation of benefits reflecting their out of pocket owed. Payment will be accepted from patients for self-pay balances of any amount.

Committee Approval	**Date**
Finance Leadership Meeting	10/30/2018

Revised 10/19/2018
Reviewed 10/19/2018
Supercedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Credit Balance Refund Processing	
Scope: Business Office	Department: Business Office
Source: Revenue Cycle Director	Effective Date: 11/01/2018

PURPOSE:

To assure timely overpayment recognition and refund to the appropriate patient, party, intermediary, and or insurance company in accordance to the provisions of law.

POLICY:

Review credit balances to ascertain cause or activity creating credit balance. Provide corrective action necessary to resolve credit and to provide accurate disbursement of refund. If balance is recognized to be refund due to patient or other party, process and issue refund in a timely manner in accordance to the provisions of the law.

PROCEDURE:

Credit Balance report is analyzed weekly for processing refund requests. Each credit is verified for source of overpayment. The Business Office Coordinator responsible for the processing of all Patient and Insurance Company refunds.

Each patient overpayment is verified to determine the party due the refund. Refund is cross-checked to verify if patient or any guarantors related to the patient have any other open accounts where the credit may be applied to. When applicable credit balance transfers have been completed, a refund request is initiated for any remaining credit balance due to the patient.

Credits as a result of duplicate payment are researched for posting errors or other open accounts for the patient and dispensed accordingly.

Credits resulting from discounts taken prior to Insurance Company's payment are recalculated accordingly. Any remaining credit due to patient is handled per policy.

Insurance Company duplicate payments are researched for posting errors. If no posting errors, a refund request to the Insurance Company is created via the HIS, Refund Request Function with Accounts Payable processing the refund. Refunds are sent with an accompyaning letter providing explanation for the refund.

Refund requests are submitted with a Credit Balance Review Disposition Form detailing the basis of the refund. *(see attached Credit Balance Review Disposition Form)*

Refunds are submitted to and approved by Business Office Coordinator. Final review and approval is performed by Revenue Cycle Director.

When two different Insurance Companies have paid on a claim resulting in the credit, the Explanation of Benefits are reviewed to determine the primary insurance. If it cannot be determined the correct coordination of benefits for the patients insurance, the account will be forwarded to the Credit & Billing Information Office for follow up with the patient for

Coordination of Benefits resolution. Until the Coordination of Benefits have been resolved, no refund will be issued.

Credits resulting from a correction in charges require the request of a corrected claim. A corrected claim is submitted to the Insurance Company intiating an automated recoupment process which will be retracted via a Remittance Advice. In the event an insurance company does not recoup their overpayment, a refund will be issued to them.

Refunds are issued in the form of a check, or a credit back to patient's (individual who paid) original credit card. If original credit card no longer exists, refund will be issued in form of a check.

Medicare, Medi-Cal, and some Contracted Commercial Payors, do not accept refunds from providers. Rather, the process for these payors is for them to perform a "recoupment" of the overpayment in a future Remittance Advice.

Included in the Credit Balance Review is the analysis of trends or potential activity consistently occurring that results in credit balances. Such process, includes action to mitigate or resolve such activity.

During Credit Balance Review, CMS's required "Medicare Credit Balance Report" is performed. This report is due at the end of each quarter and must be submitted to our Medicare Administrative Contractor by the end of the following month. Medicare Credit Balance Report is requested for each quarter. See Medicare Credit Balance Report Procedure. Medicare credit balances are managed and processed in same fashion as all credit balances, processing refunds per Medicare instruction.

During Credit Balance Review, DHCS's required "Medi-Cal Credit Balance Report" is performed. This report is reported annually to DHCS upon request. See Medi-Cal Credit Balance Report Procedure. Medi-Cal credit balances are managed and processed in same fashion as all credit balances, processing refunds per Medi-Cal instruction.

Committee Approval	**Date**
Finance Managers Meeting	10/30/2018

Revised 10/19/2018
Reviewed 10/19/2018
Supersedes

CREDIT BALANCE REVIEW DISPOSITION

Completed by: _____ **Date:** _____

Account #: _____ **DOS:** _____ **Patient Name:** _____

CREDIT BALANCE IS A RESULT OF FOLLOWING ACTIVITY: *(select reason)*

Review account, verify charge and payment activity.

Does charge exist?
What payments exist?
What contractual exist?

No Charge was posted

- Post the appropriate charge
- If applicable, move balance to patient; send patient bill is applicable
- If credit, proceed below as applicable

Insurance over paid

Attach supporting EOB(s)
Charges: _____
Ins Pmt: _____ Insurance: _____
Ins Pmt: _____ Insurance: _____
Credit: _____ = Refund* in amount of $ _____ Due to: _____

**For Insurance refunds, attach applicable insurance refund letter*

Insurance contractual posting error

Attach supporting EOB(s)
Charges: _____
Ins Pmt: _____ Insurance: _____
Ins Pmt: _____ Insurance: _____
Contrctl: _____
Contrctl: _____
Credit: _____ = Reverse contractual amount of $ _____

Patient over paid

Attach supporting detail
Charges: _____
Pt Pmt: _____
Disc.: _____
Credit: _____ = Refund in amount of $ _____ Due to: _____

Notes: _____

_____

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Compliance Report
November 2018

1. Comprehensive Compliance Program review
    a. As of October 30, 2018, 80% of the District's employee workforce have reviewed the Compliance Program.
    b. The Compliance Department has been following up individually with employee workforce members who have not read the assigned Compliance Program, since it is mandatory.
2. Breaches
    a. Calendar Year (CY) 2018 – (attachment A)
        i. 58 alleged breaches of PHI (Personal Health Information) potentially affecting 133 patients have been investigated by the Compliance Office
        ii. 23 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. CDPH has completed investigation of 13 cases. Ten breaches were substantiated, but assigned no deficiency. Three have been assigned deficiencies and penalties are possible.
            2. Ten (10) cases are still pending CDPH investigation.
        iii. The most common breaches are misdirected faxes and mishandled discharge paperwork
            1. Compliance and ITS have created a "request for programmed fax number form" so that ITS can program and Compliance can verify to further reduce misdirected faxes.
            2. Compliance and ITS are working to add all new referring providers, ordering providers, and authorization referral numbers to the FOUR databases in the new systems, to further reduce misdirected faxes and paperwork.
            3. Compliance and ITS have worked to designate specific printers for discharge instructions to further reduce mishandled paperwork.
            4. The patient portal may be able to further reduce required handling of actual paper, reducing mishandled paperwork.

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3. Issues and Inquiries
    a. CY 2018 – More than 250 requests for research and input on a wide variety of topics have been made to the Compliance Department.
        i. Compliance and regulation research tops the list.
        ii. Policy advice and research
        iii. Potential compliance concerns that do not reach the level of a full investigation. (Usually require training and education)
    b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2018, Compliance has verified over 400 providers. Conducting business with anyone on an exclusions list places NIHD at risk. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.
    c. Compliance is assisting ITS in ensuring provider databases in the 4 systems (Athena, 7Medical, Orchard Harvest, and Redoc) are entered correctly and remain the same. In doing this process, Compliance is reviewing the address, phone, and fax numbers of all providers entered to reduce the probability of breaches from our electronic systems. Compliance has reviewed several hundred since 10/1/18.
4. The Compliance Department has conducted over 42 investigations related to compliance concerns that are not breaches.
5. Audits
    a. Employee Access Audits (attachment B) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, "need to know," and "minimum necessary" basis.
        i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
        ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
        iii. Compliance performs between 300-500 audits monthly.
            1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.

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iv. Protenus has been selected to provide semi-automated auditing software services to NIHD beginning shortly after we go live with Athena and partners.

b. Business Associates Agreements (BAA) audit
   i. Contracts are currently under review to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
   ii. We currently have around 110 Business Associates Agreements.
   iii. Currently reviewing NIHD partnerships to assess for Organized Health Care Arrangements and Affiliated Covered Entity arrangements. These are arrangements that would be put into place between NIHD and other local healthcare partners in place of a BAA

c. HIPAA Security Risk Assessment – scheduled for Nov 6, 2018
   i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.

6. Conflicts of Interest questionnaires
   a. Compliance has processed more than 640 Conflict of Interest disclosure forms since January 1, 2018.
   b. The Management Plan form has been re-designed to simplify the process for our leadership team. We have management plans in place for 98% of the workforce for whom they are needed. We are working with leadership teams to develop and review the plans for the remaining 1 employee.
7. CPRA Requests
   a. The Compliance office has prepared documents for 2 CPRA request in CY 2018.
   b. This is a significant reduction in public records requests from the past several years.
8. Compliance Workplan (attachment C)
   a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
   b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.

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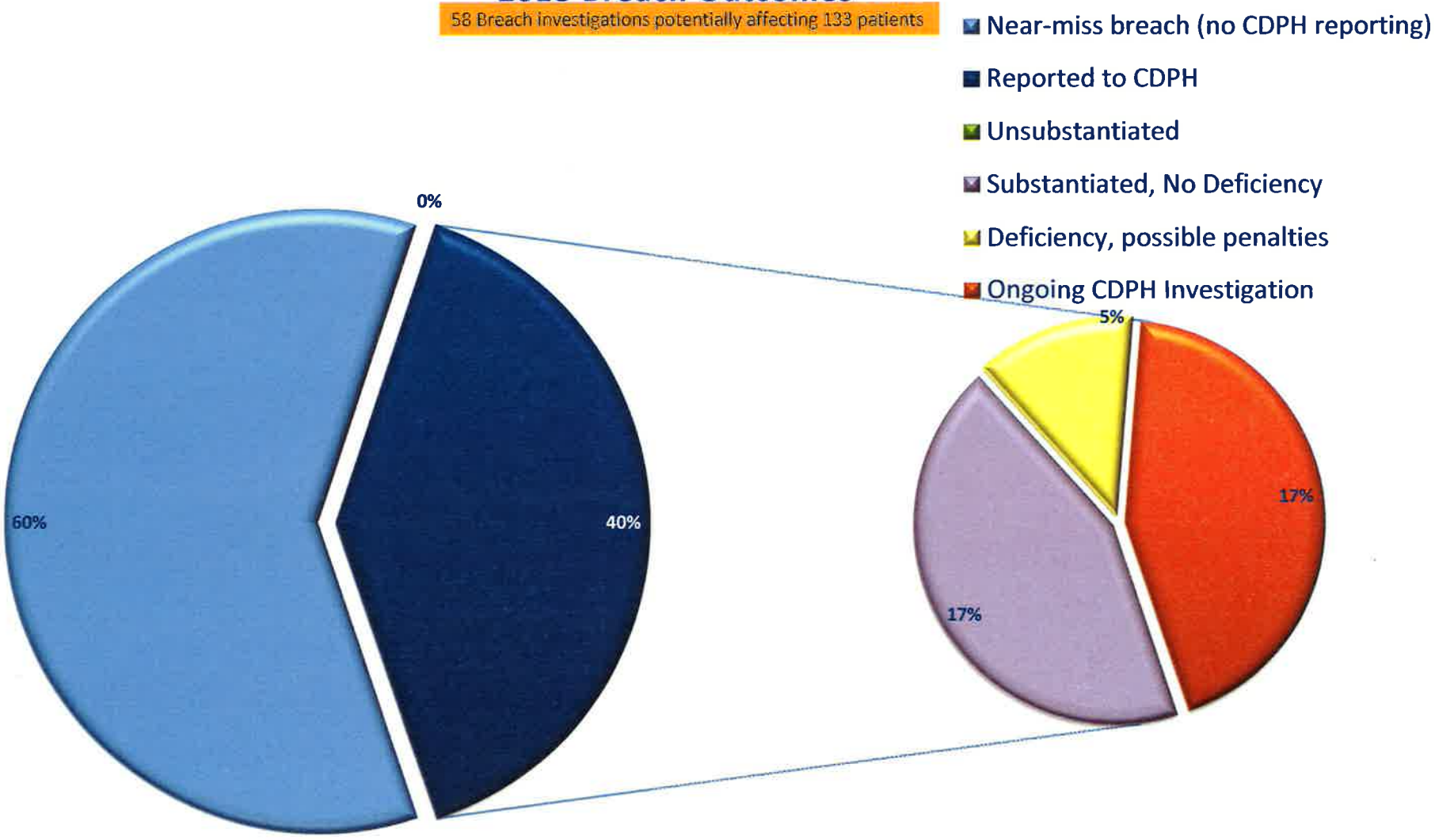
c. The attached workplan was approved by the Compliance and Business Ethics Committee in its April 2018 meeting, and updated in October 2018 for progress.

9. Quality Review Reports
   a. Transition to Unusual Occurrence reports (UOR) – next two quarters
   b. Compliance (Quality/Kristen) has processed 525 QRRs since 1/1/2018.
   c. Trending (see attached)
   d. ComplyTrac- tracking software – allows combination of QRR/UOR, complaints, breaches, and investigations to be tracked and followed in the same system, using same tools, allowing crossover evaluation and trending
10. CDPH Licensing Survey Response Monitoring
   a. Compliance will be working with Department leadership teams to follow corrective actions and monitor for sustained compliance. Those metrics will be reported here, no less than annually.
      i. Referral arrangements from non-staff ordering providers.
      ii. Pediatric Consultations
      iii. Code Amber drills
      iv. RN Competency Validations
      v. Sterile compounding area ceiling, and refrigerator temperature monitoring
      vi. Staff knowledge of location of Malignant Hyperthermia cart
      vii. Add crash cart medication list to Crash Cart Policy – completed. No additional monitoring required.
      viii. Titratable sedatives and sedation scale use
      ix. Proper storage of clove oil in ED dental box
      x. Beyond-use-date labeling of medications
      xi. Expired supply in crash cart
      xii. TB Surveillance program – letter of compliance sent to CDPH. No additional monitoring is required.
      xiii. Infection Prevention Program monitoring
      xiv. Workforce N95 mask fit testing
      xv. Equipment preventative maintenance stickers

2018 Breach Outcomes

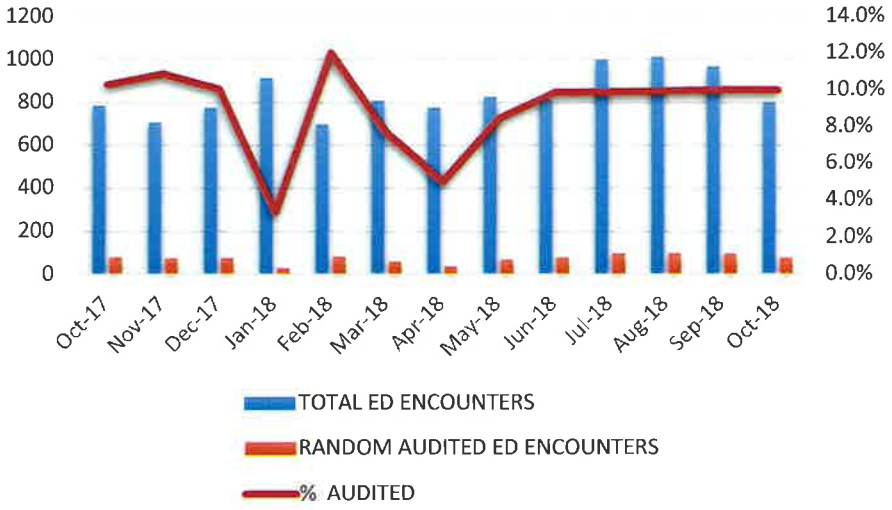
58 Breach investigations potentially affecting 133 patients



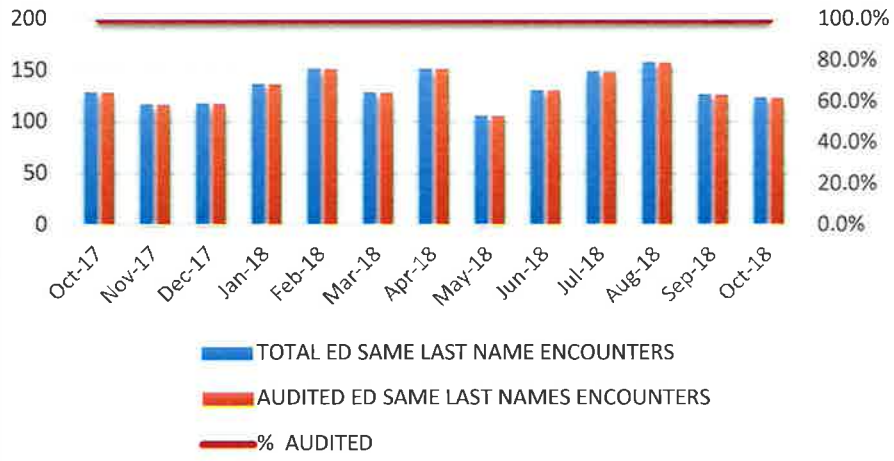
Employee EHR Access Audits

Emergency Room Encounters

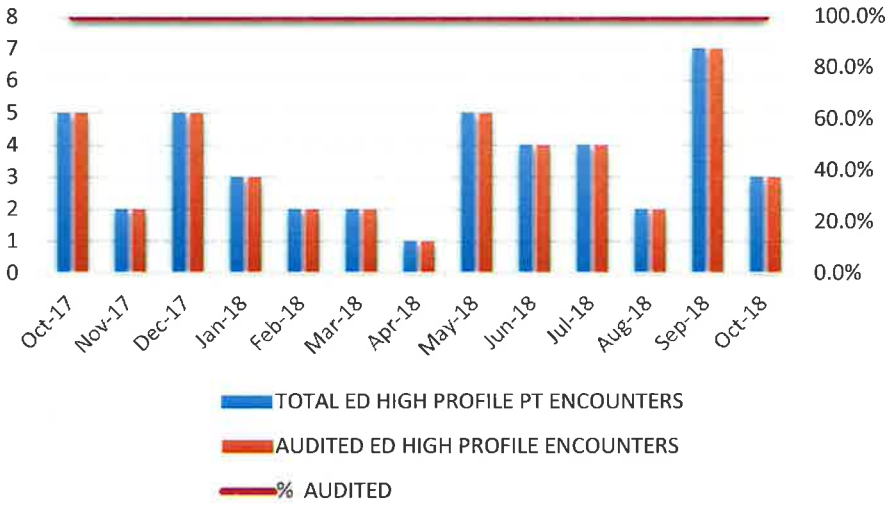
Random ED Encounter Audits



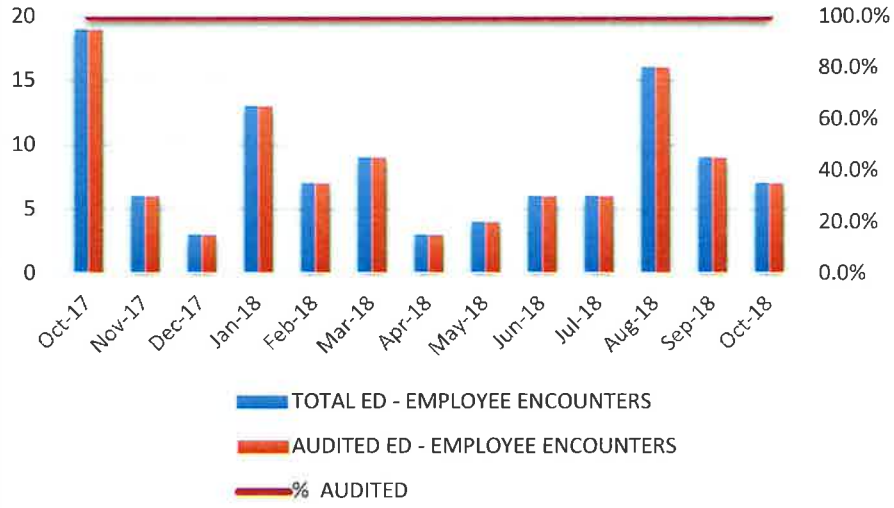
ED Patient with the same last name as an employee



HPP ED Encounters



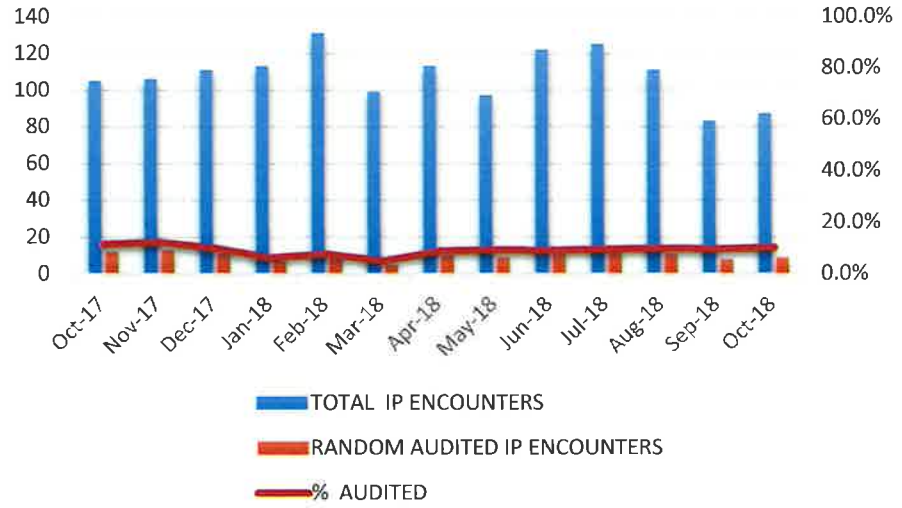
Employee ED Encounters



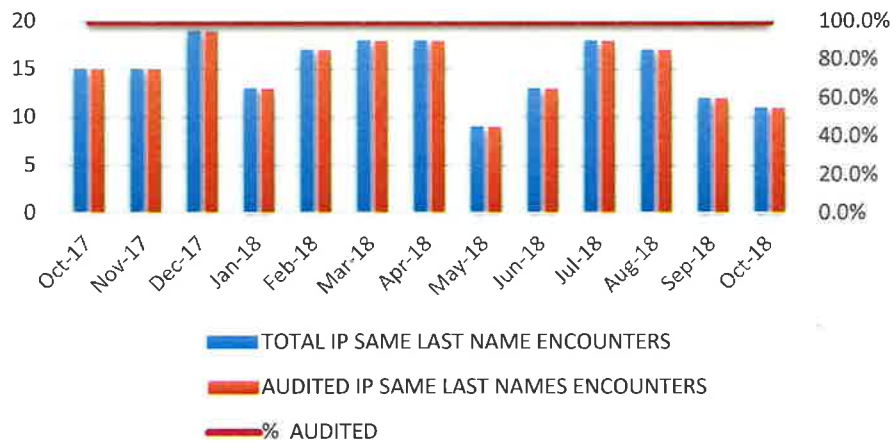
Employee EHR Access Audits

Inpatient Encounters

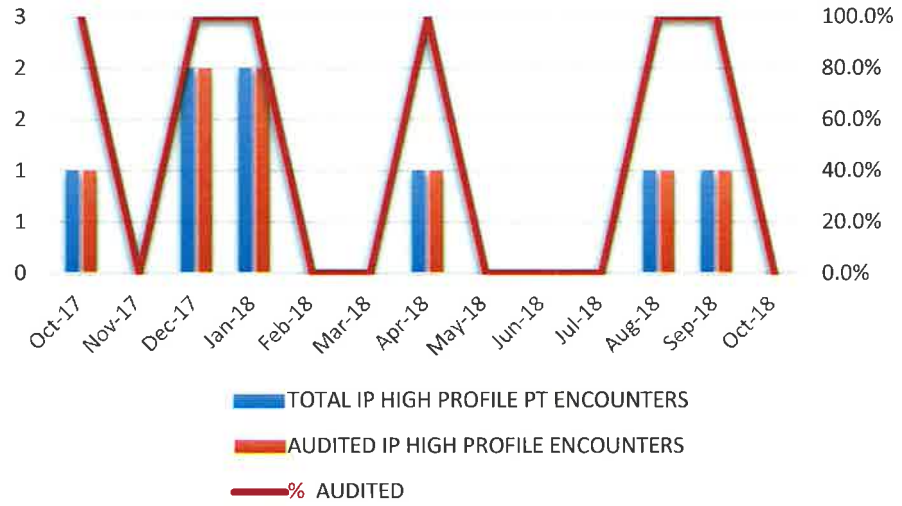
Random IP encounter Audits



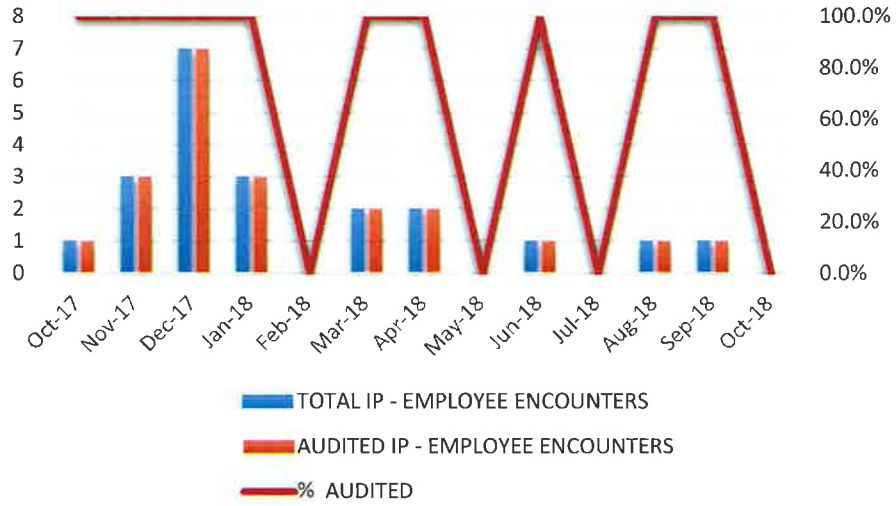
Inpatient with the same last name as an employee



HPP IP Encounters



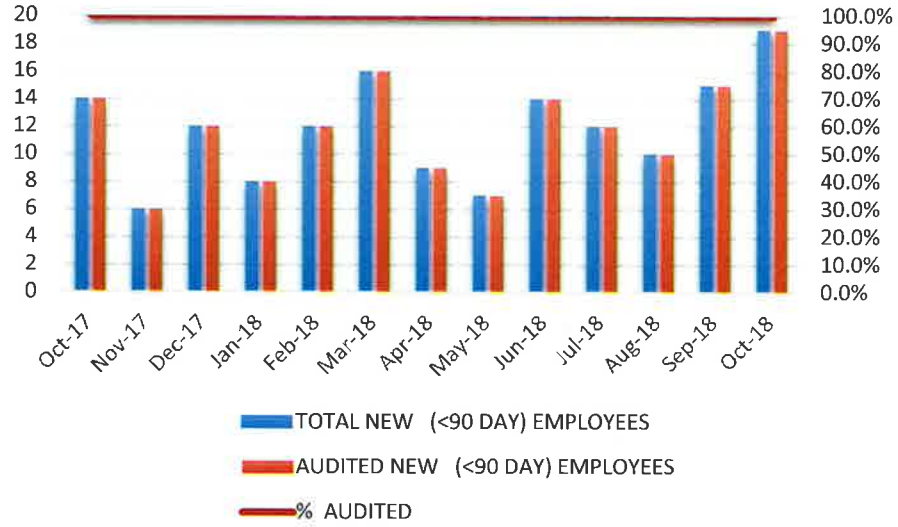
Employee IP Encounters



B

Employee EHR Access Audits

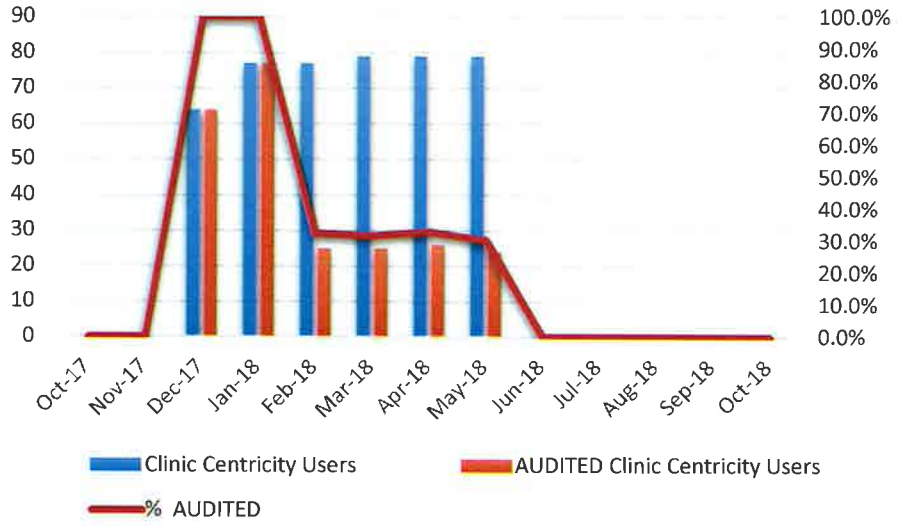
New Employee



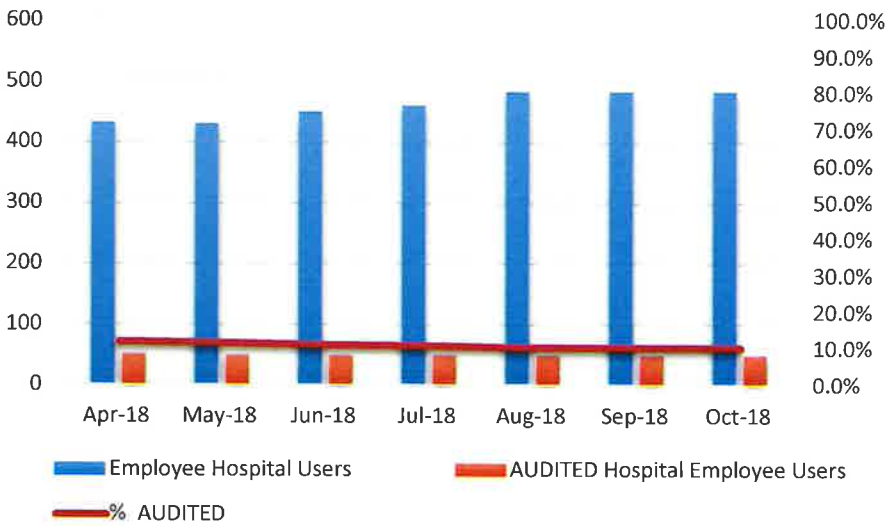
FOR-CAUSE AUDITS

28

Clinic EHR Users



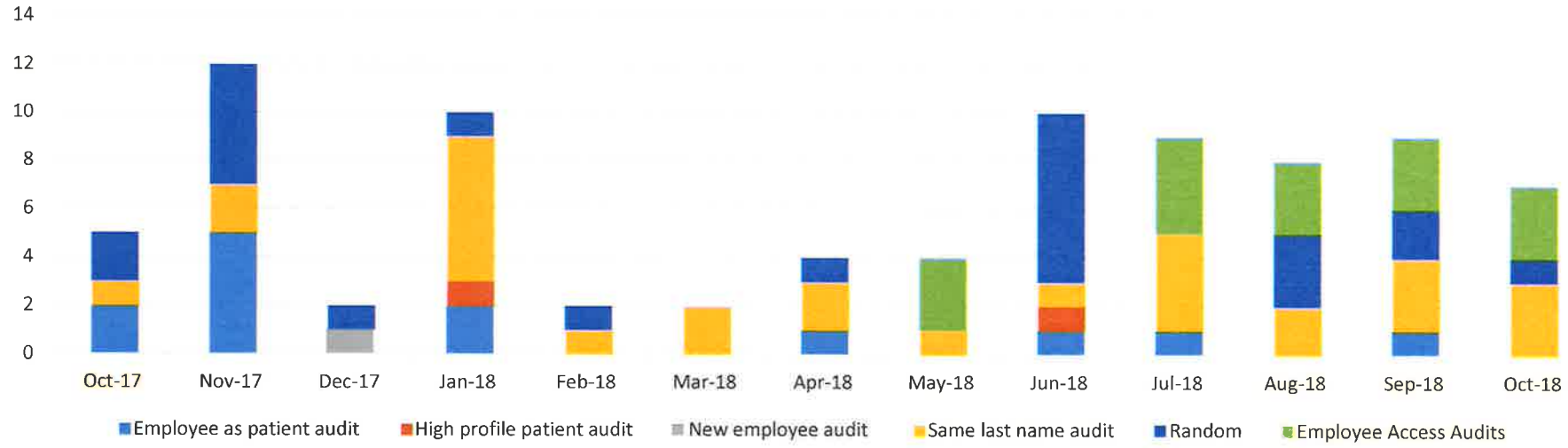
District EHR Users



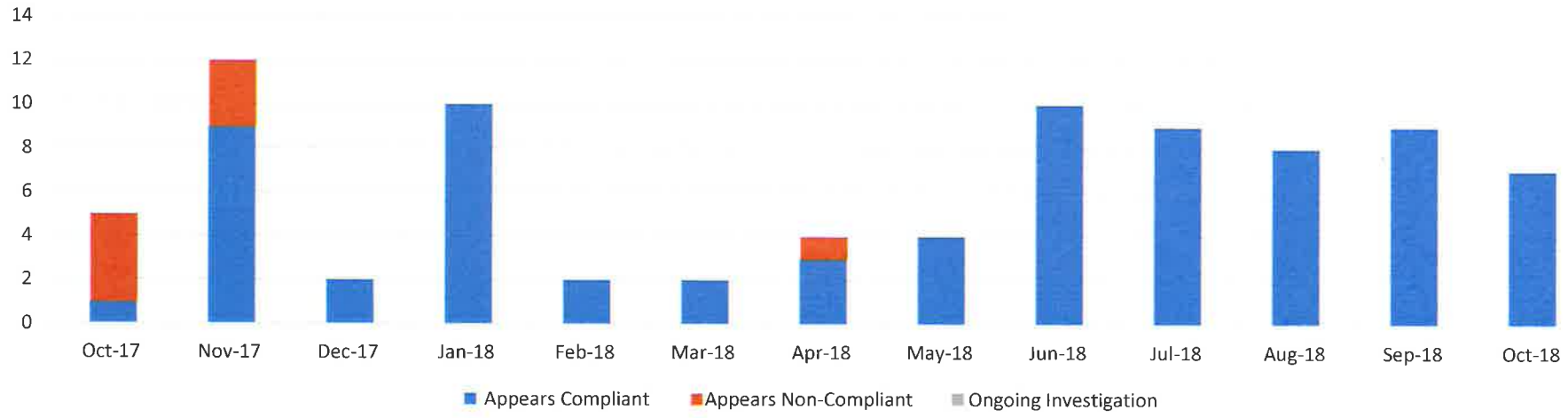
B

Employee EHR Access Audits

"FLAGS" - Audits requiring further investigation



"FLAGS" Outcomes



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No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	7/30/2018 – in progress
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Completed June 1, 2018
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		7/30/2018 - Completed
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		7/30/2018 - Completed
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Completed 7/2018
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		January 2018
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.		In progress, Role – based access team created 7/2018
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.		
Compliance Communication			
11.	Review investigation log. Prepare summary report for Compliance Committee on types of issues reported and resolution		Quarterly 2018
12.	Develop a report that evidences prompt documenting, processing, and resolution of		

C

	complaints and allegations received by the Compliance Department.		
13.	Document test and review of Compliance Hotline.		Completed 7/2018
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Verified 7/2018
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.		Completed 6/2018
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		
	a. Arrangements with physician (database)		
	b. EMTALA		
	c. Cost reports	Wipfli	
	d. Payment patterns		
	e. Bad debt/ credit balances		
	f. OPS – Home health and DME	HHS OIG target	
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		November 2018
	a. Annual Security Risk Assessment		Security Risk Assessment due in Feb 2019
	b. Periodic update to SRA		Nov 6, 2018
	c. Monthly employee access audits		Current through 10/2018
19.	Audit required signage		Proper signage is posted in all areas except the DI waiting area. It is in progress. 11/2018
20.	Audit HIMS scanned document accuracy		
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		
22.	Implement automated access monitoring/auditing software (Protenus)		Starts January 2019
23.	~~Review CMS CoPs (CAH)~~		Push to 2019 WP

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Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		In progress October 2018
27.	QRR tracking and trending – QRR/Unusual occurrence reporting is now a function on the Compliance Department.		
	a. Provide trend feedback to leadership to allow for data driven decision-making		
	I. Overall QRR process		August 2018
	II. Workplace Violence		September 2018
	III. Sharps		October 2018
	IV. Overweight laundry		October 2018
	V.		

2018 Compliance Work Plan – updated10/2018

RESOLUTION NO. 18-07
OF THE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS

WHEREAS, the Northern Inyo Healthcare District has conducted a review of its business needs and the potential acquisition of additional property; and

WHEREAS, the Board has determined it has a business need to acquire the property and personal property to utilize the premises for the District's business needs at 376 W. Yaney Street; and

WHEREAS, proper survey, appraisal and other normal property transaction documents and inspections have been completed to the District's satisfaction;

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 14th day of November, 2018 hereby authorizes the purchase of the property and related personal property located at 376 W. Yaney Street from the Ruland Family Trust for a total amount of $1,206,125.57 as outlined on the attached Buyer's Estimated Settlement Statement.

BE IT FURTHER RESOLVED that Management is instructed to transfer funds and/or execute any and all agreements necessary to make the purchase and occupancy of the property occur.

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

_____
President

Attest: _____
Secretary

Close of Escrow:	11/30/2018
Escrow officer/Closer:	Caroline Phillips
Escrow Number:	IMT-00007302-I
Buyer:	Nothern Inyo County Local Hospital District 150 Pioneer Lane Bishop, CA 93514
Seller:	Ruland Family Trust Dated January 4, 2017 376 W. Yaney Street Bishop, CA 93514
Property location:	376 W. Yaney Street Bishop, CA 93514

	Buyer	
	Debit	**Credit**
Financial Consideration		
Sale Price of Property	1,050,000.00	
Deposit		100,000.00
Prorations/Adjustments		
11/30/18-12/01/18	5.52	
County Taxes 11/30/18 - 01/01/19	502.47	
Personal Property	150,000.00	
Escrow/Title Charges		
Express Mailings/Handling to Inyo-Mono Title Company	50.00	
Messenger Recording Fee to Inyo-Mono Title Company	75.00	
Settlement Fee to Inyo-Mono Title Company	1,300.00	
Wire Fee/Handling to Inyo-Mono Title Company	100.00	
Recording Charges		
Recording Fee - Grant Deed to County Recorder	25.00	
Miscellaneous Debits/Credits		
2nd half Taxes 2018/2019 to Inyo County Tax Collector	2,917.58	
Pest Inspection to Big Pine Pest Control	300.00	
Refundable Pad to Nothern Inyo County Local Hospital District	500.00	
Roof Invoice to Chris Freeman Roofing	125.00	
Sewer Bill to Morales Rooter	225.00	
Subtotals	1,206,125.57	100,000.00
Balance Due FROM Buyer		1,106,125.57
TOTALS	1,206,125.57	1,206,125.57

Buyer

Nothern Inyo County Local Hospital District

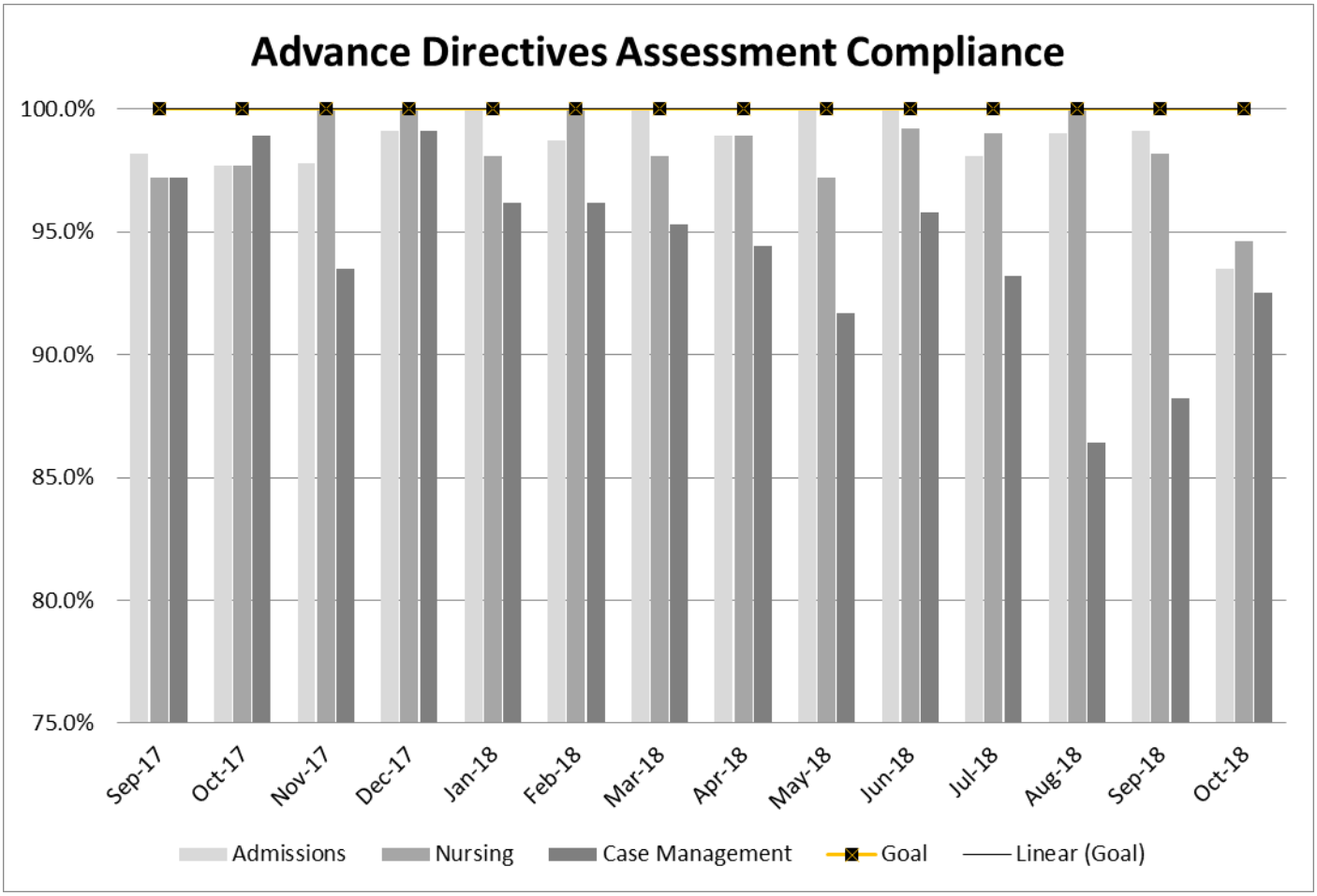
BY:_____
Kevin S. Flanigan
Hospital Administrator

_____
Inyo-Mono Title Company
Settlement Agent

2013 CMS Validation Survey Monitoring-November 2018

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.

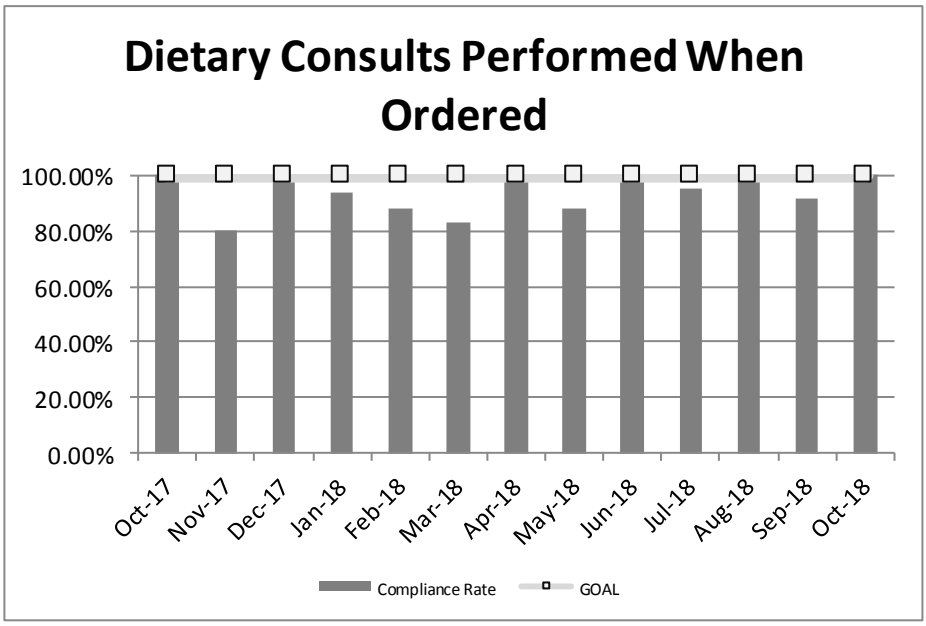


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

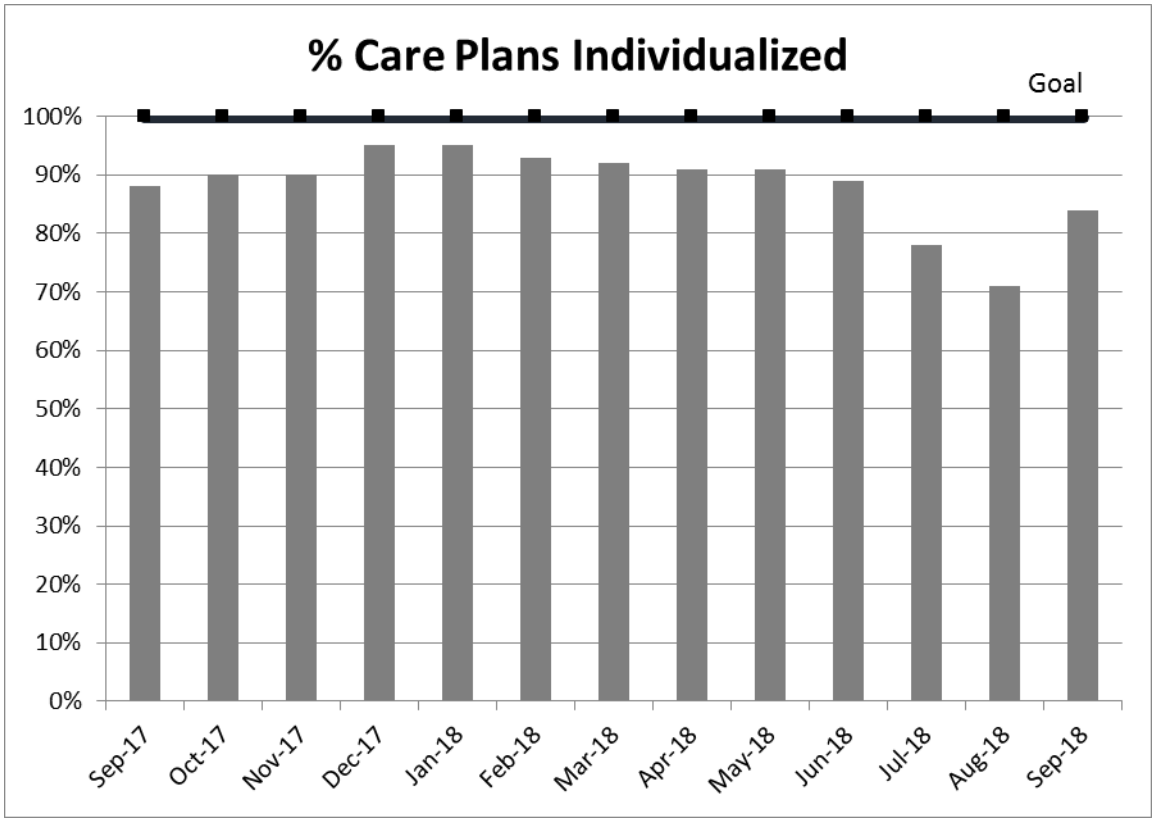
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    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.



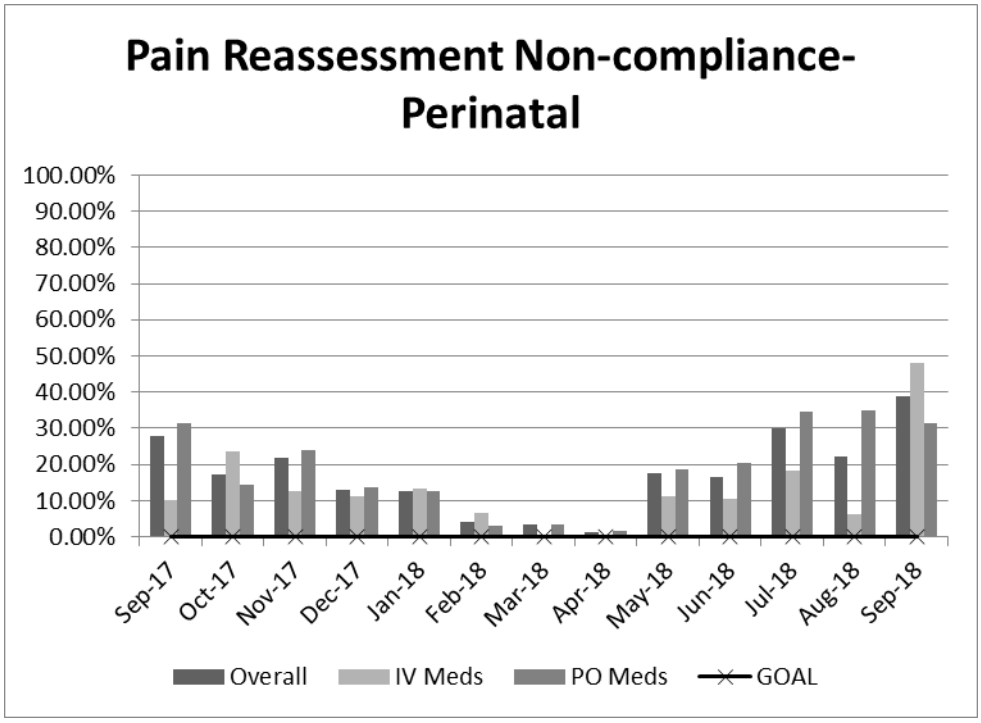
e. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

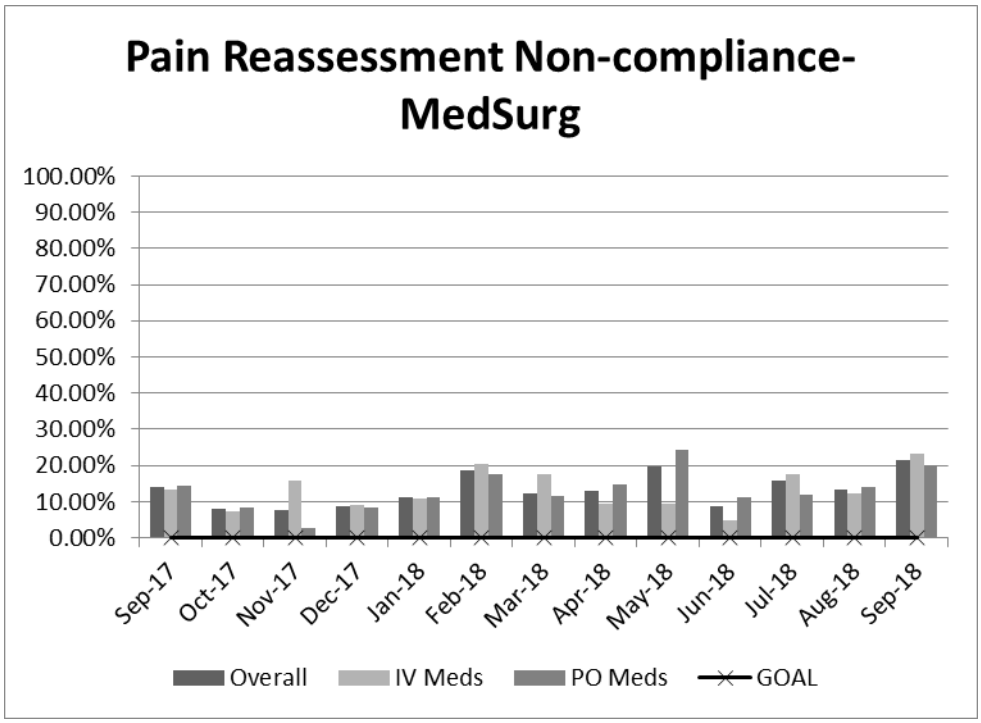


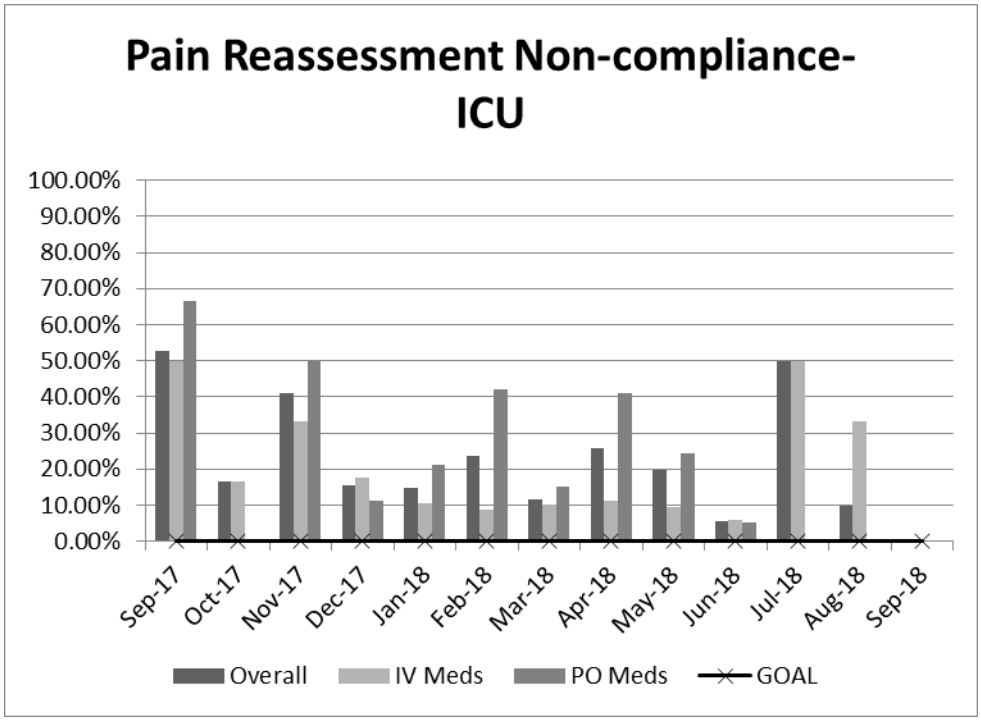
- October data not yet available

f. 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.

g. 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.

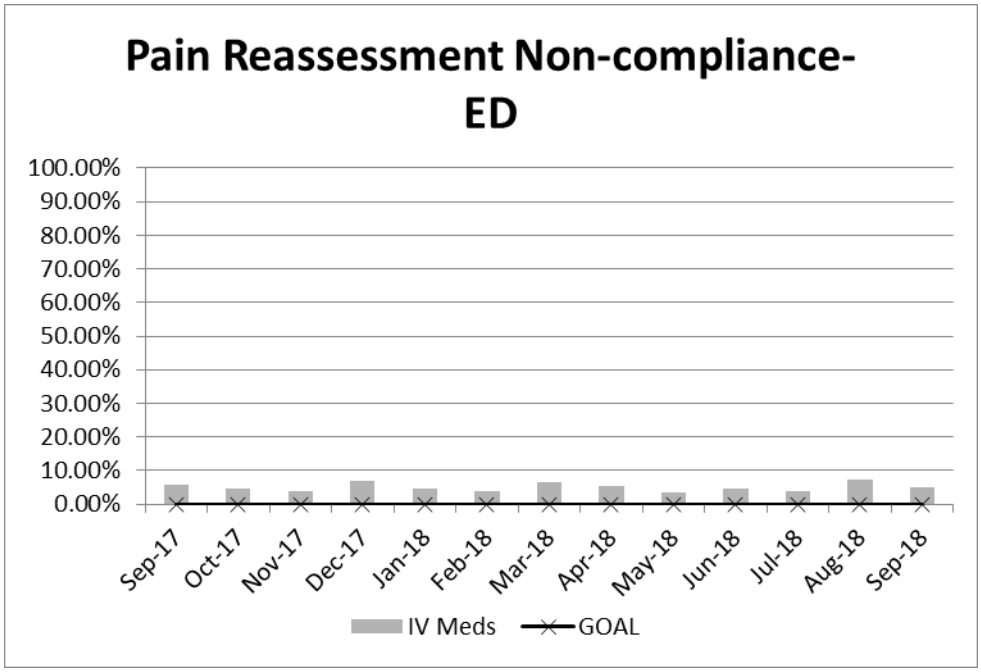


Table 6. Restraint chart monitoring for legal orders.

	Mar 2018	***April 2018***	***May 2018***	***June 2018****	***July 2018****	***Aug 2018****	***Sept 2018****	***Oct 2018***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	2/2 (100%)	1/1 (100%)	1/2 (50%)					2/2 (100%)	100%
Physician signed order within 24 hours	2/2 (100%)	1/1 (100%)	1/2 (50%)					1/2 (50%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	1/2 (50%)	0/1 (0%)	1/2 (50%)					1/2 (50%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	3/6 (50%)	N/A	N/A					N/A	100%
Orders are for 24 hours	8/8 (100%)	1/1 (100%)	2/2 (100%)					2/2 (100%)	100%
Is this a PRN (as needed) Order	0/8 (0%)	0/1 (0%)	0/2 (0%)					0/2 (0%)	0%

***Indicates no patients for this time frame**

POLICIES TO THE BOD

ENVIRONMENTAL

POLICY & PROCEDURES TO THE BOARD **11/14/2018**

DEPT. ENVIRONMENTAL

	(EVS)		TO BOD	COMMENTS
1	Pest Control for Northern Inyo Hospital		11/14/2018	
2	Rotation Procedures for Patient Cubicle Curtains and Shower Curtains		11/14/2018	
3	Special Transportation Options		11/14/2018	
4	Home Health Care		11/14/2018	
5	Infection Control Measures for Environmental Services		11/14/2018	
6	Infection Control Measures for Environmental Services Staff		11/14/2018	
7	Infection Control: Care of Handwashing Products		11/14/2018	
8	Infection Control: Special Dress Requirements		11/14/2018	
9	Infectious/Bio-Hazardous Substance Communication Program		11/14/2018	
10	Intimate Partner Abuse Guidelines for Victoms of Investigation and Reporting of Unlawful Access, Use or Disclousre of Protected Health Information		11/14/2018	

Maintenance *EOC Utility Systems* Policy and Procedures
2018

1. Utility Systems Management Plan
2. Designing & Installing Utility Systems
3. Policy on Utility Systems Inventory
4. Inspecting, Testing & Maintenance
5. Inspecting, Testing & Maintenance New Utility Systems
6. Criteria for Alternate Operations of Utility Systems
7. Labeling for Emergency Shutdown
8. EOP (Emergency Operations Plan), ERP (Emergency Response Plan)- Electrical and Generator Failure
9. EOP (Emergency Operations Plan), ERP (Emergency Response Plan)-Elevator Failure
10. EOP (Emergency Operations Plan), ERP (Emergency Response Plan)-HVAC Failure EM.02.02.09EP7
11. EOP (Emergency Operations Plan), ERP (Emergency Response Plan)-Medical Gas Failure EM.02.02.09EP6
12. EOP (Emergency Operations Plan), ERP (Emergency Response Plan)-Pneumatic Tube System Failure
13. EOP (Emergency Operations Plan), ERP (Emergency Response Plan)-Sewer and Water Failure
14. Utility Systems Failure & Emergency Response
15. Emergency Clinical Interventions
16. Managing Biological Agents
17. Instll. & Mgt. Approp Press Relations in Critical Areas
18. Mapping the Distribution of Utility Systems Controls
19. Medical Gas Storage Rooms
20. Emergency Power Systems
21. Repair & Maintenance Risk Management
22. **Initial Testing** of Utility Systems
23. Inspection, Testing & Maintenance of Utility System
24. Battery Powered Exit Signs & Egress Lights
25. (SEPSS) Stored Emergency Power Supply System
26. Emergency Power Generator Testing
27. Automatic & Manual Transfer Switch Testing
28. Policy for 4-hour Emergency Generator Test & Failures
29. Maintenance & Testing of Piped Medical Gas & Vacuum Systems
30. Bulk Oxygen Systems
31. Accessibility & Labeling of Medical Gas Systems
32. Medical Gas Cylinders & Storage Rooms

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending September 30, 2018

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Inpatient Service Revenue						
Routine	796,839	1,125,870	(329,031)	2,548,785	3,415,134	(866,349)
Ancillary	2,359,141	2,953,987	(594,846)	7,528,667	8,960,428	(1,431,761)
Total Inpatient Service Revenue	3,155,980	4,079,857	(923,877)	10,077,453	12,375,562	(2,298,109)
Outpatient Service Revenue	8,601,381	9,125,352	(523,971)	27,763,063	27,680,237	82,826
Gross Patient Service Revenue	**11,757,361**	**13,205,209**	**(1,447,848)**	**37,840,515**	**40,055,799**	**(2,215,284)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	135,289	233,650	(98,361)	477,493	708,738	(231,245)
Contractual Adjustments	5,542,647	5,128,154	(414,493)	17,628,752	15,555,402	2,073,350
Prior Period Adjustments	104	(107,500)	107,604	198	(326,084)	326,282
Total Deductions from Patient Service Revenue	**5,678,040**	**5,254,304**	**(405,251)**	**18,106,443**	**15,938,056**	**2,168,387**
Net Patient Service Revenue	**6,079,321**	**7,950,905**	**(1,871,584)**	**19,734,073**	**24,117,743**	**(4,383,670)**
Other revenue	297,154	71,274	2,051,170	2,792,964	216,199	2,576,765
Total Other Revenue	**297,154**	**71,274**	**2,051,170**	**2,792,964**	**216,199**	**2,576,765**
Expenses:						
Salaries and Wages	2,436,422	2,458,844	(22,422)	6,888,260	7,442,098	(553,838)
Employee Benefits	1,768,945	1,720,497	48,448	5,104,992	5,207,368	(102,376)
Professional Fees	1,152,592	935,837	216,755	3,552,222	2,832,465	719,757
Supplies	724,933	744,152	(19,219)	2,344,984	2,252,297	92,687
Purchased Services	268,036	350,906	(82,870)	953,226	1,062,078	(108,852)
Depreciation	342,228	360,419	(18,191)	1,021,294	1,090,868	(69,574)
Bad Debts	4,106	250,000	(245,894)	426,630	758,333	(331,703)
Other Expense	404,726	426,131	(21,405)	1,466,683	1,289,757	176,926
Total Expenses	**7,101,988**	**7,246,786**	**(144,798)**	**21,758,292**	**21,935,264**	**(176,972)**
Operating Income (Loss)	**(725,512)**	**775,393**	**(1,500,905)**	**768,745**	**2,398,678**	**(1,629,933)**
Other Income:						
District Tax Receipts	48,743	47,513	1,230	146,229	142,539	3,690
Tax Revenue for Debt	137,596	125,400	12,196	328,957	376,200	(47,243)
Partnership Investment Income	20	-	20	20	-	20
***Grants and Other Contributions Unrestricted**	42,365	42,000	365	55,716	126,000	(70,284)
Interest Income	54,821	16,302	38,519	159,163	48,906	110,257
Interest Expense	(236,292)	(245,078)	8,786	(708,876)	(728,869)	19,993
Other Non-Operating Income	623	2,000	(1,377)	7,389	6,000	1,389
Net Medical Office Activity	(481,567)	(416,960)	(64,607)	(1,607,070)	(1,240,050)	(367,020)
340B Net Activity	64,084	20,252	43,832	63,010	59,967	3,043
Non-Operating Income/Loss	**(369,607)**	**(408,571)**	**38,964**	**(1,555,462)**	**(1,209,307)**	**(346,155)**
Net Income/Loss	**(1,095,119)**	**366,822**	**(1,461,941)**	**(786,717)**	**1,189,371**	**(1,976,088)**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending September 30, 2018

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	52,795	4,672,837	(4,620,042)
Short-Term Investments	22,022,256	22,272,220	(249,965)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	512,810	512,810	-
Patient Receivable	58,812,503	59,520,374	(707,870)
Less: Allowances	(46,356,292)	(46,589,500)	233,209
Other Receivables	2,004,284	1,506,612	497,672
Inventories	3,703,199	3,968,497	(265,299)
Prepaid Expenses	1,930,884	1,992,259	(61,375)
Total Current Assets	**42,682,439**	**47,856,108**	**(5,173,669)**
Internally Designated for Capital Acquisitions	0	0	-
Special Purpose Assets	100,078	100,078	-
Limited Use Asset; Defined Contribution Pension	1,878,118	1,628,154	249,965
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	26,117	26,117	-
Revenue Bonds Held by a Trustee	3,233,661	2,908,043	325,619
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**18,603,360**	**18,027,776**	**575,583**
Long Term Investments	1,100,000	1,100,000	-
Intangible Assets	581,219	581,219	-
Property & equipment, net of Accumulated Depreciation	76,806,374	76,574,393	231,981
Unamortized Bond Costs	-	-	-
Total Assets	**139,773,391**	**144,139,496**	**(4,366,105)**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending September 30, 2018

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	1,098,089	2,110,089	(1,012,000)
Accounts Payable	2,003,534	3,764,674	(1,761,139)
Accrued Salaries, Wages & Benefits	7,400,383	6,475,717	924,666
Accrued Interest and Sales Tax	193,089	268,711	(75,622)
Deferred Income	663,401	2,586,177	(1,922,776)
Due to 3rd Party Payors	1,163,235	1,163,235	-
Due to Specific Purpose Funds	83,786	(44)	83,830
Other Deferred Credits; Pension	4,530,000	4,530,000	-
Total Current Liabilities	**17,135,517**	**20,898,557**	**(3,763,041)**
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	521,319	530,102	(8,783)
Accreted Interest	12,525,325	12,304,228	221,098
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**85,374,124**	**85,161,809**	**212,314**
Net Assets			
Unrestricted Net Assets less Income	36,773,398.44	36,493,659	279,739
Temporarily Restricted	1,585,470	1,585,470	-
Net Income (Income Clearing)	(1,095,118.84)	279,740	(1,374,859)
Total Net Assets	**37,263,750**	**38,079,129**	**279,739**
Total Liabilities and Net Assets	**139,773,391**	**144,139,496**	**(4,366,105)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending September 30, 2018

		FYE 2019	FYE 2018		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	263	776	905	(129)	-14%
Total Patient Days without NB	242	710	818	(108)	-13%
Swing Bed Days	46	111	71	40	56%
Discharges without NB	76	229	274	(45)	-16%
Swing Discharges	3	6	8	(2)	-25%
Days in Month	30	92	92		
Occupancy without NB	8.07	8	8.89	(0.8)	-9%
Average Stay (days) without NB	3.18	3	2.99	0.2	7%
Average LOS without NB/Swing	2.68	3	2.81	(0.1)	-4%
Hours of Observation	1132	2,733	2,241	492	22%
Observation Adj Days	47	114	93	21	22%
ER Visits All Visits	842	2,921	2,823	98	3%
RHC Visits	1,779	5,888	9,258	(3,370)	-36%
Outpatient Visits	3,653	11,499	7,743	3,756	49%
IP Surgeries	15	55	74	(19)	-26%
OP Surgery	101	298	311	(13)	-4%
Worked FTE's	397.81	355.00	344.12	11	3%
Paid FTE's	437.02	397.20	394.25	3	1%
Hours Worked to Hours Paid%	91.0%	89.4%	87.3%	2.1%	2%
Payor %					
Medicare		41%	38%	2%	
Medi-Cal		23%	23%	1%	
Insurance, HMO & PPO		34%	37%	-3%	
Indigent (Charity Care)		0.3%	0%	0.1%	
All Other		2%	2%	-1%	
Total		100%	100%		

Northern Inyo Healthcare District

Preliminary Financial Indicators as of September 30, 2018

	Target	Sep-18	Aug-18	Jul-18	Jun-18	May-18	Apr-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17
Current Ratio	>1.5-2.0	2.49	2.34	2.45	2.70	2.44	2.46	2.43	2.47	2.50	2.41	2.18	2.26
Quick Ratio	>1.33-1.5	2.05	1.98	2.09	2.07	1.63	1.63	1.66	2.06	2.09	1.99	1.83	1.84
Days Cash on Hand prior method	>75	156.34	178.83	185.76	147.15	134.64	132.72	137.59	168.44	166.36	165.72	169.35	165.31
Days Cash on Hand Short Term	>75	93.34	110.27	118.59	86.06	61.83	57.21	51.38	83.49	81.30	83.05	87.18	81.28
Debt Service Coverage	>1.5-2.0	1.05	1.70	2.03	2.56	2.47	2.49	2.52	2.68	2.73	2.67	2.74	2.78
Operating Margin		3.39	5.11	6.67	5.29	5.57	5.50	5.18	5.09	4.87	5.79	5.87	7.64
Outpatient Revenue % of Total		73.37	70.96	73.43	69.96	70.10	69.97	69.49	69.74	69.53	69.25	69.52	69.46
Cash flow (CF) margin (EBIDA to revenue)		(2.04)	0.44	1.64	2.87	3.33	3.43	3.53	4.17	4.31	4.05	4.30	4.69
Days in Patient Accounts Receivable	<60 Days	68.10	73.10	73.10	75.40	75.40	79.80	81.50	85.60	85.90	82.80	81.80	81.40

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivlable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income /(Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Fiscal Year Ending June 30, 2019

Year to date for the month ending September

	-129	or	-14.3%	less IP days than in the prior fiscal year
$	(2,298,109)	or	-18.6%	underbudget in Total IP Revenue and
$	82,826	or	0.3%	over budget in OP Revenue resulting in
$	(2,215,284)	or	-5.5%	under budget in gross patient revenue &
$	(4,383,670)	or	-18.2%	under budget in net patient revenue

Year-to-date Net Revenue was			$	19,734,073
Total Operating Expenses were:			$	21,758,292
				Fiscal Year To Date:
$	(176,972)	or	-0.8%	Total expenses were under budget.
$	(553,838)	or	-7.4%	Salaries and Wages were under budget.
$	(102,376)	or	-2.0%	Employee Benefits were under budget.
			74%	Employee Benefits as Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$	719,757	or	25.4%	Professional Fees are over budget due to several late invoices received for contract labor
$	176,926	or	13.7%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending
$	(331,703)	or	-43.7%	Bad Debts are under budget due to complexity of bad debt calculation to be reevaulated next month

Other Information:

$	768,745			Operating Income, less
$	(1,555,462)			loss in non-operating activities resulted in a Net
$	(786,717)	or	$ (1,976,088)	under budget year-to-date.
			47.85%	Actual Contractual Percentages for Year versus
			39.79%	Budgeted Contractual Percentages including
$	(198)	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		

Non-Operating activities included:

$	(1,607,070)	loss	$ (367,020)	unfavorable to budget in Medical Office Activities
$	55,716		$ (70,284)	unfavorable to budget in Grants and Other

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of September 30, 2018

Purchase Date	Maturity Date	Institution	Broker	Rate		Principal Invested		
30-Aug-18	1-Sep-18	Local Agency Investment Fund	Northern Inyo Hospital	2.06%		21,122,255.62		
28-Nov-14	28-Nov-18	American Express Centurion Ba	Financial Northeaster Cor	2.00%		150,000.00		
15-Jun-18	15-Mar-19	BK Phoenixville - FNC	Financial Northeaster Cor	2.20%		250,000.00		
2-Jul-14	2-Jul-19	Barclays Bank	Financial Northeaster Cor	2.05%		250,000.00		
2-Jul-14	2-Jul-19	Goldman SachsBank USA NY C	Financial Northeaster Cor	2.05%		250,000.00		
			Short Term Investments			22,022,255.62	1006-1006	##########
20-May-15	20-May-20	American Express Centurion Ba	Financial Northeaster Cor	2.05%		100,000.00		
26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00		
2-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00		
28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00		
28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00		
			Long Term Investments		$	1,100,000.00		
			Total Investments		$	23,122,255.62		
31-Jul-18	1-Aug-18	LAIF Defined Cont Plan	Northern Inyo Hospital	2.06%	$	1,878,118.12	1129-1129	
			LAIF PENSION INVESTMENTS		$	1,878,118.12		

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending September 30, 2018

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,670	$ 1,098,670	-
Equipment Fund Savings Account	$ 26,726	$ 26,726	-
Total Board Designated Funds:	**$ 1,098,670**	**$ 1,098,670**	**$ -**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,454,944	$ 1,454,944	$ -
Nursing Scholarship Savings Account	$ 30,448	$ 30,448	$ -
Joint NIHD/Physician Group Savings Account	$ 100,078	$ 100,078	$ -
Total Specific Purpose Funds:	**$ 1,585,470**	**$ 1,585,470**	**$ -**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,684,140**	**$ 2,684,140**	**$ -**

CALL TO ORDER	The meeting was called to order at 5:36pm by Mary Mae Kilpatrick, Vice President.
PRESENT	Mary Mae Kilpatrick, Vice President Jean Turner, Secretary Robert Sharp, Treasurer Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Allison Robinson MD, Chief of Staff Sandy Blumberg, Executive Assistant
ABSENT	M.C. Hubbard, President Peter Tracy, Member at Large Evelyn Campos Diaz, Chief Human Resources Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Kilpatrick announced at this time person in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board, and speakers will be limited to a maximum of three minutes each. No comments were heard.
STRATEGIC PLAN UPDATE, QUALITY AND PERFORMANCE COMMITTEE	Chief Executive Officer Kevin S. Flanigan MD, MBA introduced the Quality and Performance Improvement Committee, which provided a report on quality and performance improvement projects relating to the District's Strategic Plan. The group reported on metrics regarding staff education, infection control, and on efforts to establish a culture of safety at Northern Inyo Healthcare District (NIHD). The Committee's report also included statistics on the flu vaccination rate among NIHD staff, and on safety improvements recently implemented within the District.
APPROVAL OF MOU WITH AFSCME (NURSE'S UNION)	Doctor Flanigan called attention to a proposed Memorandum of Understanding (MOU) between NIHD and the American Federation of State, County, and Municipal Employees (AFSCME) and to Board Resolution 18-05 relating to that agreement. He provided an overview of significant differences between the proposed and the prior MOUs, and also commended both sides involved in the negotiation process on a job well done. He additionally noted that the term of the new agreement will be one year. It was moved by Jean Turner, seconded by Robert Sharp, and unanimously passed to approve the MOU between NIHD and AFSCME, and District Board Resolution 18-05 as presented.
RECEIPT OF ANNUAL AUDIT (TABLED)	Doctor Flanigan reported that due to the fact that Wipfli LLP has yet to finalize the District's audit report for the 2017/2018 fiscal year, that agenda item will be tabled to the November regular meeting of the District Board. It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve tabling approval of the NIHD Annual

Audit for the 2017/2018 fiscal year to the November 2018 meeting of the District Board.

MAINTENANCE DEPARTMENT POLICY AND PROCEDURE APPROVALS

Doctor Flanigan called attention to approval of the following District-wide Maintenance Department Policies and Procedures:

1. *Fire Safety – Fire Hazards during Surgical Procedures*
2. *Fire Safety – Compliance with NFPA 99-20121 Chapter 15*
3. *Managing Risks – Library of EOC Information*

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve all three Maintenance Department Policies and Procedures as presented.

DETERMINATION OF NOVEMBER AND DECEMBER 2018 BOARD MEETING DATES

Following brief discussion of the best dates for the November and December 2018 Board of Directors regular meetings, it was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve November 14, 2018 and December 19, 2018 to be the dates for the next two regular meetings of the District Board.

QUARTERLY MEDICAL STAFF PILLARS OF EXCELLENCE

Doctor Flanigan called attention to the quarterly Medical Staff Pillars of Excellence report for July through September 2018, which reflects a high level of performance regarding provider credentialing and privileging, and processing of Medical Staff applications.

COMBINE JANUARY 2019 ACHD MEETING WITH BOARD EDUCATION

Doctor Flanigan requested the opinion of the Board of Directors regarding the possibility of combining the January 2019 Association of California Healthcare Districts (ACHD's) leadership meeting with a Board education opportunity immediately following. Following brief discussion it was determined that the Board is interested in pursuing that possibility further, and that potential dates for Board education will be discussed at the December regular meeting.

POSSIBLE DEVELOPMENT OF POLICY REGARDING COMMUNICATIONS SENT TO MULTIPLE BOARD MEMBERS

Doctor Flanigan opened discussion on the possibly of developing a Board Policy regarding how to handle communications sent to multiple members of the District Board. It was determined that this question will be posed to District Legal Counsel during the Board education session that will take place in January of 2019.

APPROVAL OF PHARMACY RELOCATION PROJECT AGREEMENT

Doctor Flanigan called attention to a proposed agreement with Pings and Associates architects (the successful candidate from a District RFP process) for the NIHD Pharmacy relocation project. It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve the agreement with Pings and Associates architects as presented.

ATHENA IMPLEMENTATION UPDATE

Director of NIHD Information Technology Services Robin Cassidy provided an update on the District Health Information System implementation, which has gone as smoothly as possible thanks to extensive planning and teamwork on the part of NIHD staff.

CONSENT AGENDA

Ms. Kilpatrick called attention to the Consent Agenda for this meeting, which contained the following items:

- Approval of minutes of the September 19, 2018 regular meeting
- 2013 CMS Survey Validation Monitoring, October 2018
- Financial and Statistical reports for August 2018
- Policy and Procedure annual approvals

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve all four Consent Agenda items with a correction being made to the minutes of the September 19 2018 regular meeting.

CHIEF OF STAFF REPORT

Chief of Staff Allison Robinson MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the Medical Staff resignation of David Huddleston MD, effective September 6, 2018. It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve the Medical Staff resignation of David Huddleston MD as requested.

BOARD MEMBER REPORTS

Ms. Kilpatrick asked if any members of the Board of Directors wished to comment on any items of interest. Director Turner praised the District's recent breast cancer wellness presentation, which she felt was very well done. Director Kilpatrick also praised those involved in the NIHD and AFSCME MOU process on a job well done. On behalf of Director Hubbard, Doctor Flanigan reported that the Eastern Sierra Cancer Alliance annual fundraising walk will take place this weekend. No other comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 6:51pm Ms. Kilpatrick announced the meeting would adjourn to Closed Session to allow the Board of Directors to:

A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
B. For discussion of a real estate negotiation regarding price, 376 West Yaney Street, Bishop, California, agency negotiators Kevin S. Flanigan MD, MBA and the Ruland Trust (*pursuant to Government Code Section 54956.8*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 7:08pm the meeting returned to open session. Ms. Kilpatrick reported that the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 7:11pm.

_____
Mary Mae Kilpatrick, Vice President

Attest: _____
Jean Turner, Secretary

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: Allison Robinson, MD, Chief of Medical Staff
DATE: November 6, 2018
RE: Medical Executive Committee Report

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

A. Policies/Procedures/Protocols/Order Sets (*action items*)
    1. *Cardiac Monitoring*
    2. *Malignant Hyperthermia*
    3. *Pediatric and Newborn Consultation Requirements*

B. Medical Staff Appointments/Privileges (*action item*)
    1. Laura Sullivan, MD (*cardiology, Renown*) – telemedicine staff

C. Allied Health Professional Appointments/Privileges (*action items*)
    1. Nancy Fong, FNP (*Rural Health Clinic)*
    2. Alissa Dell, FNP (*Rural Health Clinic/Internal Medicine Clinic*)

D. Telemedicine Staff Appointment/Privileges – credentialing by proxy (*action item*)

    As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Quality Nighthawk's credentialing and privileging decisions.

    1. Benjamin Ge, MD (*diagnostic radiology, Quality Nighthawk*)

E. Additional privileges (*action item*)
    1. Erik Maki, MD (*interventional radiology*) – new privileges in Radiofrequency Ablation
    2. Tammy O'Neill, PA-C (*Rural Health Clinic*) – new privileges as a generalist Physician Assistant in the Rural Health Clinic

F. Medical Staff Resignations (*action items*)
    1. Sheldon Kop, MD (*radiology*) – effective 10/30/2018
    2. David Landis, MD (*radiology*) – effective 10/30/2018
    3. Arsen Mkrtchyan, MD (*internal medicine*) – effective 12/31/2018

G. Core Privilege Forms (*action items*)
    1. Pathology (new)
    2. Psychiatry (new)
    3. Pediatrics (revised)
    4. Obstetrics and Gynecology (revised)
    5. Family Medicine (revised)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager - ICU Acute/Subacute	Effective Date: 1/17/17

PURPOSE:

1. To ensure all patients who have orders for telemetry receive cardiac monitoring by trained staff within the constraints of the physician orders

2. To standardize process for nursing management of the patient on the Acute Sub Acute unit caring for the telemetry patients, and for the nurse monitoring the patient in the Intensive Care Unit (ICU)

3. To guide appropriate placement of patients requiring cardiac monitoring in the Acute Sub Acute Services Department

4. To define required competency for registered nurses (RN) caring for patients on a cardiac monitor in the Acute Sub Acute Services Department and for the nurse monitoring the patient in the ICU

5. To define parameters for and delineate response to clinical alarms related to cardiac monitoring in the Acute Sub Acute Services Department

6. To ensure that accommodation and billing codes are accurate

POLICY:

1. A physician's order is required to place a patient on a cardiac monitor
    a. Patients who present with or develop the following conditions while being admitted to the Acute Sub Acute department may be monitored on telemetry without being transferred to ICU:
        i. Syncope of unknown origin
        ii. Uncomplicated congestive heart failure (CHF)
        iii. Chest pain without diagnostic ECG findings or elevated biomarkers
        iv. Hemodynamically stable post-acute myocardial infarction (MI)
        v. Non-life threatening arrhythmias
        vi. Chronic, rate-controlled atrial fibrillation
        vii. Postoperative/post-procedure monitoring for patients at low risk for cardiac arrhythmias
        viii. Newly placed permanent pacemakers
        ix. Renal insufficiency

    b. Patients who present with or develop the following conditions require cardiac monitoring in the ICU:
        i. Hemodynamic compromise requiring vasoactive or antiarrhythmic medications
        ii. Unstable angina
        iii. ECG changes or life-threatening arrhythmias
        iv. Acute MI
        v. Atrial fibrillation requiring intravenous medications or procedures not approved for Acute Sub Acute Services
        vi. Unstable postoperative course
        vii. If it has been determined that the above patient no longer needs ICU interventions, they may be transferred to lower level of care with a physician's order.

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager - ICU Acute/Subacute	Effective Date: 1/17/17

2. RNs caring for patients on a cardiac monitor, or nurses monitoring the patient in the ICU, will successfully pass a cardiac dysrhythmia test and demonstrate accurate dysrhythmia interpretation skills within 6 months of hire and every 2 years.

3. Any patient on telemetry monitoring will be assigned to a registered nurse (RN) with a patient ratio of 1:4 or fewer.

4. The Acute Sub Acute RN will ensure that Standards of Care for the Telemetry patient are met:
   a. The Acute Sub Acute RN will assess the patient a minimum of once every shift and more frequently as ordered by the physician and if the patient's condition changes.
   b. Vital signs will be measured and documented every 4 hours or as ordered by the physician.
   c. Patient weight will be measured and documented daily.
   d. Patent IV access will be maintained.
   e. Telemetry will be continuously monitored (except as ordered by physician) with 24-hour staffing of the central monitor by the central monitoring technician~~an ICU RN/LVN~~.
   f. The Acute Sub Acute RN will initial ~~co-sign~~ the rhythm strip, verifying interpretation, with the central monitoring technician,~~the ICU RN/LVN~~ a minimum of once per shift, and as needed for verification of alarms.
   g. The Acute Sub Acute RN will notify the physician for any acute changes in rate or rhythm.

5. Cardiac monitor alarms will be on at all times, audible to and visible to~~by~~ the central monitoring technician. ~~the ICU RN/LVN~~

6. The central monitoring technician ~~ICU RN/LVN~~ will immediately notify the Acute Sub Acute RN of any new alarms, rate changes, or rhythm changes via telephone.

EQUIPMENT:

1. See Lippincott procedure "Cardiac monitoring"

PROCEDURE:

A. Initial Setup

1. Verify the physician's order for telemetry monitoring

2. Obtain equipment from ICU

3. Follow procedure in Lippincott "Cardiac Monitoring" for Five-lead placement

4. Electrodes must be changed at least every 48 hours. If one electrode becomes loose and needs to be changed, change all of the electrodes.

5. Electrodes and lead-wires may be placed by CNA with verification by the Acute Sub Acute RN.

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager - ICU Acute/Subacute	Effective Date: 1/17/17

B. Monitoring:

1. On admission or start of cardiac monitoring:
    a. When all the electrodes are in place, attach the lead-wires and check for a tracing on the telemetry monitor at the nurses' station on the Acute Sub Acute department
    b. The RN will check with the central monitoring technician~~the ICU RN/LVN~~ to ensure quality ECG tracing is being monitored.
    c. ~~The department clerk will be made aware of the new order to ensure change of service is documented~~The central monitoring technician will ~~inform the registration department of the telemetry order, allowing them to enter the appropriate accommodation level~~coordinate changing the patient to the appropriate accommodation status.
    d. The Acute Sub Acute RN will notify the central monitoring technician~~the ICU RN/LVN telemetry monitor~~ of the patient's:
        i. Name
        ii. Room number
        iii. Diagnosis
        iv. Pertinent medications
        v. Pertinent labs
        vi. Pacemaker status
    e. The Acute Sub Acute RN will perform an initial head to toe admission assessment and additional assessments each shift, as stated in the standards of care.~~as listed below~~
    f. The central monitoring technician~~ICU RN/LVN~~ will select one of the available telemetry windows.
        i. In the patient window, select "Admit Patient".
        ii. ~~Click on the "medical record number" window and scan the patient's label.~~Input the medical record number
        iii. Ensure that all of the information entered is correct.

2. Throughout monitoring:
    ~~a. The Acute Sub Acute RN will perform a nursing assessment every four (4) hours, to include:~~
    ~~b. Skin assessment to assure intact skin around electrodes~~
    ~~c. Electrode and lead-wire placement~~
    ~~d. Identification of new signs or symptoms of cardiac compromise~~
    ~~e. Vital signs (may be delegated to CNA)~~
    ~~f.~~a. The Acute Sub Acute RN will analyze, review, and initial ~~co-sign~~ the printed rhythm strip once per shift~~every eight (8) hours along~~ with the central monitoring technician ~~the ICU RN/LVN~~.
    ~~g.~~b. The central monitoring technician ~~The ICU RN/LVN~~ will analyze, review and initial~~co-sign~~ the rhythm strip every 8 hours and will review the patient's rhythm every 4 hours.
    ~~h.~~c. Temporary discontinuation of telemetry monitoring requires:
        i. Physician order stating patient may shower or bathe off telemetry
        ii. Physician order stating patient may be off telemetry for ordered tests and procedures.
        iii. Notification to the central monitoring technician ~~the ICU RN/LVN~~ when the patient is being taken off telemetry
        iv. Notification to the central monitoring technician ~~the ICU RN/LVN~~ when the patient is being returned to telemetry

~~i.~~d. If the patient needs to go to a test on telemetry, an ~~Acute Sub Acute~~ RN or cardiac arrhythmia qualified personnel will accompany the patient using the portable telemetry monitor

~~j.~~e. The Acute Sub Acute RN will notify the central monitoring technician ~~the ICU RN/LVN~~ when the patient is being given medications that may affect the cardiac rate and rhythm

~~k.~~f. Default alarm parameters will include:

i. Heart rate lower than 50
ii. Heart rate higher than 120
iii. SVT defined as greater than 180 beats per minute for greater than 5 beats
iv. Run of PVCs defined as greater than 2 PVCs in a row
v. Ventricular rhythm defined as greater than 14 PVCs in a run
vi. Ventricular tachycardia defined as greater than 100 bpm with greater than 5 PVCs in a run
vii. Greater than 10 PVCs in one minute
viii. Atrial fibrillation
ix. Pause defined as 2 seconds without electrical activity
x. Asystole defined as greater than 4 seconds without electrical activity

~~l.~~g. Alarm parameters may be modified at the ICU central monitor as ordered by the physician, depending on baseline rate and rhythm in order to avoid alarm fatigue. An example would be a patient with a hear rate greater than 120 that the physician allows the alarm limits to be set higher than 120.

~~m.~~h. The Acute Sub Acute ~~S~~ RN will notify the physician of any acute changes in rate or rhythm.

3. On discharge or upon discontinuation of cardiac monitoring:
   a. An Acute Sub Acute RN, CNA, or department clerk will notify the central monitoring technician ~~the ICU RN/LVN~~ of discontinuation.
   b. An Acute Sub Acute RN, CNA, or department clerk will return telemetry unit to ICU for cleaning and storage.
   c. ~~An Acute Sub Acute RN~~Upon discontinuation of cardiac monitoring, the central monitoring technician ~~-~~will ~~notify the registration department~~department clerk to assure ~~the appropriate documentation of of change of service takes place.~~coordinate changing the accommodation status of the patient.

C. Documentation

1. On admission or start of telemetry monitoring:
   a. If telemetry is started after the patient is already admitted, the central monitoring technician ~~The department clerk~~ will assure that~~, at the time of the physician's order, the registration department is informed of change of service, to "Med/Surg Intermediate" will be completed~~ there is a physician's ordre and that the accommodation status of the patient is accurate.
   b. Acute Sub Acute RN will enter time of "Telemetry Start" in the EHR
   c. Acute Sub Acute RN will enter "Unit Telemetry Initiated" in the EHR
   d. Acute Sub Acute RN will document rate, rhythm, lead used with verification by the central monitoring technician ~~the ICU RN/LVN~~, in the EHR
   e. Acute Sub Acute RN will document initial placement of electrodes in the EHR

f. Acute Sub Acute RN will open care plan "Alteration in Cardiac Output"

2. Throughout monitoring:
   a. Acute Sub Acute RN will document above assessment in EHR every ~~4 hours~~shift.
   b. Initialed~~Co-signed~~ rhythm strips will remain in ICU for 24 hours, then will be placed in patient's paper chart ~~located in AS- Services department~~
   c. Acute Sub Acute RN will document any acute changes, including time notified by the central monitoring technician~~ICU RN/LVN~~, and time of notification of physician in EHR
   d. Acute Sub Acute RN will document any response to PRN medications in the EHR ~~EMAR~~
   e. Acute Sub Acute RN will verify once per shift that admission information was documented in EHR
   f. Acute Sub Acute RN will ensure electrodes are changed at least every 48 hours, and documented in EHR. Electrode changes may be delegated to CNA, with confirmation of placement and documentation by RN.
   g. Acute Sub Acute RN will review care plan each shift and document progress towards goals.

3. On discharge or at the end of telemetry monitoring:
   a. The central monitoring technician ~~The department clerk~~ will ensure that the change in service will be processed with the time of the physicians written order
   b. Acute Sub Acute RN will enter time of "Telemetry Stop" in EHR
   c. Acute Sub Acute RN will complete Alteration in Cardiac Output care plan.

REFERENCES:

1. California Department of Public Health. (2007). *Changes to the minimum licensed nurse-to-patient ratios effective January 1, 2008*. Retrieved from http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-07-26.pdf

CROSS REFERENCE P&P:

1. Cardiac monitoring. (July 10, 2015). *Lippincott Procedures*. Retrieved on April 14, 2016 from http://procedures.lww.com/lnp/view.do?pId=3260727

Approval	**Date**
CCOC	8/27/18
MED/ICU	10/25/18
MEC	11/6/18
Board	
Last Board of Director review	4/18/18

Developed: 4/10/16
Reviewed: 1/17 la
Revised: 8/23 JN
Supersedes:

1. Transfer to Medical-Surgical Intermediate Care/Telemetry

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager - ICU Acute/Subacute	Effective Date: 1/17/17

2. Telemetry Monitoring – Philips.
3. Med/Surg unit standards of care for patients on telemetry

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Malignant Hyperthermia*	
Scope: Nursing Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Perioperative Director of Nursing	Effective Date: 5/24/16

PURPOSE:
To provide quick detection and intervention in the rare instance of malignant hyperthermia (MH).

POLICY:
The following procedure will be used as a guideline in the instance that a patient experiences a malignant hyperthermic crisis.

EQUIPMENT:
- MH emergency Cart
- Refrigerated IV Normal Saline (in cart)
- Ice (large quantity)
- Regular insulin
- Defibrillator cart

PRECAUTIONS:
Malignant hyperthermia is a life-threatening syndrome that occurs in individuals who have a hereditary skeletal muscle disorder. In these people, a triggering anesthetic agent may cause an acute hypermetabolic crisis which may occur during anesthesia induction (ie. immediately upon exposure to a triggering anesthetic agent) or anytime throughout the intraoperative or postoperative phase. Perioperative nurses and anesthesia personnel need to be alert to the signs and symptoms of malignant hyperthermia (MH), a medical emergency that must be detected early and treated immediately and vigorously.

PROCEDURE:
1) Prior to surgical interventions all patients will be assessed for risk factors associated with malignant hyperthermic susceptibility.
    a. Family history of MH, complications or death arising from anesthesia.
    b. History of hereditary skeletal muscle disorder, unusual muscle weakness or muscle cramps.
    c. Dark, cola-colored urine or unexplained high fevers following anesthesia.
    d. Muscle hypertrophy exhibited by round or bulky muscle groups.
    e. Higher incidence in children.
    f. Personal history of unexplained high fever following surgery.
2) Health care team members will monitor the patient and observe for signs and symptoms of MH. Signs and symptoms to report to the anesthesiologist immediately include:

    a. Increase in end-tidal carbon dioxide (the earliest sign of MH)
    b. Muscle rigidity, including masseter spasm which may be one of the earliest signs of a MH crisis. (The masseter muscle raises and lowers the jaw).
    c. Tachycardia (up to 200 bpm) and/or dysrhythmias.
    d. Tachypnea.
    e. Unstable or rising (initially) systolic B/P.
    f. Oxygen desaturation/cyanosis.
    g. Mottling of the skin.

Title: Malignant Hyperthermia*	
Scope: Nursing Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Perioperative Director of Nursing	Effective Date: 5/24/16

h. Fever (i.e. temperature increases of as much as 2 degrees C. (3.6f) every five minutes with possible temperatures of 43.3 degrees C. (110f) or more.
i. Palpable warmth in viscera, anesthesia tubing, soda lime canisters (with soda lime possible turning blue).
j. Diaphoresis.
k. Dark blood in surgical field.
l. Do not give triggering agents to patients with Ducheene Dystrophy, Central core Disease, Mytonia or other forms of Muscular Dystrophy.

INTERVENTION:

1. At onset of crisis, RN will initiate code blue system. **(MH Hotline # is 1-800-644-9737).**
2. Assist anesthesiologist intubate and/or secure airway. As soon as possible, anesthesia circuit and soda lime units need to be changed.
3. Obtain MH cart and defibrillator cart.
4. Discontinue triggering agents (i.e. volatile inhalational anesthetic agents, depolarizing neuromuscular blocking agents).
5. If the patient is stable and the surgical procedure is to continue, employ a non-triggering, anesthetic technique.
6. Hyperventilate the patient with 100% oxygen at high flow rates 10 L/min. or more.
7. Under the direction of the anesthesiologist administer Dantrolene IV. Initial dose is 2.5/kg Rapid IV, repeat until there is control of the signs of MH. Sometimes more than 10mg/kg (up to 30mg/kg) is necessary.

Supplies needed:

1) 60ml syringes, Mini Spike Dispensing Pins, IV bags of sterile water for drug dilution, and Clave Multiple IV Access (all located in MH Cart).
2) Each vial contains 20mg of Dantrolene and needs to be reconstituted with 60cc of sterile water for injection (preservative free). Vial needs to be shaken until solutions are clear.
   a) **First nurse** will Insert Mini Spike into Dantrolene bottles.
   b) **Second nurse** will attach Clave Multiple IV Access to Sterile Water for IV and then attach 60ml syringe, drawing up solution and handing to **first nurse** with Dantrolene.
   c) **First nurse** will then instill the sterile water into the Dantrolene bottle and shake up until dissolved.
   d) After diluted, the Dantrolene is to be administered to the patient per physician order.
   e) This routine is to be repeated until desired amount of Dantrolene has been diluted and injected into patient.
   f) If additional nursing personnel are available this process could be expedited
3) For **Dantrolene dose conversion** refer to **Malignant Hyperthermia Emergency Dantrolene Dosage Chart**. (located on top of Malignant Hyperthermia Cart and in front of the Information Book.
4) Notify Pharmacy if more Dantrolene is needed.

*Note: Dantrolene is a skeletal muscle relaxant that inhibits the release of calcium from the sarcoplasmic reticulum**. (CARE MUST BE TAKEN TO PREVENT DANTROLENE FROM INFILTRATING TISSUE AROUND THE IV SITE**).

8. Initiate cooling: For patients > 39 degrees C. Circulating nurse must direct members of the team who are unfamiliar with the OR.
   a) Iced normal saline IV's and normal saline for irrigation in the refrigerator**. *DO NOT USE LACTATED RINGERS** - may contribute to acidosis).
   b) Ice patient - crushed ice in plastic bags lay next to the patient's neck, axilla and groin areas. ** Can use Ice Packs in freezer until ice arrives
   c) Gastric or peritoneal lavage.
   d) Cooling blanket.
   e) Indirectly lavage stomach (i.e. connect NG tube to refrigerated normal saline irrigation with cystoscopy tubing).
   f) Lavage rectum (i.e. connect a three-way foley catheter with 30cc balloon to refrigerated normal saline irrigation with cystoscopy tubing. ***NOTE: BLADDER IRRIGATION IS TO BE AVOIDED BECAUSE OF THE NEED TO MONITOR URINE OUTPUT).**

Discontinue cooling measures when the patient's temperature reaches < 38 degrees C. **and falling to prevent drift <36 degrees C**.
(100.4f).
Note: Care should be taken to avoid too rigorous cooling, which can result in **inadvertent hypothermia.**

9. The RN will call the lab and respiratory therapy to obtain necessary lab work including, blood gases to obtain ph status.

10. The RN will be familiar with other medications that may be administered under the direction of the anesthesiologist.
    a) IV sodium bicarbonate (HCO3) 1-2 meq/kg (after the first ABG's are drawn).
    b) Treat hyperkalemia in adults with 10 units regular insulin in 50% dextrose 50ml IV bolus. **Pediatric patients** may be treated with regular insulin 0.15 units/kg and 1mg/kg 50% glucose. Life threatening hyperkalemia in both adult and pediatric patients may be treated with Calcium chloride 10mg/kg or Calcium gluconate 10-50mg/kg.
    c) Dysrhythmias usually respond to treatment of acidosis and hyperkalemia. Use standard drug therapy **except calcium channel blockers which may cause hyperkalemia or cardiac arrest in the presence of Dantrolene sodium.**

    d) Maintain a high urine output of at least **2cc/kg/hr** by giving the following:
       - A foley catheter will be inserted if not already present.
       - IV normal saline per physician order (**2-8 ml/kg**) body weight for initial volume loading with subsequent amounts based on CVP readings and urine output.
       - May consider furosemide.

11. Transfer the stable patient to PACU/ICU in the following manner:

a) Give advanced notice so nursing staff can prepare to receive a post-crisis MH patient.
b) Transport/transfer patent to a bed with a hypothermia blanket.
c) Vital signs, EKG, arterial line, oximetry, and B/P shall be monitored.
d) Continuous oxygen administration shall be given during transport.
e) Dantrolene 1mg/kg should be given every 4-6 hours for at least 36 hours. Further doses may be indicated.
f) MH cart shall be kept at the patient bedside if needed.

12. Observe the patient in an ICU for at least the first 24 hours, due to the risk of recrudescence. For the first 24-48 hours following surgery, each caregiver who is new to the patient shall be given a comprehensive report to include a review of the signs and symptoms and history of M.H. All personnel in the unit should be advised of the patient's diagnosis.

13. Monitor all parameters (ie. ECG, V.S., CVP if present, oximetry, ABG, CK, K+ (potassium levels) every 6 hours for 24-48 hrs following surgery because triggering of MH may occur. Major indications of renewed trouble are:

    - Rigidity
    - Acidosis
    - Change in vital signs
    - Any of the signs and symptoms associated with the initial acute episode, Including monitoring the patient's coagulation status watching for DIC and Myoglobinuria

14. Continue Dantrolene 1mg/kg body weight IV every 4- 6 hours for hours following surgery titrated to tachycardia, acidosis, elevated body temperature and muscle rigidity to prevent post-crisis recurrence in the patient.

15. Avoid using potassium-containing solutions. Allow electrolytes to normalize. For as long as 24 hrs post-crisis, muscle breakdown is occurring and spontaneously releasing intracellular potassium, making serum potassium assessment difficult.

16. Give a narcotic analgesic to treat severe muscle tenderness that occurs following a MH episode. Observe the patient for signs and symptoms of compartment syndrome. NOTE: Great care is required in handling patients because of extreme muscle tenderness that results from an MH episode.

17. Avoid stress and anxiety. If the patient's condition warrants, allow family members to provide comfort and reassurance.

18. Caution should be exercised during patient ambulation because of the muscle damage caused by MH crisis and muscle relaxation resulting from the administration of Dantrolene. Patient should ambulate initially only with assistance.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Malignant Hyperthermia*	
Scope: Nursing Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Perioperative Director of Nursing	Effective Date: 5/24/16

FAMILY PATIENT TEACHING:

1. If a patient has an equivocal MH episode or is a first-degree blood relative of a newly diagnosed MH patient, and therefore requires diagnosis, he or she may be referred to a regional medical testing center for a skeletal muscle biopsy. Currently, a skeletal muscle biopsy is the only definitive diagnostic test for MH and is available only at specific center. Forms for reporting MH episodes are available from: North American MH Registry of MHAUS c/o The Department of Anesthesiology, Children's Hospital of Pittsburgh, Room 7449, 3705 Fifth Avenue at De Soto Street, Pittsburgh, Pa 15213-2583 – Phone 412-692-5464.

2. Instruct the patient and family members on the signs and symptoms of MH as soon as possible following the crisis. Help them understand the importance of reporting these signs and symptoms immediately to an emergency care facility.

3. Advise the patient and family members of possible post-Dantrolene therapy symptoms. These may include nausea, diarrhea, muscle weakness (ie, decrease in hand grip; weakness of leg muscles, especially when walking down stairs), double vision, and dizziness or lightheadedness. The patient should be kept in Hospital for 48 hours after Dantrolene, and because these symptoms may persist for up to 48 hours, the patient should be instructed not to operate a vehicle or engage in other hazardous activity during this time.

4. Discuss with the patient and family members the potential for malignant hyperthermia susceptibility (MHS) in other blood relatives. These family members should be notified in writing that they are to be considered MHS until proven otherwise.

5. Instruct the patient and family members in writing to inform all of their health care providers of their known or suspected MH susceptibility. They should notify the following in writing: local hospitals and anesthesia departments, family doctors, dentists, and school nurses. The patient should ask the anesthesia departments of his or her local hospitals to take precautionary steps to make sure an adequate supply of fresh Dantrolene is available.

6. Inform the patient of the need to discuss with anesthesia personnel his or her MHS as soon as any further surgery is contemplated. Let the patient know that when anesthesia personnel are prepared, a patient's risk associated with anesthesia is markedly decreased.

7. Instruct the patient and family members on the importance of wearing a medical identification bracelet and carrying a card in the wallet regarding the history of MH.

8. Give the patient and family members the MH Association of the United States' address: 39 East State Street, PO Box 1069, Sherburne, NY 13460-10669, (607)674-7910 – E-mail: mhaus2norwich.net / www.mhaus.org

9. Follow up phone call to assess whether patient/family has followed up contacting the MH Association.

Triggering agents commonly used at NIH:

- Sevoflurane (Ultane)
- Isoflurane (forane)
- Halothane (fluothane)
- Succinylcholine (anectine)
- Desflurane

Non-triggering anesthetic agents that can be used as an alternative:

Neuromuscular blocking agents:

- Atracurium (tracrium)
- Pancuronium (pavulon)
- Vecuronioum (norcuron)
- Pipecuronium (ardvan)
- Mivacurium (mivacron)
- Tubocurare (curare)
- Cisatracurium

IV anesthetic agents:

- Propofol (diprivan)
- Etomidate (amidate)
- Ketamine (ketalar)
- Thiopental

Inhalation agents:

- Nitrous oxide

Benzodiazepines:

- Diazepam (valium)
- Midazolam (versed)
- Lorazepam (ativan)

Opiates:

- Morphine
- Meperidine (demerol)
- Hydromorphine (dilaudid)
- Fentanyl (sublimaze)
- Sufentanil (sufenta)

- Alfentanil (alfenta)

Barbiturates:

- Thiopental (pentothal)
- Methohexital (brevital)

Local anesthetics:

- Lidocaine (xylocaine)
- Bupivicaine (marcaine)
- Mepivacaine (carbocaine)
- Cocaine
- Tetracaine (pontocaine)
- Procaine (novacaine)
- Chloraprocaine (nesacaine)
- Ropivicaine (Naropin)

Note: Controversial drugs include Atropine and Neostigmine on their safety.

Supplies in MH Cart: (Kept in PACU)
**Supply list for cart is located under attachments on left grey sidebar
**Supplies need to be restocked immediately after code

- Calcium Chloride 10% 10 ml PFS
- Dextrose 50 % 50ml PFS
- Furosemide 40 meq/4ml Vial
- Mannitol 20% 500ml bag
- Sodium Bicarbonate 50 meq/50ml PFS
- Dantrolene 20 mg (6 boxes of 6 bottles)
- Lidocaine 1% (50mg/5ml) PFS (3)
- Lidocaine 2% (100mg/5ml) PFS (1)
- Amiodarone 150mg/3ml (3)
- Secondary IV Set #11953-48
- Sterile Water for Injection 1000ml bag x 4
- Clave Multiple IV Access #12114 x 4 (attach to sterile water for injection above)
- Mini Spike Dispensing Pin DP-1000 x 25
- 60ml Luer Lock Syringes x 20
- Blood Gas Kits x 4
- Esophageal Stethoscopes
- Salem Sump Tube Size 14fr, 18 French.
- Urine Meter
- 3M Wall Drape
- Toomey syringe
- 60ml Irrigating Syringe

Title: Malignant Hyperthermia*	
Scope: Nursing Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Perioperative Director of Nursing	Effective Date: 5/24/16

- Irrigation Set #750307
- Soda Lime (1 new machine – 2 old machine)
- Anesthesia circuit
- Blood draw tubes (bags x 3)
- Zip lock bags for Ice
- Foley Catheters (#10, #16, #18)
- Rectal Tube

Refrigerator on Cart:

- Novolin R Insulin 100units/ml 10 ml
- TB Syringes x 2
- Normal Saline IV 1000ml Bag x 4
- Normal Saline Irrigation 1000ml x 4
- Ice Packs in freezer compartment x 6

DOCUMENTATION:

The incident shall be documented on the Operating Room Record, Anesthesia record and on an incident report describing fully the presenting signs and symptoms, treatment and patient response. Names of all attending personnel will be included on the operating room record. If personnel and time permit, a code sheet shall be filled out in entirety.
****Malignant Hyperthermia Crisis Flow Sheet is located under attachments in left grey sidebar.**

REFERENCE:

MHAUS literature on Malignant Hyperthermia
Berry and Kohns Operating Room Technique
AORN, Pharmacy, PDR

CROSS REFERENCE P&P:

Malignant Hyperthermia Cart Check

Approval	**Date**
CCOC	10/22/18
Pharmacy & Therapeutics	10/18/18
Surgery Tissue	10/24/18
MEC	11/6/18
Board of Directors	
Last Board of Directors Review	1/17/18

Developed: 4/29/13
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Malignant Hyperthermia*	
Scope: Nursing Services	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Perioperative Director of Nursing	Effective Date: 5/24/16

Revised: 02/11 BS; 8/2011 BS/TS, 4/25/2013, 2/26/15AW, 10/18ta
Index Listings: Malignant Hyperthermia

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pediatric and Newborn Consultation Requirements	
Scope: Medical Staff, Pediatrics	Manual: Medical Staff
Source: Chief of Pediatrics	Effective Date:

PURPOSE:
The purpose of this policy is to outline the requirements for pediatric and newborn patient consultation to the pediatric service.

POLICY:
1. Consultation on pediatric patients is required in the following circumstances:
    a. Any critically ill infant or child.
    b. Prior to surgery in any child with potential for significant complications.
    c. Following surgery for unexpectedly prolonged inpatient stay or prolonged IV therapy or electrolyte imbalance.
    d. At any time a provider has concerns.
2. Consultation on newborns/nursery patients is required in the following circumstances:
    a. Any newborn admitted to Neonatal Pediatrics for any reason (IV therapy, oxygen therapy, etc.).
    b. Any infant requiring transfer to another facility.
    c. Infants requiring phototherapy.
    d. Infants requiring treatment for hypoglycemia.
    e. Infants with unstable vital signs or suspected sepsis.
    f. Infant with persistent vomiting or abdominal distension.
    g. Infants born before 35 weeks gestation.
    h. Infant of mother with signs/symptoms concerning for chorioamnionitis.
    i. At any time a provider has concerns.
3. The request for consultation should be directed to the physician listed as being on-call for the pediatric service and/or a pediatric or neonatal specialist if higher level of care is needed. Medical staff members on-call for the pediatric service may be a pediatrician or a family practice physician having qualified for and been granted the appropriate privileges to provide consultation.

REFERENCES:
1. 22 CCR §70537. Pediatric Service General Requirements.
2. American Academy of Pediatrics.

CROSS REFERENCE P&P:
1. Pediatric Standards of Care and Routines
2. Admission Procedure of Pediatric Patient
3. Admission, Care, Discharge, and Transfer of the Newborn

Approval	**Date**
Clinical Consistency Oversight Committee	
Perinatal/Pediatrics Committee	10/12/18
Medical Executive Committee	11/06/18
Board of Directors	
Last Board of Directors Review	

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pediatric and Newborn Consultation Requirements	
Scope: Medical Staff, Pediatrics	Manual: Medical Staff
Source: Chief of Pediatrics	Effective Date:

Developed: 10/2018 ch, dp
Reviewed:
Revised:
Supersedes: n/a
Index Listings: pediatric newborn consultations, pediatric newborn consults

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

PATHOLOGY

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA
Education/Formal Training: • Completed accredited residency training in Anatomic Pathology and Clinical Pathology. • Board Certified/Board Eligible by the American Board of Pathology or recognized equivalent (AOA or foreign).
CORE PRIVILEGES
☐ Anatomic and Clinical Pathology, including provision of consultation to physicians for diagnosis, exclusion, and monitoring of disease, as well as the ordering of diagnostic studies. ☐ Supervise clinical laboratory (blood bank, microbiology, hematology, urinalysis, clinical chemistry) ☐ Perform and interpret bone marrow examinations ☐ Autopsies ☐ Blood banking/transfusion medicine ☐ Chemical pathology ☐ Cytogenetics ☐ Cytopathology, including fine needle aspiration or biopsy ☐ Dermatopathology ☐ Forensic pathology ☐ Frozen section ☐ Hematopathology/laboratory hematology ☐ Immunopathology ☐ Microbiology/virology ☐ Neuropathology ☐ Pediatric pathology ☐ Surgical pathology ☐ Toxicology
SPECIAL PRIVILEGES (require additional training and/or experience within last two years)
☐ Invasive biopsy (needle or surgical)

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

_____ _____
Chief of Surgery *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

PSYCHIATRY

Instructions: Please check box next to each core privilege requested.

INITIAL CRITERIA
Education/Formal Training: • Completed accredited residency training in Psychiatry. • Board Certified/Board Eligible by the American Board of Psychiatry and Neurology or recognized equivalent (AOA or foreign).
CORE PRIVILEGES
☐ Evaluate, diagnose, treat, perform H&P, and provide consultation to adult patients presenting with mental, behavioral, addictive or emotional disorders (e.g., psychoses, depression, anxiety disorders, substance abuse disorders, developmental disabilities, sexual dysfunctions and adjustment disorders) at the request of the patient's attending practitioner privileged at Northern Inyo Healthcare District. ☐ Provide consultation to healthcare providers at Northern Inyo Healthcare District in fields regarding mental, behavioral, or emotional disorders, as well as order diagnostic laboratory tests and prescribe medications. ☐ Provide emergency psychiatry to patients of all ages; assess, stabilize, and determine disposition of patients with emergent conditions
SPECIAL PRIVILEGES (*requires proof of training in pediatric psychiatry*)
☐ Evaluate, diagnose, treat, perform H&P, and provide consultation to pediatric patients presenting with mental, behavioral, addictive or emotional disorders (e.g., psychoses, depression, anxiety disorders, substance abuse disorders, developmental disabilities, sexual dysfunctions and adjustment disorders) at the request of the patient's attending practitioner privileged at Northern Inyo Healthcare District.

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

Practitioner Name: _____ Date: _____
Please Print

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

_____ _____
Chief of Medicine *Date*

_____ _____
Chief of Pediatrics *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

PEDIATRICS

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in Pediatrics.
- Board Certified/Board Eligible by the American Board of Pediatrics or equivalent.

INPATIENT CORE PRIVILEGES

PALS and NRP required. STABLE preferred.

Request	
☐	• Admit, evaluate, diagnose, treat, perform H&P, and provide consultation to patients from birth to young adulthood (21 years of age) with acute and chronic disease including routine newborn care. • Attendance at delivery to assume care of newborns including stabilization and coordination of transfer of sick or premature infant. • Endotracheal intubation.

OUTPATIENT CORE PRIVILEGES

BLS or PALS required.

Request	
☐	• Assess, evaluate, stabilize and/or provide treatment to patients from birth to young adulthood (21 years of age) who presents to the outpatient pediatric clinic with any illness, condition, or symptom. • Evaluate, diagnose, perform H&P, consult, and provide non-surgical treatment to patients.

SPECIAL PRIVILEGES

(requires experience within last 2 years and recommendation by Chief of Pediatrics)

- ☐ Arthrocentesis and joint injection
- ☐ Application of cast/splint
- ☐ Bladder catheterization
- ☐ Burn management, 1st and 2nd degree
- ☐ Cerumen impaction removal
- ☐ Circumcision with clamp
- ☐ Cryotherapy, skin
- ☐ Conscious sedation (requires tutorial and current ACLS certificate)
- ☐ Digital nerve/ring block anesthesia
- ☐ Drainage of subungual hematoma
- ☐ Frenulectomy
- ☐ Incision and drainage of abscess
- ☐ Insertion and management of chest tubes – emergent only
- ☐ Insertion/removal of implanted contraceptive device (e.g. Nexplanon)
- ☐ Intraosseous (IO) placement – emergent only
- ☐ Local anesthetic techniques
- ☐ Manage uncomplicated minor closed fractures and uncomplicated dislocations
- ☐ Microscopic examination (urine, vaginal wet mount and skin preparations)
- ☐ Nail removal
- ☐ Perform simple skin biopsy or excision
- ☐ Peripheral nerve blocks
- ☐ Ligation of extra digit
- ☐ Lumbar puncture – emergent only
- ☐ Preliminary EKG interpretation – emergent only
- ☐ Placement of anterior and posterior nasal hemostatic packing
- ☐ Remove non-penetrating foreign body from the skin, eye, nose or ear
- ☐ Skin tag – ligation
- ☐ Suture uncomplicated lacerations
- ☐ Suprapubic bladder tap – emergent only
- ☐ Tympanometry
- ☐ Umbilical catheterization – emergent only
- ☐ Uncomplicated wound debridement

CONSULTING PRIVILEGES

(for Consulting Staff only)

Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgement on next page.

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

_____ _____
_____ _____
Chief of Pediatrics *Date*

_____ _____
Chief of Surgery *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

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OBSTETRICS & GYNECOLOGY

Instructions: Please check box next to each core privilege/special privilege requested.
Draw a line through and initial next to any core privilege NOT requested.

INITIAL CRITERIA	
Education/Formal Training: • Completed accredited residency training in Obstetrics and Gynecology. • Board Certified/Board Eligible by the American Board of Obstetrics and Gynecology or equivalent. • All practitioners requesting privileges to manage and attend births in Labor and Deliver at Northern Inyo Hospital will complete the appropriate BETA (Quest for Zero: Excellence in OB) requirements and will comply with NICHD terminology in the OB setting.	
INPATIENT CORE PRIVILEGES	
Request	
☐	• Admit, evaluate, diagnose, consult, perform H&P, and manage the care of female patients in any condition or stage of pregnancy who present to the hospital or Emergency Department. • Admit, evaluate, diagnose, consult, perform H&P, and provide pre-operative, intra-operative and post-operative care for management of female patients presenting with illness, injury, disorders of the gynecologic or genitourinary system. • Vaginal delivery • Hysterectomy • Cesarean section • Cesarean hysterectomy • Diagnostic cystoscopy • Diagnostic and operative hysteroscopy • Diagnostic and operative laparoscopy • Diagnostic and operative laparotomy • Adnexal surgery • Ultrasound • Suburethral slings
OUTPATIENT CORE PRIVILEGES **Current BLS or ACLS required**	
Request	
☐	• Assess, evaluate, diagnose, consult, perform H&P, and manage the care of female patients in any condition or stage of pregnancy or with illness, injury, or disorders of the gynecologic or genitourinary system who present to the outpatient clinic.
SPECIAL PRIVILEGES (requires experience within the last 2 years)	
☐ Circumcision with clamp, pediatric only ☐ Robotic Surgery (per Robotic credentialing policy)	☐ Insertion/removal of implanted contraceptive device (e.g. Nexplanon) ☐ Cervical cerclage
CONSULTING PRIVILEGES (for Consulting Staff only)	
Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgment on next page.

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

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Please Print

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

_____ _____
Practitioner Signature *Date*

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

_____ _____
Chief of Obstetrics *Date*

_____ _____
Chief of Surgery *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

FAMILY MEDICINE

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in family medicine.
- Board Certified/Board Eligible by the American Board of Family Medicine **OR** equivalent.

OUTPATIENT CORE PRIVILEGES

Current BLS or ACLS required

- Assess, evaluate, stabilize and/or provide treatment to patients of any age who present to the outpatient environment with any illness, condition or symptom.
- Evaluate, diagnose, perform H&P, consult, and provide non-surgical treatment to a patient of any age.

Primary Care

- ☐ Incision and drainage of abscess, excluding peri-rectal
- ☐ Allergy immunotherapy
- ☐ Anoscopy
- ☐ Arthrocentesis/joint injections
- ☐ Incision and drainage of Bartholin's cyst/abscess
- ☐ Bladder catheterization
- ☐ Bone marrow aspiration/biopsy
- ☐ Burn management, 1st and 2nd degree
- ☐ Aspiration of breast cyst
- ☐ Application of cast/splint
- ☐ Cancer chemotherapy(in consultation with oncologist)
- ☐ Cerumen impaction removal
- ☐ Cervical dilation (mechanical)
- ☐ Removal of cervical polyps, simple
- ☐ Circumcision with clamp, pediatric only
- ☐ Colposcopy, with or without cervical biopsy
- ☐ Cryotherapy, skin
- ☐ Cryotherapy, cervix
- ☐ Dermoscopy
- ☐ Endometrial biopsy
- ☐ Flexible sigmoidoscopy
- ☐ Foreign body removal (skin, superficial corneal/conjunctival, nose and ear)
- ☐ Ganglion cyst aspiration/injection
- ☐ Incision of thrombosed external hemorrhoid, simple
- ☐ Insertion/removal of implanted contraceptive device (eg, Nexplanon)
- ☐ Insertion/removal of intrauterine device (IUD)
- ☐ Laceration repair, simple
- ☐ Lumbar puncture

Primary Care (continued)

- ☐ Microscopic examination (urine, vaginal wet mount and skin preparations)
- ☐ Myringotomy/tympanocentesis
- ☐ Nail removal
- ☐ Paracervical block
- ☐ Pessary placement
- ☐ Digital nerve/ring block anesthesia
- ☐ Injection sclerotherapy (telangectases only)
- ☐ Skin biopsy (excisional, shave, or punch)
- ☐ Soft tissue injections/trigger point injections
- ☐ Drainage of subungual hematoma
- ☐ Tonometry
- ☐ Tympanometry
- ☐ Application of Unna paste boot
- ☐ Vasectomy
- ☐ Uncomplicated wound debridement

Obstetrics/Gynecology

- ☐ Endocervical curettage
- ☐ Vulvar/vaginal biopsy
- ☐ Abdominal/transvaginal OB/GYN ultrasonography
- ☐ Saline infusion hysterosonography

Physical Examinations

- ☐ Pre-employment physicals
- ☐ Commercial driving medical exams (DOT Medical Examiner's Certificate required)
- ☐ Disability evaluations
- ☐ Independent medical evaluations (Workman's Compensation)
- ☐ Return to work evaluations

ADULT INPATIENT CORE PRIVILEGES

Requires inpatient experience within the last 2 years, current ACLS certification, and recommendation by Hospitalist Director.

- ☐ Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to adult patients presenting with general medical problems.
- ☐ Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to adult patients presenting with critical illnesses, needing ICU care.
- ☐ Ventilator management.

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

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Please Print

SPECIAL PRIVILEGES *All require experience within last 2 years*	
☐ Well newborn care/admit to nursery (NRP and recommendation by Chief of Pediatrics required) ☐ Pediatric consultation and admission (advanced experience managing peds/newborns; NRP required, PALS preferred; approval by Chief of Pediatrics) ☐ Conscious sedation (requires tutorial and current ACLS certificate per Procedural Sedation policy) ☐ Surgical first assist (requires experience in last 2 years and recommendation by Chief of Surgery)	**Special Privileges in Obstetrics**: require experience in last 2 years and recommendation by Chief of OB/GYN ☐ Vaginal delivery; spontaneous ☐ Vacuum-assisted vaginal delivery ☐ Episiotomy and repair of vaginal lacerations (1st and 2nd degree only; 3rd/4th degree must consult OB) ☐ Manual extraction of the placenta ☐ FSE application/IUPC insertion ☐ Induction of labor/cervical ripening

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

_____ _____
Practitioner Signature *Date*

APPROVALS
COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

_____ _____
RHC/Outpatient Clinic Medical Director Date Chief of Medicine Date

_____ _____
Chief of Pediatrics Date Chief of Surgery Date

_____ _____
Chief of Obstetrics Date Hospitalist Director Date

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)