Northern Inyo Hospital

January 17 2018 Regular Meeting

January 17 2018 Regular Meeting - January 17 2018 Regular

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

January 17, 2018 at 5:30 p.m.

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

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business
   A. Introduction to Adventist Health telemedicine program (*information item*).
   B. Introduction of Interim Director of Pharmacy (*information item*).
   C. Approval of Radiology Services agreement with Tahoe Carson Radiology (*action item*).
   D. NIHD Auxiliary fundraising report (*information item*).
   E. Rental Agreement with Kern Regional (*information item*).
   F. 2013 CMS Validation Survey Monitoring, October 2017 (*information item*).
   G. Medical Staff Services Pillars of Excellence quarterly report (*information item*).
   H. Policy and Procedure approval, *Fatigue Management Program* (*action item*).
   I. Policy and Procedure approval, *Competency Plan* (*action item*).
   J. NIHD Rural Health Clinic growth (*information item*).
   K. Budget Philosophy 2018 (*information item*).
4. Old Business
   A. Bishop Union High School Clinic update (*information item*).
   B. Pioneer Home Health (Hospice) update (*information item*).
   C. Athena implementation update (*information item*).
   D. 340B Pharmacy Agreement with Dwayne's Pharmacy (*information item*).
   E. Urology services update (*information item*).
   F. Physician recruitment updates (*Internal Medicine/Pediatrics, Surgery*).

Consent Agenda (action items)

5. Approval of minutes of the December 13, 2017 regular meeting

6. Policy and Procedure annual approvals (*action item*).

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7. Chief of Staff Report; Richard Meredick, MD:
   A. Telemedicine Services (*action item*):
      - *In processing a request for telemedicine privileges, the Medical Staff and Hospital may follow the normal credentialing process described in Section 2of the Medical Staff Bylaws. Alternatively, the Medical Staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in Section 3.6.1 of the Bylaws, including being party to a written agreement with the distant-site (NIHD Medical Staff Bylaws, Section 3.6.1*).
        1. The NIHD Medical Staff has voted to accept the provision of the following services offered by Adventist Health via a telemedicine link:
           a. Gastroenterology
           b. Hematology/Oncology
           c. Infectious Disease
           d. Orthopedic Surgery
           e. Pulmonary Disease
           f. Rheumatology
           g. Sleep Medicine
           h. Dermatology
           i. Interventional Cardiology
           j. Neurology – outpatient
           k. Endocrinology
           l. Pediatric Endocrinology
           m. Psychiatry

   B. Telemedicine Privileging Request Form for use with proxy credentialing (*action item*)
   C. Medical Staff Resignations (*action items*):
      1. The following Medical Staff members' privileges have expired effective January 1, 2018:
         a. Jennifer Scott MD (*emergency medicine*)
         b. A. Douglas Will MD (*neurology*)

2. The following Temporary privileges practitioner has relinquished clinical privileges effective December 30, 2017:
    - Erica Rotondo DO *(family practice – locum tenens)*

8. Reports from Board members (*information items*).
9. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
    B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*).
    C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
    E. Discussion of employment contract for a public employee, to wit: Administrator/Chief Executive Officer (*Government Code Section 54957*).
10. Return to open session and report of any action taken in closed session.
11. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

NORTHERN INYO HOSPITAL AUXILIARY
2017 BOUTIQUE REPORT

RECEIPTS: DAY OF BOUTIQUE	
See's candy	$689.00
Baked goods	880.00
Ticket sales	396.00
Boutique items	3,933.93
BALANCE	$5,898.93
minus square fee	-44.15
TOTAL DAY OF BOUTIQUE	$5,854.78
MONETARY DONATION	
resulting from letter	$23,361.00
PRE TICKET SALES	2,260.00
HALL SALE with BAKERY	1,577.75
BALANCE	$33,053.53
DEPOSIT START UP MONEY	300.00
minus square fee	17.83
BALANCE	$33,335.70
EXPENSES	2,376.26
BOUTIQUE INCOME	$30,959.44

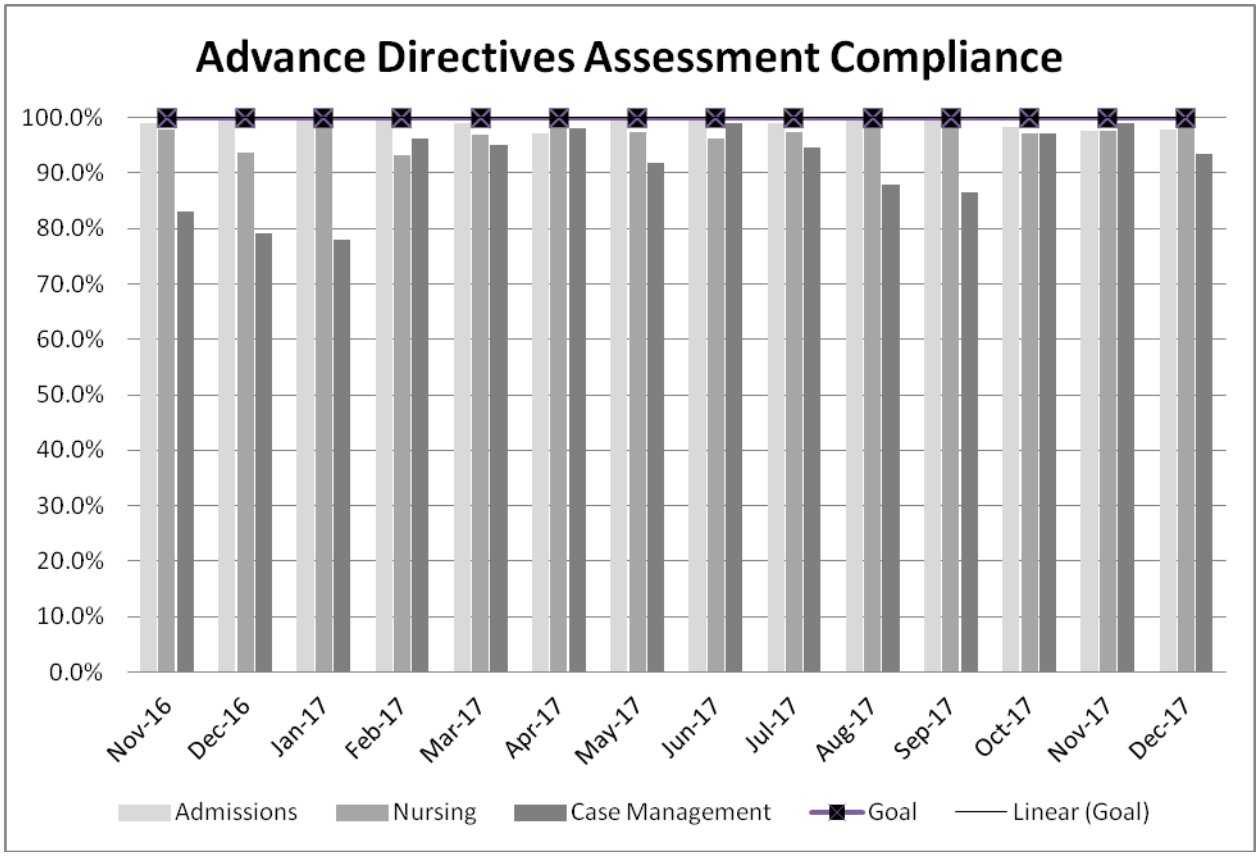
Submitted by Sharon Moore, Treasurer

10,770.06 more than 2016

2013 CMS Validation Survey Monitoring-January 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.

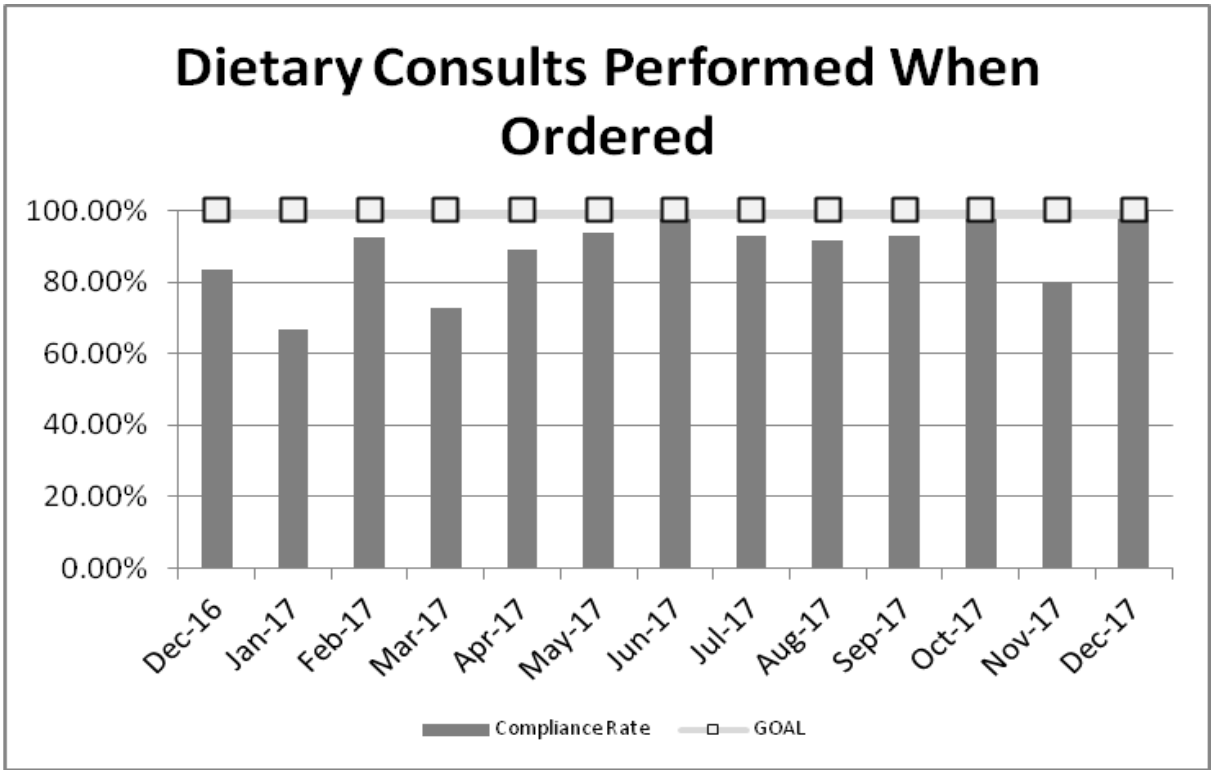


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

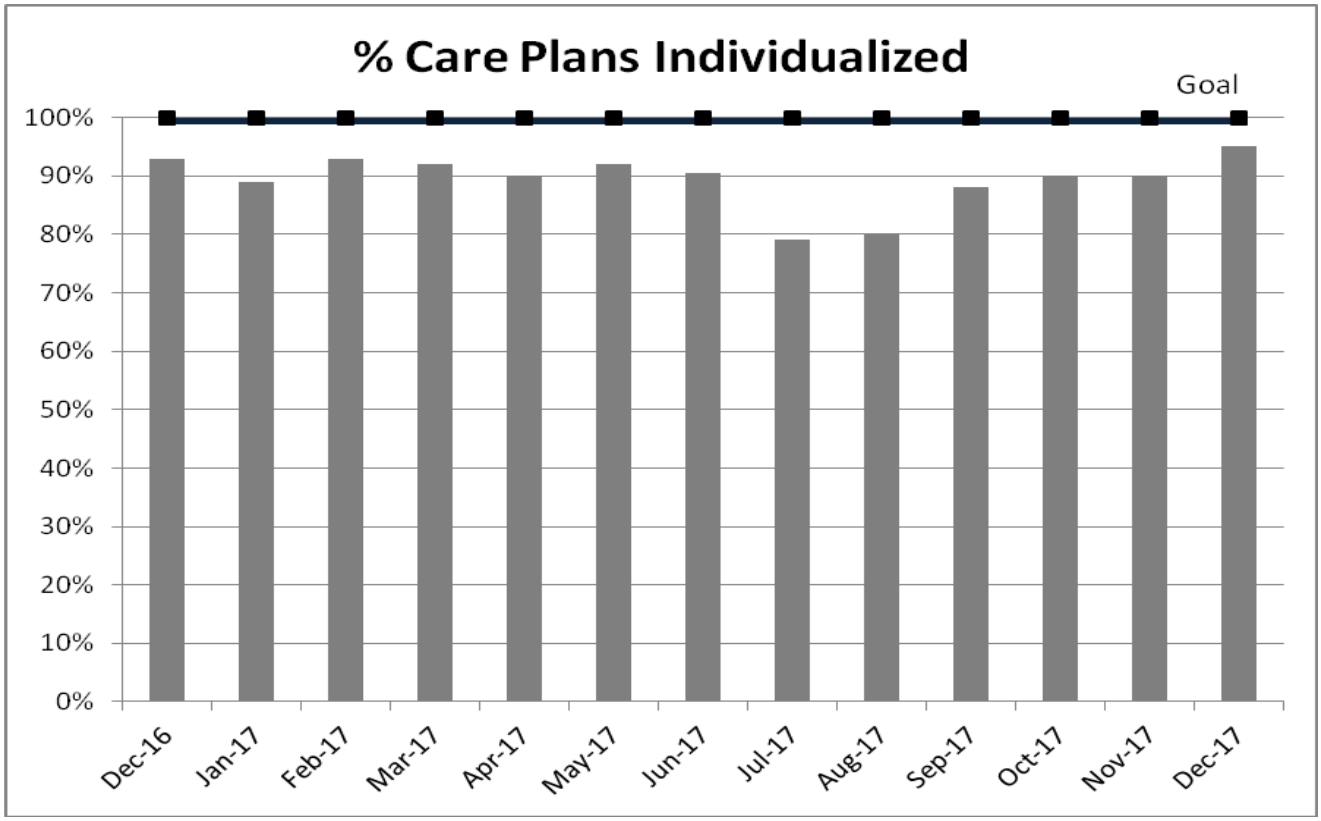
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    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.



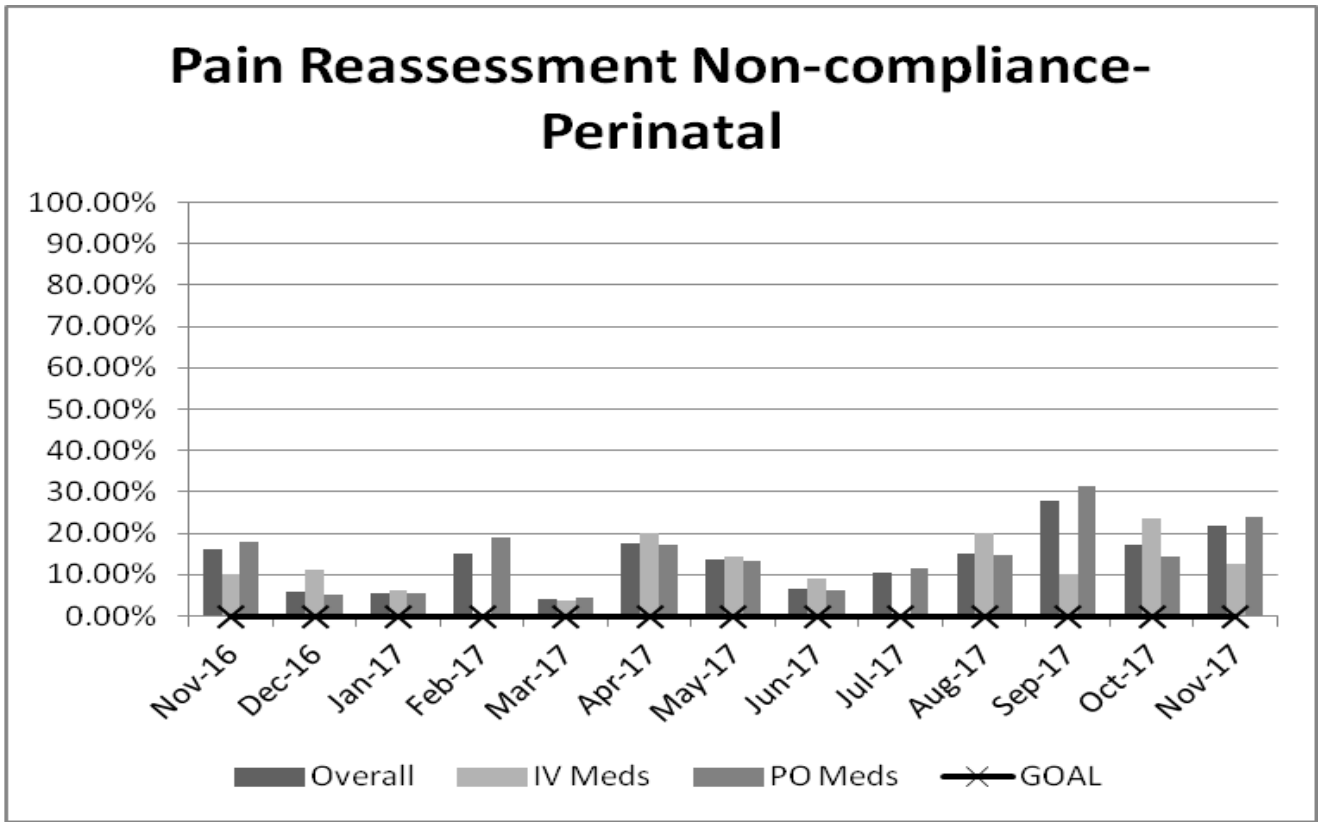
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

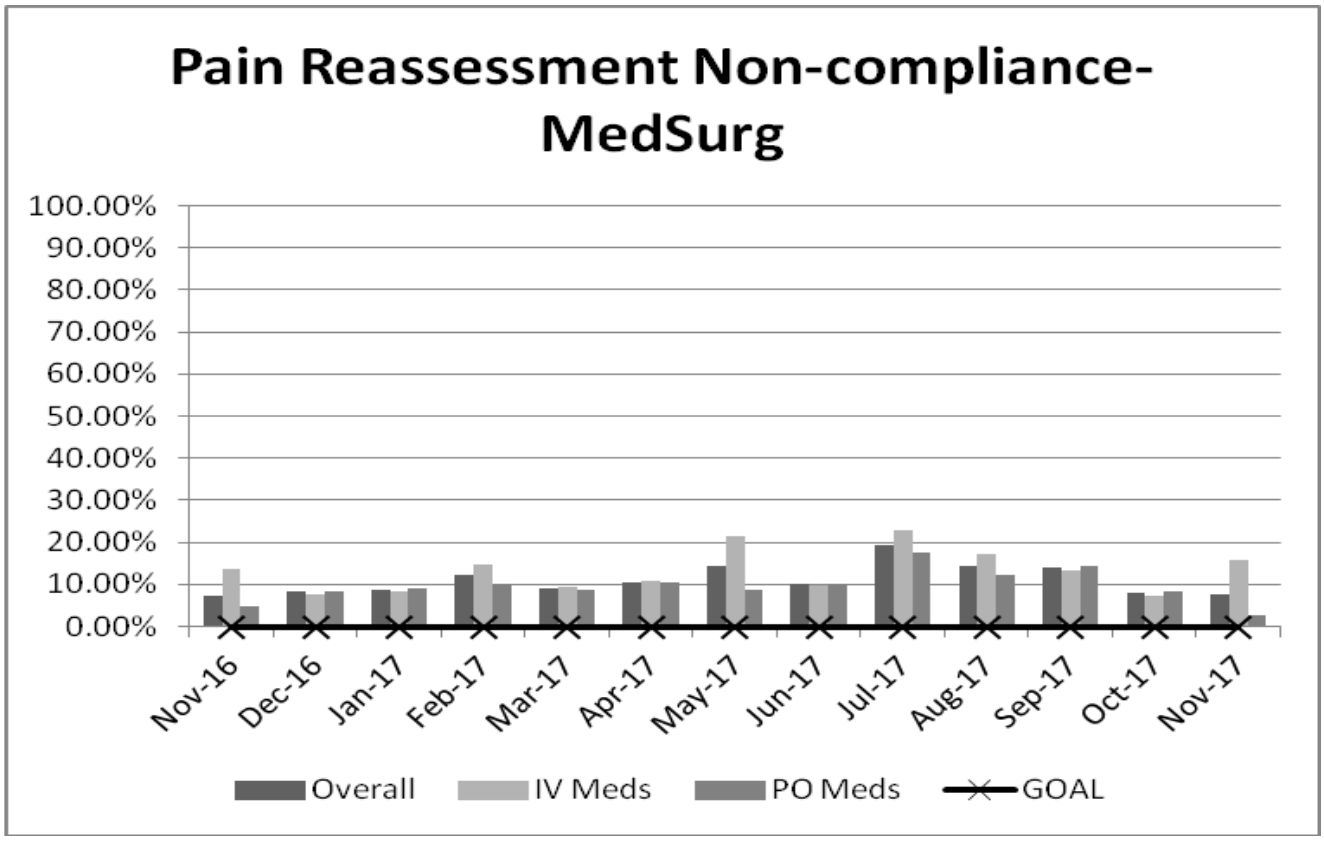


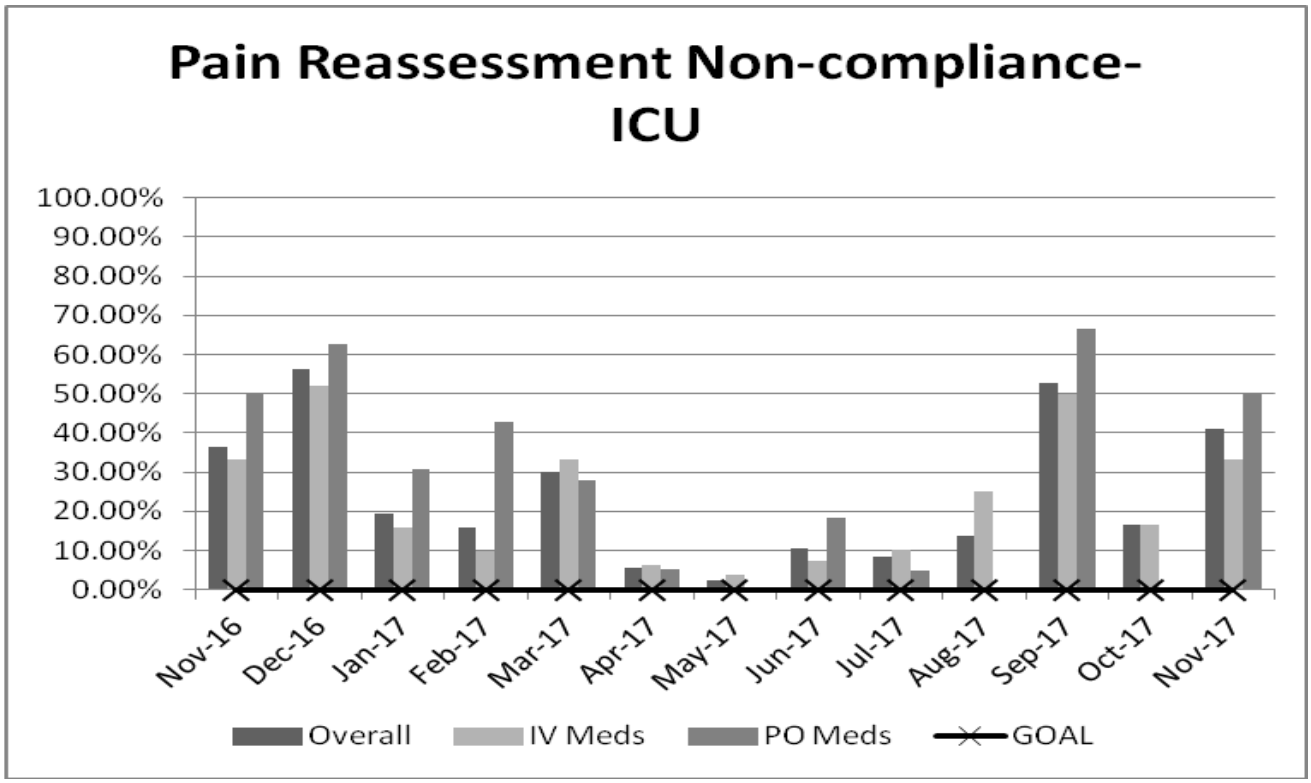
2

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

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







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

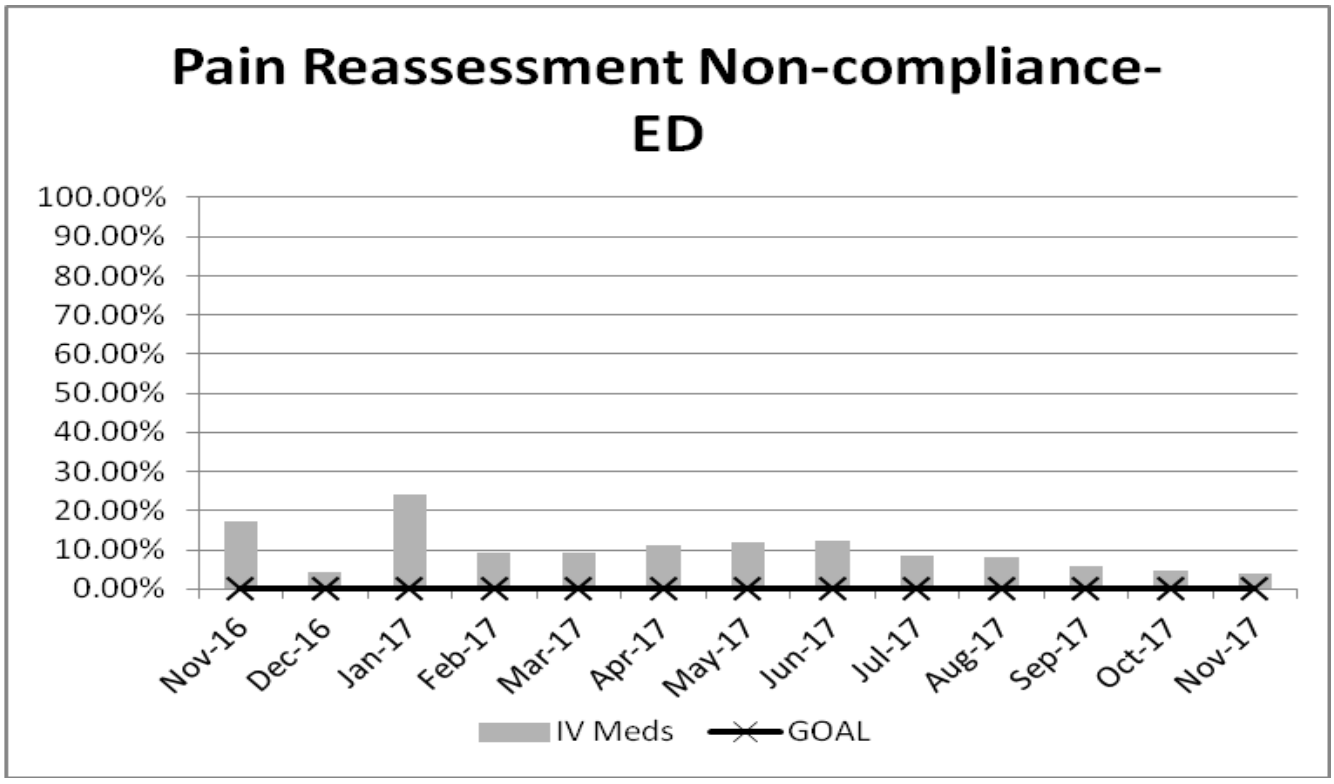


Table 6. Restraint chart monitoring for legal orders.

	May 2017	***June 2017***	***July 2017***	***Aug 2017***	***Sept 2017***	***Oct 2017***	***Nov 2017***	***Dec 2017***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	2/2 (100%)	2/2 (100%)	3/3 (100%)	3/3 (100%)	2/2 (100%)	3/3 (100%)	1/1 (100%)	3/3 (100%)	100%
Physician signed order within 24 hours	2/2 (100%)	2/2 (100%)	3/3 (100%)	2/3 (66%)	1/2 (50%)	2/3 (66%)	1/1 (100%)	2/3 (66%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	2/2 (100%)	1/2 (50%)	3/3 (100%)	1/3 (33%)	0/2 (0%)	2/3 (66%)	1/1 (100%)	1/3 (33%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	0/1 (0%)	3/3 (100%)	2/5 (40%)	2/8 (25%)	0/2 (0%)	1/2 (50%)	N/A	2/6 (33%)	100%
Orders are for 24 hours	3/3 (100%)	5/5 (100%)	8/8 (100%)	11/11 (100%)	4/4 (100%)	5/5 (100%)	1/1 (100%)	9/9 (100%)	100%
Is this a PRN (as needed) Order	0/3 (0%)	0/5 (0%)	0/8 (0%)	0/11 (0%)	0/4 (0%)	0/5 (0%)	0/1 (0%)	0/9 (0%)	0%

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

Medical Staff Services

Department: Medical Staff Administration

Pillars of Excellence: FY July 1, 2017-June 30, 2018 (**rolling quarter**)

Indicator	Baseline	Goal	Jan-Mar 2017 Q3	Apr-Jun 2017 Q4	Jul-Sep 2017 Q1	Oct-Dec 2017 Q2	YTD
Service							
1. Customer satisfaction							
a. Average Credentialing TAT (from receipt of complete application)	1 day	<21 days	7 d	14 d	9 d	8 d	10 d
b. Average Privileging TAT (from receipt of complete application)	17 days	<60 days	19 d	30 d	18 d	22 d	22 d
c. Percent on-time start	50%	100%	100%	100%	92%	92%	94%
2. Application times							
a. Average time for any application materials to be returned	23 days	<14 days	25 d	29 d	11 d	18 d	19 d
b. Average time for complete application to be returned	64 days	<45 days	49 d	48 d	36 d	38 d	41 d
Quality							
1. Credentialing/Privileging							
a. Percent processed within time frame specified in bylaws	100%	100%	75%*	100%	100%	100%	97%
b. Percent of applicants granted temporary/expedited privileges	50%	<50%	75%	13%	58%	33%	43%
People							
1. Active Staff	38	N/A	39	39	39	41	
2. All Medical Staff Members and Allied Health Professionals	83	N/A	88	92	82	88	
3. Locums/Temporary Staff	1	N/A	3	3	9	5	
Finance							
1. Number of applications processed	3	N/A	4*	8	12	12	36
2. Number of locum tenens applications	1	N/A	1	3	6	5	15
3. Number of applications abandoned/discontinued	1	N/A	0	5	1	3	9

* One application received in June 2016 (2 FY ago) was unattended during the MSO personnel changes and was completed during the Q3 reporting period of 2016-2017 FY. This application was not processed within the time specified in the bylaws. This application was excluded from all other metric analysis, as no relevant dates were known to calculate TATs.

LEGEND	
	Exceeds/far exceeds goal
	Meets goal
	Does not meet goal
	Far from meeting goal

Dev. 2/17

NORTHERN INYO HEALTHCARE DISTRICT
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Medical Staff Services

FY 2017-2018
Q2: October - December 2017

Narrative Notes:

The credentialing and privileging turn-around times achieved by the Medical Staff Office personnel continue to meet or exceed expectations, despite the sustained increase in the number of applications processed (about triple the typical quarter volumes from FY 2016-2017). Overall, the average time it takes to privilege an applicant from the day the application is given to the practitioner is approximately 60 days. This meets the 'gold standard' of medical staff service professionals in California.

The number of locum tenens/temporary applicants continues steadily. However, about half of last quarter's temporary staff members have now become permanent members of our staff.

As in the previous quarter, we did not meet the goal of 100% "on-time start." This was due to the delay in the start of the second optometrist (part of the diabetic retinopathy screening program), as the Medical Staff Office was not involved in the early stages of this plan and credentialing delayed the anticipated start date of this applicant. Communication improvements between leadership and the Medical Staff Office will prevent this from re-occurring.

Dianne Picken, M.S.
Medical Staff Support Manager
12/29/2017

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: FATIGUE MANAGEMENT PROGRAM	
Scope: District Wide	Department: Employee Health
Source: Employee Health	Effective Date:

PURPOSE:

The purpose of this policy is to set forth the symptoms, to educate on the effects/risks of fatigue and to mitigate fatigue in the workplace.

POLICY:

Northern Inyo Healthcare District ("District") is committed to ensuring a safe and healthy work environment for all its healthcare workers and patients. The District will not tolerate fatigue in any person providing services, care and/or treatment to our customers and it is the responsibility of all employees to identify, report and seek assistance in managing fatigue, in themselves and others. All reported incidents of fatigue must be processed according to District policies.

The District will not tolerate retaliation in any form whatsoever involving an employee who reports a reasonable suspicion of fatigue or who participates in any investigation of such a claim. Any allegation of retaliation shall be immediately investigated by appropriate District leadership and the District will take corrective action as appropriate in its judgment. The confidentiality and privacy of District employees and those involved in the investigation will be protected to the highest degree possible.

PROCEDURES:

1. Responsibilities.

    a. Employees. It is the responsibility of all employees to identify concerns about their own immediate ability to perform his/her job as well as others, and take appropriate steps for the safety of all.

        i. Where the early warning signs of fatigue are observed (see below for examples of early warning signs), employees will immediately notify a member of District leadership (Assistant Manager, Manager, Director, Chief, Chief Executive Officer, or Administrator On-Call, etc.) of any reasonable suspicion of fatigue in that employee or other healthcare worker. Leadership will take appropriate action in accordance with the District's fitness for duty policy: supportive recommendations, enforcement of anti-fatigue requirements, post-incident triage investigation and corrective action as needed.
        ii. Be familiar with the early warning signs of fatigue as outlined in this policy and follow the District's policy at all times.
        iii. Be aware of what and when to eat in order to manage fatigue
        iv. Be aware of the impact of caffeine and alcohol on sleep in order to manage fatigue

v. Be aware of the impact of prescribed medications, such as antihistamines, on their alertness and on fatigue and ensure proper clearance of the use of medications from Employee Health.
vi. Manage their breaks and rest periods in accordance with District policy in order to manage fatigue
vii. Be aware of how to use their recovery and rest time appropriately in order to manage fatigue
viii. Be aware of the impact of exercise on fatigue
ix. Ensure that all teammates are working together as this is the best way to create a safe and healthy working environment

b. Assistant Manager, Manager, Director, Chief, Chief Executive Officer. Leaders' responsibilities include:

i. Be familiar with the early warning signs of fatigue as outlined in this policy and follow the District's policies (including but not limited to fitness for duty, Standards of Conduct policy, Safety policy, Injury and Illness Prevention Program policy, NIHD Code of Business Ethics and Conduct policy) at all times.
ii. Receive and manage reports of workplace fatigue when observed personally or when such a report is received
iii. Limit shifts worked by an employee to a safe number of hours
iv. Ensure employees take regular rest breaks during shifts in accordance with District policy
v. Ensure food is available to staff where appropriate to maintain alertness
vi. Provide appropriate supervision of employees on scheduled shifts and proactively assess if employees are fatigued
vii. Be aware of the times when employees are most likely to be affected by fatigue
viii. Aim to manage shift work and overtime so that employees have regular opportunities for adequate recovery through high-quality sleep
ix. If possible, schedule employees for longer periods off the schedule if they must sleep during the day to work a night shift
x. Assess if fatigue was a contributing factor when conducting workplace investigations and all work-related accidents
xi. Ensure employees are working as a team and that they are each properly trained in their jobs as these promote a safe and healthy working environment.
xii. Support staff in fatigue management and proactively seek input from employees about the best way to manage fatigue in their work areas

2. Warning Signs of Fatigue

a. The following is a listing of some early warning signs of fatigue:

- Eyes are closed or appear to go out of focus
- Struggling to keeping one's head up
- Yawning excessively
- Wandering, disconnected thoughts
- Memory lapses – one does not remember what one did the last few moments or hours, or one was acting on "autopilot"
- Erratic behavior (variable speeds with which duties are performed; performing work tasks too fast or too slow)
- Drifting in and out of thoughts as one converses with another
- Repeatedly missing steps to a process or procedure
- One is overly surprised by another's actions; passing you without you noticing their position

b. Employees must be aware of these early warning signs and be prepared to take appropriate actions to protect the safety of workers and patients. Employees are not to ignore these signs in themselves. Employees are advised that continuing to work while fatigued creates an unnecessary risk for employees, patients and others in the workplace.

3. Common Causes of Fatigue. The following are some common causes of fatigue:

i. Shift work is a common cause of disturbed sleep patterns. Shift work can lead to fatigue when it stops an employee from getting enough sleep or when shift work requires an employee to work in the early hours of the morning, when people are normally at their sleepiest. Enough recovery time should be allowed between shifts.

ii. Shifts that last longer than 12.5 consecutive hours are considered to be extended shifts. Frequent extended shifts can lead to employees getting less sleep than they need. Continuing sleep restriction can affect cardiovascular health, mental health, safety and productivity.

iii. Working at night has a greater impact than working the same number of hours in the daytime. On average, night shift workers lose 1-1.5 hours of sleep for each 24 hour period. This builds up a sleep debt of approximately six hours after approximately four nights. So working more than three or four night shifts in a row is likely to cause a significant sleep debt. At least two consecutive full night's sleep with a normal day in between is recommended in each week. Leaders are to consider the needs of their employees in scheduling consecutive shifts and employees are to consider their needs in scheduling consecutive shifts. Positions

covered by a Memorandum of Understanding are governed by the terms of the Memorandum of Understanding.

iv. Employees require regular rest and meal breaks in accordance with District policy to reduce fatigue. Dehydration can cause headaches, loss of sleep, loss of concentration and fatigue. A nutritious snack during rest breaks can restore energy levels. Physically or mentally demanding work is especially tiring and requires frequent rest breaks in accordance with District policy.

v. Personal factors such as the employees' general health, sleeping patterns, lifestyle and experience on the job affect their susceptibility to fatigue. An employee who is new to a task may need to use greater concentration when performing the job than experienced employees. Ensure employees have relevant training and support.

4. Managing Fatigue. There are three steps that leadership can take to help manage fatigue at work.

i. Step one: Consultation

Talk to your employees about what works best for them in reducing or combating tiredness on the job. Point out your responsibilities as a leader to ensure the health and safety of the employees, and the employee's responsibilities to ensure his or her own safety, plus the safety of others who might be affected, for example by poor judgment made as a result of fatigue. The employee's responsibility also extends to personal health care. For example, an employee working with medical or other kinds of equipment machinery who arrives at work fatigues could endanger the safety of others.

ii. Step two: Evaluation

Shift-working arrangements are a part of the District's business. Some of these shifts take place when people are usually asleep. An employee's need to take breaks and get enough sleep between shifts is an important step to evaluate when managing fatigue. A balance must be struck as to how leadership can balance these needs.

iii. Step three: Training and Education

Leaders, in collaboration with the District Education Coordinator and Clinical Skills Educators will provide training on how to manage fatigue. Learning how to manage shifts to reduce fatigue and learning how to manage fatigue can help both

leadership and our employees. Managing fatigue is a joint responsibility of both leadership and employees.

5. General Procedures. Although not every situation can be predicted, the following is the general procedure to be used when fatigue is at issue:

   i. If employees, members of the Medical Staff, volunteers, and/or contractors arrive at the workplace and there is reasonable cause to believe that they are fatigued, this must be immediately reported to leadership and leadership shall immediately remove them from the work environment. If there is any doubt about whether they are, or are not fatigued, err on the side of caution, make the report and remove him/her from the work environment. A QRR must be entered by the reporter or leadership.

   ii. If, as determined by leadership, an employee or other healthcare worker (if a member of the medical staff is identified, referral will be made to the Chief Medical Officer immediately) appears to be fatigued, leadership shall take appropriate safety measures to remove the employee or healthcare worker from work-related activities and immediately refer that person under the District's policy for an appropriate evaluation. Pending such an evaluation, the employee or healthcare worker will remain off duty until such time as cleared by a health care professional to return to duty as prescribed in the District's policies.

   iii. Unexpected circumstances can arise when an off-duty employee is requested to work. It is the employee's responsibility to assess the request and ask that the request be directed to another person if the employee feels unfit due to fatigue. Employees calling off duty staff to work will ensure that they conduct a reasonable inquiry as to whether an employee is fit for duty when asking such an employee to work.

   iv. Employees who are prescribed medication are expected to ask their doctors if the medication will have any potential negative effect on job performance and are expected to follow District policy to report such prescriptions to Employee Health for appropriate clearance to work. Employees are required to report to their leaders if there is any potential risks, limitations or restrictions for whatever reason that may require modification of duties or temporary reassignment, and provide appropriate medical verification on any restrictions in performance of their duties as per District policy. Such requests shall be coordinated by the District's Employee Health.

   v. If an employee or other person reasonably believes an employee in a more senior position is in violation of this policy, employees are expected to report this to a member of District leadership. Any employee who fails to report a reasonable

Title: FATIGUE MANAGEMENT PROGRAM	
Scope: District Wide	Department: Employee Health
Source: Employee Health	Effective Date:

belief of fatigue is enabling the fatigue. Such enabling behavior leads to ongoing health and safety concerns for an individual affected by fatigue and those around that person.

REFERENCES:

Gardner, L.A. & Dubeck, D (2016). *Healthcare Worker Fatigue.* The American Journal of Nursing, Vol. 116, Issue 8, pp. 58-62. Wolters Kluwer
Monk, T.H. (1988) *How to make shift work safe and productive.* Des Plaines, IL: American Society of Safety Engineers
National Academy of Medicine (2004) *Keeping Patients Safe: Transforming the Work Environment for Nurses.* Washington, DC: The National Academies Press
Plain Language about Shift Work. National Institute for Occupational Safety and Health (NIOSH Pub. No. 94-145, July 1997)
The Joint Commission (2011) *Sentinel Event Alert Healthcare Worker Fatigue and Patient Safety*

CROSS REFERENCE P&P:

NIHD Master Staffing Plan
Safety Policy
Employee Drug and Alcohol Policy
Standards of Conduct Policy
Safety Policy
Injury and Illness Prevention Program Policy
NIHD Code of Business Ethics and Conduct Policy

Approval	**Date**
Human Resources	12/12/2017
Nurse Executive Council	1/3/2018
Executive Leadership	
Board of Directors	

Developed: December 2017
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: COMPETENCY PLAN	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date:

PURPOSE:

The purpose of this policy is to establish a District-wide competency plan for the workforce at Northern Inyo Healthcare District ("District") so as to ensure that the competence of all employees is assessed, maintained, improved, and appropriately aligned with organizational needs on an ongoing basis.

POLICY:

The District believes that safe and excellent patient care treatment and service are provided by members of the workforce who have the required skills and who employ the knowledge necessary to perform their District positions. Therefore, in order to fulfill the District's Mission, Vision and Values, the District will provide an adequate number of employees whose demonstrated competencies are commensurate with their responsibilities. The District will define the competencies it requires of its employees who provide patient care, treatment, or services.

The competencies are defined based on mandated requirements, new or changed procedures or equipment, low-volume/high risk or high volume/high risk and/or problem prone activities that may be identified by aggregate data. Completed competency documentation will be housed in the employee's official personnel file.

Competence is defined as having adequate abilities and/or qualities to meet each District position's performance standards. Core (or Initial) Competencies are defined as the minimally necessary abilities and/or qualities to meet the District's basic performance standards at the conclusion of the departmental introductory period.

The District uses assessment methods to determine individuals' competence for each skill being assessed. An individual (content expert/supervisor/preceptor) with the educational background, experience, or knowledge related to the skill being reviewed assesses competence.

Competency validation occurs at the time of hire and on an ongoing basis at intervals outlined by external mandates, hospital and/or departmental requirements. When there are two or more conflicting interval requirements, the District will follow the stricter mandate. Competencies are predetermined for each position by District leadership and are reassessed annually for continued eligibility.

PROCEDURE:

1. Initial Competency verification at the Time of Hire. Initial competency assessment at the time of hire includes the following tools:

    - Interview
    - References

Title: COMPETENCY PLAN	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date:

- Primary Source verification for required credentials (e.g. license).
- Job Qualification verification

2. Core (Initial) Competency Verification. Core Competency assessment post District-wide orientation and during the course of the departmental orientation can use the following methods of validation:

   - Observation by an individual with the educational background, experience, or knowledge related to the skill being reviewed whom District Leaders deem eligible to assess competence;
   - Online testing using case studies as the basis for questions;
   - National testing deemed to be reliable and valid;
   - Demonstration of required skill or activity;
   - Evaluation of documentation;
   - Documented return demonstration which may also be documented through any online Learning Management System.

3. Ongoing Competency Verification. Ongoing Competency Verification occurs at least annually and/or at intervals required by external mandates, District and departmental requirements including the following:

   - District annual training is required for all District employees.
   - Department specific competencies are assessed.
   - Population or condition specific competencies are assessed. Populations and/or conditions can include but are not limited to age and populations with high risk equipment or processes in place e.g., urinary catheters, IV's and transfusions and other populations as indicated.
   - Individualized competencies are assessed as identified by Leadership.
   - Items can be added or removed from the ongoing validation competency list throughout the year as determined by Leadership
   - Skill and/or knowledge demonstration is a method used to determine competence.
   - Feedback will be provided to all employees who participate in competency demonstration and remediation may be offered as directed by District Leadership and employees who do not have completed competency documentation submitted to their Official Personnel File as required will not be permitted to work.
   - Employees will use the following resources as indicated for high risk high volume or high risk low volume activities when they recognize a potential gap in their skills: (a) Time out for expert consultation; (b) request placement in areas where staff competence is high; (c) practice processes or skills prior to execution; (d) use job aids as needed.

Title: COMPETENCY PLAN	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date:

4. Responsibilities:

   a. District Leadership defines the job qualifications and competencies for all District positions in his/her respective areas and authorize content experts/ supervisors/ preceptors.

      - District Leaders and/or designee content experts/supervisors/preceptors must ensure their competencies are up to date and that employees meet competency requirements at least annually unless directed differently by external mandate, District or departmental requirements. Communication that is clear from Leader to employee is a priority to ensure the requirements under this Policy are timely met.
      - Predetermine competency requirements for each position at the District and reassess continued eligibility annually.
      - Maintain all completed competency documentation and ensure that it is submitted to Human Resources for inclusion in the official personnel file
      - Align competency requirements across the District for the same topic in different departments/work areas. If it is recommended that a competency is required of more than the Leaders' department personnel, Leaders must coordinate these requirements with Executive Leadership before launching required competencies.
      - Ensure that the competence of persons in each position are assessed, maintained, improved and appropriately aligned with business needs on an ongoing basis and periodically evaluate the overall performance of persons assigned to positions.
      - Communicate information about resources to use when staff are unsure how to carry out duties during all evaluation times to all employees.
      - Communicate to each employee by October 1 of each calendar year competencies to be completed by December 31 of that calendar year
      - The District Leader and/or designee will determine the appropriate method/tools to validate the employee's competency within the guidelines of this Competency Plan.
      - The District Leader and/or designee will determine appropriate training/re-training of the employee who does not demonstrate competence in any required area.

   b. Employees exercise professional accountability as follows:

      - Understanding what requirements are needed, scheduling/completing the requirements timely, and submitting completed documentation to their Leader on time.
      - Recognizing skills that are high risk high volume or high risk low volume for his/her practice.
      - Seeking out/implementing strategies identified within this policy to mitigate risk.
      - Notifying supervisors immediately when gaps in competence are recognized.

Title: COMPETENCY PLAN	
Scope: District Wide	Department: Human Resources – Employee Handbook
Source: Human Resources	Effective Date:

- Maintaining competence in areas designated if designated by their Leader as a content expert/supervisor/preceptor.
- Any employee who fails any aspect of the competency requirements must engage in a remediation of that competency and satisfy the remediation requirements within 90 days (or other such time as designated by his/her District Leader) in order to continue District employment.

c. Methodology. Approved methods used in the assessment of employee competencies include, but are not limited to:

- Observation by an individual with the educational background, experience, or knowledge related to the skill being reviewed whom District Leaders deem eligible to assess competence;
- Online testing using case studies as the basis for questions;
- National testing deemed to be reliable and valid;
- Demonstration of required skill or activity;
- Evaluation of documentation;
- Documented return demonstration which may also be documented through any online Learning Management System.

References: *The Joint Commission Standards*, HR.01.01.01, HR.01.06.01, PI.03.01.01

Approval	**Date**
Human Resources	1/2/2018
Executive Leadership	
Board of Directors	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

POLICIES TO THE BOD
MEDICAL RECORDS

	POLICY & PROCEDURES TO THE BOARD	JAN, 2018			
	MEDICAL RECORDS				
	TITLE	TO BOD	APPROVED	COMMENTS	P & P UPDATED
1	Entries in the Medical Record	1/17/2018			
2	Forms Development and Control Policy	1/17/2018			
3	Information Security and Data Integrity	1/17/2018			
4	Legal Health Record	1/17/2018			
5	Responsibility and Process for Releasing PHI	1/17/2018			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD	JAN, 2018			
	PHARMACY DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Administration of Drugs & Biologicals	1/17/2018			
2	340B Contract Pharmacy Policy & Procedure	1/17/2018			
3	Access to Medications in the Absence of the Pharmacist	1/17/2018			
4	Administration of Drugs: Patient's Own Drugs	1/17/2018			
5	340B Hospital Administered Drugs Covered Entity Policy	1/17/2018			

Policies from Ann Wagoner – Perioperative Services for January Board Review:

Pentax Emergency Bedside Intubating Laryngoscope
Perioperative Scope of Practice
Philosophy of Perioperative Nursing Practice
Pneumatic Tourniquet
Point of Care Testing (Blood Glucose, Urine Dipsticks) OPD/PACU
Portacath Vascular Access System
Positioning of the Surgical Patient
Post Anesthesia Recovery
Post Operative Follow-up Phone Calls
Postoperative Teaching
Postpartum Patient Care in the PACU
Pre and Post Operative Anesthesia Visits
Precleaning of Soiled Instruments*
Pregnant Personnel in the Peri-Operative Unit*
Preoperative EPT Testing Protocol*
Preoperative Instruction Sheet
Preoperative Interview
Preoperative Medication Guidelines
Preoperative Medications
Preoperative Preparation and Teaching
Preoperative Skin Preparation
Principles of Asepsis in the Operating Room
Procedural Sedation*
Quick Rinse
Rabies Vaccination
Radiation Protection in the OR
Rapid Fluid/Blood Infuser
Records and Reports Surgery
Reprocessing Single Use Items
Responsibility of Service Perioperative
Restocking and Maintenance of Anesthesia Equipment
Returning of Instrument to Central Sterile Processing*
RN First Assistant, RNFA
Safety in the Operating Room*
Scheduling Surgical Procedures
Scope of Anesthesia Practice
Scope of Perioperative Nursing Practice
Scope of Service - PACU*
Scope of Services, Infusion Center*
Secretin Test
Selection and Use of Packaging Systems
Shoulder Arthroscopy 3 Point Distraction System*
Skin Preparation in the Perioperative Unit*

Policies from Ann Wagoner – Perioperative Services for January Board Review:

Special Procedure Trays
Sponge, Sharps, and Instrument Counts*
Staffing Patterns Anesthesia
Staffing Plan in the Operating Room*
Staffing Plan OP/PACU*
Standards of Care OPD
Standards of Care PACU
Standards of Care Perioperative Unit
Sterile Processing Disaster Plan
Sterile Processing Philosophy
Sterile Processing Objectives and Functions
Sterile Processing Staffing of Unit
Sterile Processing Standards of Practice
Sterilization Recall Policy*
Sterilization of CMI Vacuum Pump
Sterilizing of Orthopedic Implants
Steris Century Medium Steam Sterilizer
Steris Prevacuum Sterilizer Surgery
Steris System 1E Processor
Steris Vision Single Chamber Washer Disinfector
Steris V-Pro 1 Low Temperature Sterilizer System
Storage Requirements for Sterile and Clean Items
Supplies After Hours Sterile Processing
Surgeries Requiring an Assistant*
Surgery Charges*
Surgery Emergency Generator Power
Surgery Equipment and Routine Supplies
Surgery Medication and Solution Policy
Surgery Scope of Service*
Surgery Tissue / Bone Graft "Look Back" Policy*
Surgical Anesthesia Privileges and Limitations
Surgical Drains Care of
Surgical Hand Hygiene and Hand Scrub
Surgical Procedures
Taxol (Paclitaxel) Administration OPD
Transfer of Evidence
Ulnar Nerve Check
Universal Protocol
Warming Cabinet for Blankets/Solutions
Wound Vac - Vacuum Assisted Closure System ATS
Wrapping and Dating of Supplies and Instruments

Policies by Cindy Oney – Employee Health for review by the Board

Adult Immunization in the Healthcare Worker*
Employee Tuberculosis Surveillance Program
Environmental Disinfectant - Cleaning Solution
Handling of Soiled Linen
Health Care Workers with Influenza like Illness
Home Health Care
Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu
Initial Evaluation of Exposure Incident
Injury and Illness Prevention Program*
Nuclear Scan
Post-Offer Physical Examinations for New Hires
Post-Offer Physical Requirements
Prevention and Treatment of Pertussis in Hospital Employees*
Safe Patient Handling – Minimal Lift Program
Scope of Service - Employee Health*
Work Related Accidents/Exposures

Policies Owned by Marjorie Kidd – District Education

American Heart Association Training Center Faculty and Course Instructor Roles and Training*
American Heart Association Training Center Policies and Procedures*
American Heart Association Training Center QAPI*
Community Skills Session; Reservation, No Show or Cancellation Policy*
Course Evaluation
Ensuring Compliance with Continuing Education Guidelines at NIH*
Environmental Disinfectant - Cleaning Solution
FUNCTIONAL RISK ASSESSMENT CRITERIA FOR THERAPY REFERRAL*
Handling of Soiled Linen
Home Health Care
Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu
Instructor/Course Concern Form
NIH Nursing Department Organizational Chart
Nuclear Scan
Nursing Education Department Plan
Nursing Instructor Policy
Smoking Policy
Staff Development Dispute Resolution Policy

Policies from Ann Wagoner – Perioperative Services for January Board Review:

Heat Sealer
Immediate Use Sterilization Procedure (IUS)
Implantation of Medical Devices
Infection Control Sterile Processing Policy
Instrument Cleaning Process
Intraoperative Nursing Care for the Pediatric Patient
Iron Dextran (Imferon) Administration
IVIG (Intravenous Immune Globulin)
Laryngeal Mask Airway Removal
Latex Precautions
Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
Lithotripsy
Loaner instruments Care
Malignant Hyperthermia Cart Check*
Malignant Hyperthermia*
Manufacturer's Information on Hardware/Equipment
Manufacturer's Recall Sterile Processing
Medical Device Tracking
Medical Students in the OR
Medication/Solution Transfer to the Sterile Field*
Microbiological Specimen Handling
Myocardial Perfusion Stress Test: Nuclear
Neupogen / Procrit Administration
NPO Guidelines
Nursing Care Guidelines in PACU
Nursing Care of Outpatient Interventional Radiology Patient
Nursing Management of the Patient Receiving Local Anesthesia for Procedures
Observation in the Operating Room
OPD/PACU Discharge Instructions
Operating Room Attire*
Operating Room Sanitation
Operative Consents
OR Electrical Safety
Organization of Surgical/Anesthesia Services
Orientation and Cross Training to OPD/PACU
Outpatient Department Medication and Solution Policy
Outpatient Infusion Charge Descriptions
Outpatient Intermittent Infusion Administration
PACU Discharge Criteria
PACU Equipment
Paragon, Use of in Pre-op and PACU
Pathology Specimens In The Operating Room*
Patient Warmer (Warm Air Hyperthermia System)
Pediatric Standards of Care in the OPD/PACU

Policies from Ann Wagoner – Perioperative Services for January Board Review:

3M Attest 3 Hour Steam-Plus Challenge Pack *
Airway Management
Anesthesia Clinical Standards and Professional Conduct
Anesthesia in Ancillary Departments*
Anesthesia Philosophy
Anesthesia Record
Argon Laser Therapy (Ophthalmic)*
Basic Principles of Sterilization
Biological Monitoring System for Steam Sterilizers
Bone Graft Tissue Bank*
Bubble Study*
Cardiac Arrest in the OR
Central Line Care and Maintenance
Central Venous Pressure Monitoring in PACU
Changing Patient Status
Charge Sheet and Charge Description in the PACU
Chemotherapeutic Agents in the OR
Chemotherapy Administration And Precautions
Chemotherapy Extravasation Management
Chemotherapy Spill Protocol
Cleaning / Sterilization or High Level Disinfection of Equipment
Cleaning and Care of Surgical Instruments
Collection of Aerobic and Anaerobic Cultures
Completion Dilatation and Curettage Using Berkley Suction Under Sedation
Cosyntropin Stimulation Test
da Vinci Cleaning and Processing Instruments, Accessories and Endoscopes*
da Vinci Robot Si Cleaning and Maintenance*
Death in the Operating Room
Dialysis Access Catheter: Blood Draw/Infusion/Dressing Change
Disaster Plan Perioperative Unit*
Down Time Procedures for OP/PACU
Draping for Surgical Procedures
Dress Code in the OP/PACU
Electrosurgical Cautery
Emergency Supplies in Surgery
Environmental and Infection Control OR/PACU
Environmental and Infection Control PACU
Environmental Infection Control in the PACU
Eye Wash Stations in the Perioperative and Sterile Processing Units
Fire / Safety PACU
Fire Safety in Surgery
Fire Safety in the OP Infusion Unit
Formalin Use and Spill Management*
Handling of Infants/Fetus/Stillborns and Genetic Workup

CALL TO ORDER

The meeting was called to order at 5:30 pm by Peter Watercott, President.

PRESENT

Peter Watercott, President
John Ungersma MD, Vice President
M.C. Hubbard, Secretary
Mary Mae Kilpatrick, Treasurer
Jean Turner, Trustee
Richard Meredick MD, Chief of Staff
Kevin S. Flanigan MD, MBA, Chief Executive Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
Evelyn Campos Diaz, Chief Human Resources Officer
Sandy Blumberg, Executive Assistant

ABSENT

Kelli Huntsinger, Chief Operating Officer

OPPORTUNITY FOR PUBLIC COMMENT

Mr. Watercott stated 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, and speakers will be limited to a maximum of three minutes each. Mr. Watercott then acknowledged the recent passing of Robert Denton MD, who faithfully served members of this community for several decades. No other comments were heard.

APPOINTMENT OF BOARD MEEMBER FOR DISTRICT ZONE II

Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA provided an update on the Board vacancy for Northern Inyo Healthcare District (NIHD) Zone II, explaining the posting and interview process conducted to fill that vacancy. An Ad Hoc Committee of Directors John Ungersma MD, Mary Mae Kilpatrick, and CEO Flanigan interviewed three highly qualified candidates, and following careful consideration recommend that the Board appoint Ms. Jean Turner to fill the vacancy for District Zone II. It was moved by M.C. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to appoint Ms. Jean Turner to fill the District Board vacancy for Northern Inyo Healthcare Zone II.

ELECTION OF BOARD OFFICERS FOR 2018 CALENDAR YEAR

Mr. Watercott proposed the following slate of NIHD District Board officers for the 2018 calendar year:

- President - *John Ungersma, MD*
- Vice President - *M.C. Hubbard*
- Secretary – *Mary Mae Kilpatrick*
- Treasurer – *Jean Turner*
- Member At Large – *Peter Watercott*

It was moved by Doctor Ungersma, seconded by Ms. Hubbard, and unanimously passed to approve the proposed slate of officers as presented.

FINANCIAL STRATEGY WORKSHOP

Chief Financial Officer John Tremble provided a *Health Care Finances* presentation (Workshop 3 of 3) for the purpose of strategically planning for the District's financial future. Mr. Tremble's presentation included the following:

- Review of Long Term District Strategies and Goals
- Strategies Being Deployed to Avoid Economic Issues
- Update of WIPFLI LLP Strategic Comparison Graphs
- Planning for Unexpected Negative Changes in volumes, services, and provision of care
- Analysis of Negative Changes and Payor Trends
- District Philosophy in Responding to Negative Changes in Environment/Volumes

CONSENT AGENDA

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

- *Approval of minutes of the November 13 2017 special meeting*
- *Approval of minutes of the November 15 2017 regular meeting*
- *Financial and Statistical Reports as of October 31 2017*
- *2013 CMS Validation Survey Monitoring, December 2017*
- *Compliance Department Quarterly Report*

It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve all Consent agenda items as presented, with Director Turner abstaining from the vote on minutes for previous meetings, and including one time reference change being made to the minutes for the November 13 2017 special meeting.

CHIEF OF STAFF REPORT

Chief of Staff Richard Meredick, MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Policies/Procedures/Protocols/Order Sets:

POLICIES/ PROCEDURES/ PROTOCOLS/ORDER SETS APPROVALS

- *Advanced Directives*
- *Assisted Living Facilities*
- *California Children Services Referral*
- *Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge*
- *Designated Areas for Food and Drink in Patient Care Areas*
- *DI – Handling of Radioactive Packages, non-nuclear Medicine Personnel*
- *DI – Radioactive Material Hot Lab Security*
- *DI – Radioactive Materials Delivery After-hours Policy/Procedure*
- *DI – Radioactive Waste Storage and Disposal*
- *ED Triage Protocol Policy*
- *Environmental Disinfectant – Cleaning Solution*
- *Handling of Soiled Linen*
- *Home Health Care*
- *Hospice Care*

- *Hospi-Gard Portable Filtration Unit (H.G.U.)*
- *Infection Control: Hand washing for Safe Food Handling*
- *Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu*
- *Long Term Acute Care Hospital*
- *Meals on Wheels*
- *Nursing Services Standing Committee Structure and Hospital Committee Participation*
- *Ombudsman*
- *Sharps Injury Protection Plan (supersedes: Handling and Disposal of Contaminated Needles/Syringes)*
- *Working with Other Agencies in the community*

It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve all policies/procedures/protocols/order sets as presented, with Director Turner requesting that the contact information on the *Ombudsman* policy be checked for accuracy.

MEDICAL STAFF APPOINTMENTS AND PRIVILIGING

Doctor Meredick also reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff appointments and privileging:

1. Brian Mikolasko MD (*hospitalist*) – Provisional Active Staff
2. Trong Quach MD (*hospitalist*) – Provisional Active Staff
3. Amikjit Reen MD (*hospitalist*) – Provisional Active Staff
4. Wilbur Peralta MD (*hospitalist*) – Provisional Active Staff

It was moved by Ms. Turner, seconded by Doctor Ungersma, and unanimously passed to approve all four Medical Staff appointments and privileging as presented.

MEDICAL STAFF TEMPORARY LOCUM TENENS PRIVILEGES

Doctor Meredick reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Temporary Locum Tenens Privileges:

1. H. Charlie Wolf, MD (*emergency medicine*) – for 60 days in the 2018 calendar year effective January 1, 2018. Dr. Wolf will be providing coverage for the Eastern Sierra Emergency Physicians group on a locum tenens basis.
2. Tien H. Cheng, MD (*radiology*) – for 60 days effective December 11, 2017. Dr. Cheng will be providing coverage for the Bishop Radiology Group on a locum tenens basis.

It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve both Temporary Locum Tenens Privileges as requested.

MEDICAL STAFF ADVANCEMENTS

Doctor Meredick also reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff advancements:

1. Sarah Zuger MD (*family medicine*) – advancement from Provisional Active Staff to Active Staff
2. Cecilia Rhodus MD (*pediatrics*) – advancement from Provisional Active Staff to Active Staff

It was moved by Ms. Kilpatrick, seconded by Doctor Ungersma, and unanimously passed to approve both Medical Staff advancements as requested.

MEDICAL STAFF RE-APPOINTMENTS

Doctor Meredick additionally reported that forty applicants submitted for renewal of Medical Staff privileges for the 2018 and 2019 calendar years. All applicants underwent a recredentialing process consisting of the following:

- Verification of current unrestricted licensure, certifications, and registrations
- Queries to the AMA, the NPDB, and the OIG exclusion database
- Investigation of any professional liability cases
- Verification of compliance with CME requirements
- Evaluation of evidence indicating current competence and training related to the privileges requested
- Review of the applicant's performance and standing at NIHD and outside affiliations
- Review of available Ongoing and Focused Professional Practice Evaluation data (OPPE and FPPE), which includes peer review data and evaluation of the six ACGME core competencies

1. After careful review and consideration of the applicant reappointment profiles, the Medical Executive Committee recommends the following applicants for reappointment to the Medical Staff/Allied Professional Staff in the category listed effective January 1, 2018 for a period not to exceed two years:
    - Anderson, Ivan MD, *Cardiology* (Telemedicine)
    - Black, Helena L. MD, *Emergency Medicine* (Active Medical Staff)
    - Brown, Stacey L. MD, *Family Medicine* (Active Medical Staff)
    - Bryce, Thomas MD, *Radiology* (Telemedicine)
    - Chan, Brandon MD, *Radiology* (Telemedicine)
    - Dillon, Michael L. MD, *Emergency Medicine* (Active Medical Staff)
    - Farooki, Aamer MD, *Radiology* (Telemedicine)
    - Ganchan, Richard MD, *Cardiology* (Telemedicine)
    - Harness, Jay K. MD, *Surgery* (Active Medical Staff)
    - Hathaway, Nickoline M. MD, *Internal Medicine* (Active Medical Staff)
    - Hewchuck, Andrew D. DPM, *Podiatry* (Active Medical Staff – LLP)
    - Kamei, Asao MD, *Internal Medicine* (Active Medical Staff)

- Kim, Martha MD, *Obstetrics & Gynecology* (Active Medical Staff)
- Klabacha, Rita PA-C, *Family Medicine* (AHP)
- Lin, Doris MD, *Emergency Medicine* (Active Medical Staff)
- McNamara, Thomas O. MD, *Radiology* (Active Medical Staff)
- Meredick, Richard MD, Orthopedics (*Active Medical Staff*)
- Norris, Jennifer CNM, *Nurse-Midwife* (AHP)
- Nylk, Thomas MD, *Cardiology* (Telemedicine)
- O'Neill, Tammy PA-C, *Orthopedics* (AHP)
- Phillips, Michael W. MD, *Emergency Medicine* (Active Medical Staff)
- Pisculli, Leo M. MD, *Emergency Medicin*e (Active Medical Staff)
- Pomeranz, David MD, *Emergency Medicine* (Active Medical Staff)
- Reid, Thomas K., MD, *Ophthalmology* (Active Medical Staff)
- Rhodus, Cecilia MD, *Pediatrics* (Active Medical Staff)
- Richardson, James A. MD, *Internal Medicine* (Honorary Medical Staff)
- Rowan, Christopher MD, *Cardiology* (Telemedicine)
- Saft, AMY CRNA, *Nurse Anesthesia* (AHP)
- Schweizer, Curtis MD, *Anesthesiology* (Active Medical Staff)
- Seher, Richard MD, *Cardiology* (Telemedicine)
- Swackhamer, Robert MD, *Cardiology* (Telemedicine)
- Taylor, Gregory MD, *Emergency Medicine* (Active Medical Staff)
- Tiernan, Carolyn J. MD, *Emergency Medicine* (Active Medical Staff)
- Vaid, Rajesh MD, *Radiology* (Telemedicine)
- Wasef, Eva S. MD, *Pathology* (Active Medical Staff)
- Wei, Stephen MD, *Radiology* (Telemedicine)
- Weiss, Taema F. MD, *Family Medicine* (Active Medical Staff)
- Wilson, Christopher MD, *Cardiology* (Telemedicine)
- Zuger, Sarah MD, *Family Medicine* (Active Medical Staff)

Doctor Meredick also reported the following applicant did not meet the necessary qualifications and criteria for reappointment to the NIHD Active Staff as outlined in the Medical Staff bylaws (the applicant's privileges will expire after December 31, 2017): Amr Ramadan MD, *Family Medicine* (Active Medical Staff). It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve all Medical Staff reappointments as recommended.

BOARD MEMBER REPORTS

Mr. Watercott asked if any members of the Board of Directors wished to report on any items of interest. Director Ungersma stated he recently donated a Galen Rowell photo to the Healthcare District, and in the future that photo will be on display at the Birch Street Annex. Director Kilpatrick reported she recently attended the Pioneer Home Health open house and tree lighting ceremonies, and Director Hubbard reported that she attended the NIHD employee and physician Christmas party. All three events were successful and appreciated by those in attendance. Board members also expressed kudos regarding a recent Care Shuttle event; a DaVinci (robotics) open house; positive media coverage on the topic of District services; and Healthy Lifestyles talks provided for members of this community.

CLOSED SESSION

At 7:12 pm Mr. Watercott announced the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*).
C. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*).
D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 7:56 pm the meeting returned to open session. Mr. Watercott reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 7:57 pm.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary