Northern Inyo Hospital

September 19 2018 Regular Meeting

September 19 2018 Regular Meeting - September 19 2018 Re

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
September 19, 2018 at 5:30 p.m.
At the Northern Inyo Healthcare District Board Room
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. Strategic Plan update, Patient Experience Committee (*information item*).
   B. Chief Executive Officer Report (*information item*).
   C. Policy and Procedure approval, *Fire Safety Management Plan (FSMP)* (*action item*).
   D. Policy and Procedure approval, *Fire Response Plan – Code Red* (*action item*).
   E. Archer Norris transition to Best, Best and Krieger (*action item*).
   F. Approval of Pharmacy Relocation project architect selection (*action item*).
   G. Chief Operating Officer Report (*information item*).
   H. Chief Nursing Officer Report (*information item*).
   I. Policy and Procedure Approval, *Employee Tuberculosis Surveillance Program* (*action item*).
   J. Chief Human Resources Officer Report (*information item*).
   K. Chief Financial Officer Report (*information item*).
4. Old Business
   A. HIS Implementation update (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the August 7 2018 special meeting
6. Approval of minutes of the August 15 2018 regular meeting
7. Approval of minutes of the September 5 2018 regular meeting
8. Financial and Statistical reports as of July 31 2018
9. 2013 CMS Survey Validation Monitoring, September 2018

10. Policy and Procedure annual approvals

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11. Chief of Staff Report; Allison Robinson MD:
    A. Policies/Procedures/Protocols/Order Sets (*action items*):
        1. *Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners* – modification to referral agreement.
        2. *Employee Health Access of Patient Personal Medical Record*
        3. *Intravenous Medication Policy*
        4. *QuickVue Influenza A + B Test*
    B. Medical Staff Appointments/Privileges (*action items*):
        1. Raul Easton-Carr, MD (*emergency medicine*) – temporary/locum tenens
        2. Farres Ahmed, MD (*diagnostic radiology*) – provisional consulting staff
    C. 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 has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions:
        1. Elizabeth Maslow MD (*infectious disease, Adventist Health*)
    D. Extension of temporary privileges (*action item*):
        1. Akash Rusia MD (*internal medi*cine) – extension of hospitalist privileges through January 31, 2019.
    E. Medical Staff Resignations (*action items*):
        1. Gregory Taylor MD (*emergency medicine*) – effective August 24, 2018
        2. Richard Ganchan MD (*telecardiology*) – effective August 1, 2018
    F. Core Privilege Forms (*action items*):
        1. Occupational Medicine (*new*)
        2. Internal Medicine (*revised*)
12. Reports from Board members (*information items*).
13. Adjournment to closed session to/for:
    A. Discussion of Labor Negotiations; Agency Designated Representative: AALRR; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
    B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and

significant exposure to litigation, 3 matters pending (*pursuant to Government Code Section 54956.9*).

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

14. Return to open session and report of any action taken in closed session.
15. Adjournment.

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

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Fire Safety Management Plan (FSMP) EC.01.01.01 EP 7	
Scope :NIHD	Manual: Administration, Admissions Services, Biomedical Engineering, Business Office, Case Management, Clinical Practice Manual, Community Relations, Environment of Care, EOC - Fire Safety, Maintenance
Source: Director of Maintenance	Effective Date: 12/16/15

Fire Safety Management Plan

SCOPE

The Fire Safety Management Plan (FSMP) describes the methods for minimizing the potential for a fire through the use of building systems, equipment and training. The FSMP is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, and visitors, or the environment, and protect building occupants from fire and the products of combustion. The Plan is also designed to assure compliance with codes and regulations, as applied to the buildings and services provided.

The Plan is applied to the Main Hospital, Clinics, Offices, and Satellite Buildings of Northern Inyo Healthcare District (NIHD).

FUNDAMENTALS

A. The hospital buildings must be designed and maintained In compliance with law, regulation, and accreditation requirements, including compliance with the *NFPA 101 Life Safety Code*®, 2012 Edition.

B. The fire alarm, detection, and suppression systems must be designed, installed, and maintained to ensure reliable performance.

C. District staff training is an essential part of fire safety.

GOALS & OBJECTIVES

The Objectives for the FSMP are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental rounds. The objectives for this plan are as follows:

- The FSMP defines the Districts methods for protecting patients, visitors and staff from the hazards of fire, smoke and other products of combustion and is reviewed and evaluated annually.
- The fire detection and response systems are tested as scheduled, and the results forwarded to the Safety Committee.
- Summaries of identified problems with fire detection and response systems, NFPA code compliance, and fire response plans, drills and operations, in aggregate, are reported to the Safety Committee.
- The scope and objectives of this plan, as well as program effectiveness and performance are evaluated annually.
- Fire prevention and response training includes the response to fires, at the scene of the fire, and in other locations of the facility, and the use of the fire alarm system, processes for relocation and evacuation of patients if necessary, and the functions of the building in protection of staff and patients. Staff knowledge of these issues is evaluated quarterly.

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- Performance indicators for the FSMP are reported to the Safety Committee.
- The FSMP defines the response to fire emergencies on a facility wide basis at the point of origin, and in other areas of the facility, as well as the specific roles and activity should patient relocation or evacuation become necessary.
- All fire extinguishers are inspected monthly, and maintained annually; are positioned to be in visible locations and are selected based on the hazards of the area in which they are installed.
- Automatic fire extinguishing systems, including sprinkler systems and packaged systems are tested according to applicable NFPA standards.

ORGANIZATION & RESPONSIBILITY

A. The Governing Body receives reports of the activities of the FSMP as appropriate. They also provide financial and administrative support to facilitate the ongoing activities of the FSMP.

B. The Chief Executive Officer (CEO), or other designated leader, collaborates with the Director of Plant Operations (DOPO) to establish operating, and capital budgets for the FSMP.

C. The DOPO, in collaboration with the Safety Committee, is responsible for monitoring all aspects of the FSMP. The DOPO advises the Safety Committee regarding fire safety issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

D. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific fire safety procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the DOPO provides department heads with assistance in developing department fire safety policies and procedures.

E. District staff members are responsible for learning, retaining and following job and task-specific procedures for fire safe operations.

PERFORMANCE ACTIVITIES

The performance measurement process is one part of the evaluation of the effectiveness of the FSMP.. Performance measures have been established to measure at least one important aspect of the FSMP.

The performance measure for the FSMP is: Staff knowledge and performance. New staff members attend the general orientation program and complete an annual on-line learning management program that reviews items listed below:

- *responding appropriately to fire drills*
- *knowledge on the Fire Response Plan (R.A.C.E.)*
- *knowledge on the evacuation routes for the department(when advised to by the proper Authority.)*
- *knowledge on how to use a fire extinguisher*
- *procedure for completing a Fire Drill Sign In Sheet*

- *Knowledge of zone valves and who can shut them off*

PROCESSES FOR MANAGING FIRE SAFETY RISKS

Minimize Potential for Harm

The DOPO is responsible for managing the FSMP for minimizing potential harm from fire, smoke, and other products of combustion. The FSMP includes three phases.

1. The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. The District employs qualified architects and engineers to develop building and fire protection system designs. All designs are reviewed by local or state agencies as a part of the construction and permitting process. A vigorous construction monitoring and building commissioning program round out the design phase.

2. The second phase is testing, inspection, and maintenance of the fire prevention aspects of the facility. DOPO is responsible for setting testing, inspection and maintenance documentation and frequency based on applicable codes, equipment history, and other parameters. Maintenance staff and contractors perform the fire system testing and inspection with oversight by the DOPO to ensure the end product of all work maintains or improves the level of life safety in each affected area.

3. The third phase is an active training program of fire prevention, fire safety, and fire response.

Unobstructed Exits

All exits must be maintained free and unobstructed. The status of these areas will be determined routinely by the staff and during environmental rounds. Storage will not be allowed in any exit lobby, exit stairwell.

Fire Response Plan-

The Fire Response Plan provides clear, specific instructions for staff responding to a fire emergency. The procedures provide information about notifying appropriate staff of the emergency and actions to take to protect patient safety. Each department head is responsible for maintaining copies of emergency procedures in a continuously accessible location.

The DOPO and the department heads are responsible for developing and training staff about department specific emergency fire response procedures. Each department head is responsible for providing departmental and area personnel with an orientation to emergency procedures related to their job. Additional departmental training is provided on an annual basis as part of the continuing education program or on an as-needed basis. Each department head is responsible for reviewing department specific fire safety emergency procedures.

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Source: Director of Maintenance	Effective Date: 12/16/15

The roles of all staff and licensed independent practitioners (LIP) are detailed specifically in the Fire Response Plan. The roles of all staff and LIP at and away from a fire's point of are defined. The basic response plan in the hospital is based on the acronym "R.A.C.E.":

- **R**escue anyone in immediate danger from the fire.
- **A**larm by activating fire alarm pull station to sound alarm and Report the alarm by dialing "2400" on the phone to announce the location of the alarm to staff.
- **C**onfine by closing doors to help contain smoke and the products of combustion.
- **E**xtinguish, (P.A.S.S.) and, as needed, prepare to evacuate or relocate patients if directed.

The role of all staff and LIP away from the point of fire origin is to exit area, close doors and evaluate the situation and follow RACE.. If the fire is in horizontal, above, adjacent to the fire's origin, or in areas where relocation is planned, the Fire Response Plan should emphasize moving patients to assist and relocate patients to their appropriate area of refuge or evacuation if directed to. The Fire Response Plan discusses fire response equipment, response procedures and the necessity to identify the authority to shut off the oxygen valves. The Respiratory Care Team is responsible for shutting off the oxygen in the area that is on fire, if necessary.

Fire Drills

1. Fire drills are a critical tool for maintaining the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and staff. Staff participation is necessary to maintain an acceptable level of readiness and to ensure staff knowledge of the equipment and procedures necessary to protect the staff and patients. To evaluate staff knowledge, drill activities are observed and staff is questioned about their role and responsibilities during a fire emergency nearby and elsewhere in the building.

2. Fire drills are conducted in all healthcare facilities once per shift per quarter and evaluated on a randomly selected basis. All of the quarterly drills will be unannounced with the exception of those done as corrective training activities. Fire drills are held at unexpected times and under varying conditions.

3. Fire drills are conducted every 12 months from the last date of the last drill in all freestanding buildings classified as business occupancies (e. g., clinics, offices) in which patient care takes place. These drills are witnessed, documented, and evaluated to identify improvements that may need to be made. Additional drills are held as deemed appropriate.

4. All staff who work in the buildings where patients are house or treated will participate in drills, according to the Fire Response Plan. This includes all hospital staff and all hospital staff in buildings where space is shared with others. *Fire drill during the shift hours of 9:00pm-6:00am may use alternative methods to notify staff instead of activating audible alarms and disturbing patients.*

5. Fire drills are observed and critiqued to evaluate fire safety equipment, fire safety building features and staff response. In addition, fire response knowledge is evaluated during fire drills.

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6. The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, fire protection equipment, and compliance issues. Such improvements are evaluated during monitoring activities and the results are to identify the effectiveness of the activities.

Maintaining fire safety equipment and building features

The DOPO is responsible for maintenance of the fire alarm and related systems. Troubleshooting fire alarm systems and performing corrective and preventive testing, inspection and maintenance is performed by staff and Sierra Security as appropriate. All testing, maintenance, inspection, and repairs are documented and reviewed by the DOPO. Any fire protection feature that is not operating properly will be evaluated for the appropriate Interim Life Safety Measure (ILSM).

The systems inspected, maintained, tested and documented on the inventory are completed as per Joint Commission EC.02.03.05 EP 1-28.

When appropriate, competent contractors are used to test, inspect, maintain, and repair the fire protection features, when appropriate to assure the special skills and equipment they have are available. Documentation is maintained as part of the database to assure activities are conducted in a timely fashion.

Documentation

The documentation for maintenance, testing and inspection activities for fire alarm and water-based fire protection systems will include, the date, test frequency, required frequency of the activity, inventory of devices, equipment, or other items, name and contact information of person performing the activity, NFPA standard(s) including year referenced for the activity, and the results of the activity.

Evaluating the Management Plan

Every 12 months, the DOPO evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the fire safety risks to the staff, visitors, and patients.

References:
TJC EC.01.01.01 EP7
TJC EC.02.03.01, EC.02.03.03, EC.02.03.05, EC.04.01.03

Approval	**Date**

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

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CCOC	8/27/18
Board of Directors	12/16/15
Last Board of Directors Review	6/21/17

Developed: 12/16/15
Reviewed: 3/20/18
Revised: 4/22/18, 8/27/18dw
Supersedes: 6/21/17

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Fire Response Plan – Code Red Policy and Procedure	
Scope: NIHD	Manual:
Source:	Effective Date: 12/16/15

PURPOSE: In order to assure the safety of patients, visitors, and staff, a standard response to fire, or to the potential of fire, defined plans are required. This fire plan describes the standard responses for all staff within the Northern Inyo Healthcare District (NIHD) to an activation of the Fire Alarm or to conditions that indicate the presence of a fire in the area.

POLICY

In the event of a fire, the staff and licensed independent practitioners will follow the basic plan for the building in which they are located. They will use the same plans for fire drills as they do in actual events. Fire drills will be observed to measure the effectiveness of staff response of: when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients if directed, and how to evacuate to areas of refuge, as well as to measure the response of building fire systems.

PROCEDURE

1. Code Red - In Your Work Area of the Hospital:

    a. An alarm will sound throughout the building and where the pull station was activated or where the automatic sensors have detected smoke or heat.
    b. An overhead page will follow indicating the location of the fire.
    c. If you discover smoke, fire, or the alarm system is activated in your immediate area, the appropriate response will best be remembered by using the acronym R.A.C.E.:

R- Rescue ***Remove people***

- Remove anyone in immediate danger to a safe area. This may be a patient, visitor or employee.
- Do Not Use Elevators.

A- Alarm ***Sound and Report the Alarm***

- Sound- Go to the nearest pull station and activate. This notifies the Fire Department.

Note: Drills conducted between 9:00pm and 6:00am, the building's fire alarm system activation will be activated but alternative methods to notify staff instead of activating audible alarms.

- Report- Call 2400 to notify the operator of the location of the fire. The operator will then overhead page "Code Red**, and Location"** three times until "Code Red" Secured.

Note: Drills conducted between 9:00pm and 6:00am will only be announced one time until "Code Red" Secured, if available.

C- Confin - Secure the Area

- Close all doors and windows
- Remove all items from the corridors and place them in empty patient rooms.
- The Respiratory Care Team will assess the need if oxygen supply to the affected area should be discontinued. Only the Respiratory Care Team, Maintenance or House Supervisor are

authorized to order a supply valve closed. A member of the Respiratory Care Team will be responsible for closing the valve after ensuring all persons' dependent on oxygen delivery systems are properly treated.

NOTE: With the exception in Surgery areas only, the Anesthesia personnel will turn off the oxygen.

E- Extinguish - Attempt to extinguish fire

- Fight the fire only if you are not placing yourself in danger.
- Personnel in the immediate department area should take an extinguisher and proceed to the fire.

Code Red Secured - Situation is under control

The Bishop Fire Department, House Supervisor/Incident Commander at the scene verifies that the situation has been resolved. The Incident Commander will notify the Switchboard operator and "CODE RED, SECURED will be paged overhead.

2. **General Responsibilities for Fire Alarm Activation *Above, Below or Adjacent* to the Code Area of the Hospital:**

   If your area is above, below, or adjacent to the point of origin, the following procedures are:
   i. Close all doors
   ii. Remove items from the corridors
   iii. Have patients return to their rooms
   iv. Remind patients and visitors not to use elevators
   v. Listen for overhead pages for status of situation

3. **General Responsibilities for Fire Alarm Activation *Remote* to the Code Area of the Hospital:**

   If your area is away from the point of origin (not within your immediate area or above, below or adjacent to that area), the following procedures will need to be implemented:
   i. Be ready to accept patients from the point of origin
   ii. Remind patients and visitors not to use elevators
   iii. Listen for overhead pages for status of situation

4. Defend/Protect in Place
   - Evacuation plans begin by examining the option of keeping patients exactly where they are and providing protection to them there. This technique might be used in the case of fire or a gas or smoke condition. **Evacuation is normally done at the direction of the House Supervisor/Incident Commander AND the Bishop Fire Department.**

5. Evacuation

a. Evacuation will not take place until directed by the House Supervisor/Incident Commander and/or Bishop Fire Department. At any time, when several patients are in immediate danger, moving them to a safer area can be done without these approvals. The House Supervisor/Incident Commander or Bishop Fire Department evaluates the situation and determines the need to activate the Emergency Operations Plan.
b. Do Not Use Elevators
c. There are several ways to assist and relocate patients and types of evacuations, the following are the stages of evacuation:
    i. Stage I-Horizontal-move them into an adjacent smoke compartment.
    ii. Stage II- Vertical- move one floor down taking the exit stairs.
    iii. Stage III- Building- all patients and visitors will be moved from the building to alternate care sites. These sites are:
        1. NIHD Parking Lot (Primary)
        2. (Secondary)
d. House Supervisor/Incident Commander in conjunction with Bishop Fire Department will determine the need for evacuation beyond horizontal evacuation to an adjacent smoke compartment.

For more information on evacuation, see Emergency Operations Plan- Appendix 1: Evacuation Plan.

6. **Fire Response Team**

The fire response team is made up of Maintenance Department, Security, Respiratory Care Team and the House Supervisor. They are responsible for responding to the area when a Code Red is initiated. The House Supervisor or designee will direct the Bishop Fire Department or fire response team once they arrive on the scene.

7. Code Red In Business Occupancies**:**

Freestanding or Attached Buildings other than the Hospital:

a. An alarm will activate when automatic sensors have detected smoke or heat.
b. An overhead page will indicate the location of the fire.
c. If you discover smoke, fire, or the alarm system is activated in your immediate area, the appropriate response will best be remembered by using the acronym R.A.C.E.:

R – Rescue-Remove people

- Remove anyone in immediate danger to a safe area.
- This may be a patient, visitor, or employee.
- Do Not Use Elevators.

A – Alert-Sound and Report the Alarm

- Sound- Go to the nearest pull station and activate. This activates the Fire Department.
- Report- Call 2400 to notify the switchboard operator of the location of the fire. The operator will overhead page "Code Red and Location" three times until Code Red Secured and/or
- Report- Call 911 to notify them of the location of the fire. Then overhead page in your building, "Please evacuate the building at the nearest exit and meet in the (designated area)".
-

C – Confine - Secure the Area

- Close the door to the area where the fire or smoke is located.
- Leave all other doors unlocked and open, if possible.

E – Extinguish Attempt to extinguish fire

Fight the fire only if you are not placing yourself in danger.

AND

E – Evacuation

- Everyone must evacuate from these buildings immediately.
- Meet in the designated area
- Do Not Use Elevators, if applicable.

Code Red Secured-Situation is under control

The Fire Department at the scene verifies that the situation has been resolved and whether staff may return to the building.

8. **FIRE EXTINGUISHERS**

a. Location of Fire Extinguishers:
All employees should be oriented to the location of the fire extinguishers in their respective work area/department. Storage or equipment should never block fire extinguishers. The Maintenance Staff visually inspects extinguishers every month.

b. Use of Fire Extinguishers:
Select the proper fire extinguisher for the fire. Position yourself as close to the fire as safely possible. Remember to leave a way out.

Use the P.A.S.S. method to extinguish the fire:

Pull	the pin on the extinguisher.
Aim	the extinguisher nozzle at the base of the flames.
Squeeze	the handle to discharge the extinguisher. Squeeze the handle as the contents are under pressure.
Sweep	from side to side at the base of the fire. Remember that the extinguisher will empty quickly. Do not waste the extinguishing agent.

DO NOT ATTEMPT TO EXTINGUISH THE FIRE IF IT IS TOO LARGE OR DANGEROUS. CLOSE THE DOOR, LEAVE THE AREA AND AWAIT ARRIVAL OF THE BISHOP FIRE DEPARTMENT.

Title: Fire Response Plan – Code Red Policy and Procedure	
Scope: NIHD	Manual:
Source:	Effective Date: 12/16/15

9. Fire Drills Will:

- Be conducted a minimum of once per quarter per shift for hospitals.
- Have 100% unannounced drills for hospitals. Fire drills are held at unexpected times and under varying conditions.
- Be conducted every 12 months for freestanding buildings classified as business occupancies.
- Be evaluated for performance of fire safety equipment and staff.
- Be reviewed by the Safety Committee on a regular basis.
- Simulate real-life possibilities.
- Be scheduled at unexpected times and under varying conditions.
- Be conducted by the Maintenance Department.
- Be observed from varied locations.

Evaluation of Staff Knowledge will include:

- Compartmentalization and containment.
- Areas of Refuge.
- Fire extinguishment.
- Fire response duties.
- Vertical and horizontal evacuation.

Staff response will be observed at the drill location and:

- Adjacent compartment(s).
- The compartment above and below the drill location.

Approval	**Date**
CCOC	8/27/18
Board of Directors	12/16/15
Last Board of Directors Review	12/15/16

Developed: 12/16/15
Reviewed:12/15/16
Revised: 3/28/18dw
Supersedes: 3/6/17
Index List

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September 10, 2018

VIA E-MAIL KEVIN.FLANIGAN@NIH.ORG

Kevin S. Flanigan, M.D.
Chief Executive Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

Dear Kevin,

In follow up to our recent email exchange regarding the dissolution of Archer Norris PLC, we are sending you this letter as the first step in the process of formally transferring your matters to our new firm, Best Best & Kreiger (BBK). We want to ensure there is no disadvantage to you by virtue of the move.

In order to make sure that your matters are handled on a timely basis, can you please formally confirm that you want to engage BBK to assume responsibility for your matters that Archer Norris has worked on in the past by marking the enclosed copy of this letter appropriately, signing it, and returning it to us via email at Vincent.Tanciongco@bbklaw.com. We will then arrange for prompt transfer of the appropriate files to BBK's Walnut Creek office, located at 2001 North Main Street, Suite 390, Walnut Creek, California. We will both be practicing in the Walnut Creek office of BBK and will continue to be the attorneys primarily responsible for your matters.

We very much appreciate the trust you have placed in us to handle your legal matters and we look forward to continuing to do the same at our new firm. If you have questions, please feel free to give either one of us a call.

Very truly yours,

ARCHER NORRIS

Colin J. Coffey

Noel M. Caughman

_____ I *(Client)* wish to have Best Best & Krieger LLP handle those legal matters which were previously handled by Noel Caughman and/or Colin Coffey at Archer Norris, PLC. Please transfer the appropriate files, including both electronic records and non-electronic records, to Best Best & Krieger LLP.

Date: _____ _____

(Client's) Signature

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Employee Tuberculosis Surveillance Program	
Scope: NIHD	Manual: CPM - Infection Control Orange (ICO), Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 1/2015

PURPOSE:

1. To meet regulations as required by Title XXII and best practice per the CDC.
2. To protect prevent the spread of Tuberculosis by use of surveillance per standard of practice.

POLICY:

TB testing is mandatory every two years for all employees. There are no location or job title exceptions for TB surveillance at NIHD.

All employees will be evaluated every 2 years for exposure to Tuberculosis. Employee and Director/Manager will be notified via email within 3 before the due date. **Failure to comply with mandatory screening will result in the inability to work until evidence of compliance is produced.**

Employees who are on a leave of absence for any reason when their screening is due, must provide proof of TB screening prior to their return or **complete** their screening within 5 days of their return.

All new employees will be screened to evaluate TB status. Screening will take place during the pre-employment physical exam or during orientation. Employees, who cannot provide proof of a skin test administered within the prior 12 months, will undergo 2 step TB testing. If the first skin test is negative, receive a second (2nd) skin test will be applied 1-2 weeks after the first test.

A positive reaction to the skin test does not signify the presence of disease.

Absence of, or diminished reaction to PPD, does not exclude infection with M.TB. Decreased responses to tuberculin may occur during:

- febrile or viral illnesses,
- during corticosteroid or immunosuppressive therapy,
- in face of various illnesses such as Hodgkin's, measles, HIV and others
- because of a sluggish immune system with advancing age.

DEFINITION:

The Tuberculin Skin Test (TST) is a diagnostic aid to detect infection with mycobacterium tuberculosis (M.TB).

PROCEDURE:

A). INITIAL EXAM

Title: Employee Tuberculosis Surveillance Program	
Scope: NIHD	Manual: CPM - Infection Control Orange (ICO), Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 1/2015

1. A tuberculin skin test is given to all employees, including those with a history of a (old) BCG vaccination, at time of hiring unless a previously positive reaction can be documented. The TB history will be documented on the Record of Tuberculosis Screening and skin test consent form (see attached). Special employees: MDs, Travelers, contract, and students are required to show proof of current TST or CXR within one year.
2. If a prospective employee has a history of a positive TST, they will complete a Tuberculosis Symptom Questionnaire (see attached) and have a screening chest x-ray done as soon as possible. The chest x-ray can be omitted if there is a record of a normal CXR done within 12 months of hiring. A QuantiFERON-Gold blood test may also be ordered by Employee Health.
3. If it has been greater than one year since last testing, then a Two-Step Mantoux Test will be done.
4. New positive tests, whether considered a "Reaction" or "Conversion," will be referred to the employee's private provider and the Health Department.
5. A California Confidential Morbidity Report must be completed for all positive tests and faxed to Inyo County Health Department as directed on the form. The form is located on the NIHD intranet a: http://intranet/Forms/Infection_Surveillance/CMRTB_201701-ModifiedforNIH.pdf
6. Conversions are reported to Human Resources so they can be recorded on the OSHA 300 log and provided in a manner that ensures the confidentiality of employee and without providing the name of the source patient, if known.

B). BCG Vaccination.

1. Many people born outside of the United States have been given a vaccine called BCG. People who were previously vaccinated with BCG may receive a TB skin test to test for TB infection. Vaccination with BCG may cause a false positive reaction to a TB skin test. A positive reaction to a TB skin test may be due to the BCG vaccine itself or due to infection with TB bacteria. TB blood tests (IGRAs), unlike the TB skin test, are not affected by prior BCG vaccination and are not expected to give a false-positive result in people who have received BCG. TB blood tests are the preferred method of TB testing for people who have received the BCG vaccine.
2. In the United States, vaccination with BCG is not recommended routinely for anyone, including HCWs or children. Previous BCG vaccination is not a contraindication to having a TST or two-step skin testing administered. HCWs with previous BCG vaccination should receive baseline and serial skin testing in the same manner as those without BCG vaccination. However, BCG is the most commonly used vaccine in the world. Foreign-born persons are commonly employed in the United States as HCWs. Previous BCG vaccination is not a contraindication to having a blood test (QuantiFERON Gold- QFT-G) performed. BCG does not influence QFT-G results with the version of the test approved in 2005. HCWs who have received BCG vaccination and who have a positive TST should receive a baseline QFT-G blood test as well as a CXR.

Title: Employee Tuberculosis Surveillance Program	
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C). REPEAT TUBERCULIN SKIN TESTS

1. The interval for serial TB testing of HCWs is to be a least every 2 years as indicated by institutional and community risk. **See attached letter from Richard O. Johnson, M.D. Health Officer Inyo County, dated 11/20/2014.**
2. The State Licensing and Certification Regional Office will be notified when the frequency of TB testing of health care workers in not done annually due to low risk, as per the guidance of the Inyo County Health Officer .
3. Tests may be done more often at the request of the employee for reasons not directly linked to his or her position. For example, an employee may need one for childcare or for school.
4. TSTs will be done after any known exposure to a patient with M. TB. There should be a baseline done within 2 weeks of the exposure, if possible, and then repeated in 10-12 weeks after the last known date of exposure.
5. Employees with a Baseline Positive TB test shall have a symptom screening every two years, using the Tuberculosis Symptom Questionnaire for PPD Positive Employees.

D). ADMINISTRATION OF THE TUBERCULIN SKIN TEST

1. The standard tuberculin skin test procedure (Mantoux Test) is an intradermal injection of 5 T.U. of PPD, 0.1 ml, on the flexor surface of the forearm.

2. It is of utmost importance that each PPD is administered correctly and only by personnel competent to perform this skin test.

3. If a definite bleb is raised, the test has been done correctly. If no bleb forms, the test should be repeated immediately in the other arm.

E). TWO STEP MANTOUX TEST PROCEDURE

"A second TST is not needed if the HCW has a documented TST result from any time during the previous 12 months. If a newly employed HCW has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting (Box 1). This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the setting."
A recent TST (performed in < 12 months) is not a contraindication to a subsequent TST unless the test was associated with severe ulceration or anaphylactic shock, which are substantially rare adverse

events. Multiple TSTs are safe and do not increase the risk for a false-positive result or a TST conversion in persons without infection with mycobacteria."
(From Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-care settings. MMWR Vol. 54/RR17)

The purpose of the Two Step Mantoux TST is to identify infected individuals, who have not been tested in a year or more, and whose sensitivity may have waned with time. Due to waned sensitivity, these persons may not react to a single tuberculin dose, but may show conversion to a subsequent does. If the second test is given a year after the initial dose, the person may appear to have been infected in the time between the tests, and be treated as a new converter, when this is not the case.

To avoid this misconception, for new employees who do not have a history of a positive TST and have not been tested ≥ 1 year, do the following:

1. Give initial PPD
    a. If positive, no further testing necessary.
    b. If negative, repeat PPD in 7 – 21 days.

2. Use results of 2nd test as the person's baseline result and proceed as indicated for TB testing frequency. If the second test is positive the employee is considered previously infected and cared for accordingly. This would not be considered a skin test conversion.

3. If the second test result of a two-step TST is not read within 48–72 hours, administer a TST as soon as possible and ensure that the result is read within 48–72 hours. Certain studies indicate that positive TST reactions might still be measurable from 4–7 days after testing. However, if a patient fails to return within 72 hours and has a negative test result, the TST should be repeated (42).

Box 1. Indications for two-step tuberculin skin tests (TSTs)
(From Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-care settings. MMWR Vol. 54/RR17)

Situation	Recommended testing
No previous TST result	Two-step baseline TSTs
Previous negative TST result (documented or not) > 12 months before new employment	Two-step TSTs
Previous documented negative TST result < 12 months before new employment	Single TST needed for baseline testing: this test will be the second step
≥ 2 previous documented negative TSTs but most recent > 12 months before new employment	Single TST; two-step testing is not necessary.
Previous documented positive TST result	No TST
Previous undocumented positive TST result	Two-step baseline TST(s)

Title: Employee Tuberculosis Surveillance Program	
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Previous BCG Vaccination	Two-step baseline TST(s)

E). INTERPRETATION OF TUBERCULOSIS SKIN TESTS (TST)

The interpretation of the TST is based on the California Department of Health Services/California Tuberculosis Controllers Association Joint Guidelines (see attached)

1. The TST results are read between 48 - 72 hours. In the elderly or in persons tested for the first time, reaction may develop slowly and may peak after 72 hours.

2. It is essential that local inflammatory response such as redness or edema is not interpreted as induration.

3. Immediate reactions to the tuberculin test or those occurring within 24 hours, probably indicate sensitivity to the preservative and do not indicate tuberculin infection.

4. A positive reaction is defined as an area of induration. measuring ≥ 10mm for HCWs who have no other risk factors.

5. A positive reaction demonstrates past or recent infection with M.TB; the larger the reaction, the greater the probability that the organism is M.TB.

6. Test results are never recorded as positive or negative, but in mm of induration present.

7. Documented recent infection (within past 2 years) is considered a "conversion", whereas infection which cannot be documented to have occurred within that time is rated as a "reaction".

8. Converters: if testing identifies a recent converter (those with an increase of at least <10mm of induration to ≥ 10mm within 2 years), those individuals are presumed to have recent infection and are at a higher risk of progression from Latent TB Infection (LTBI) to active TB.

9. A questionable induration may be the result of an incorrectly performed test and should be repeated in 1-3 weeks.

10. An induration of 5-10 mm may be:
    a. a cross-reaction to other mycobacteria (not tuberculosis). A repeat should be given in 1-3 weeks. A second reaction of equal size should be dismissed as cross-reaction.

b. may be considered positive for HCW who has had recent contact with persons with active TB or is severely immunosuppressed.

11. If you have a positive TST test, the following should be done:
    a. Contact Employee Health Medical Director or designee.
    b. A QuantiFERON-Gold blood test may be ordered (this test can only be drawn on M-TH).
    c. Give the employee an order for a CXR.
    d. Notify Employee Health Medical Director or designee of the results.

Additional Considerations and Recommendations in the Use of QuantiFERON-gold (QFT-G) in Testing Programs

NIHD uses the TST and not the QFT-G for routine Tuberculosis testing. At times the QFT-G test may be needed. It may be ordered after an employee has a positive TST, for diagnosis purposes.

QFT-G can be used in all circumstances in which the TST is used, including contact investigations, evaluation of recent immigrants who have had BCG vaccination, and TB screening of health-care workers and others undergoing serial evaluation for *M. tuberculosis* infection. QFT-G usually can be used in place of (and not in addition to) the TST.

A positive QFT-G result should prompt the same public health and medical interventions as a positive TST result. No reason exists to follow a positive QFT-G result with a TST. Persons who have a positive QFT-G result, regardless of symptoms or signs, should be evaluated for TB disease before LTBI is diagnosed. At a minimum, a chest radiograph should be examined for abnormalities consistent with TB disease. Additional medical evaluation would depend on clinical judgment on the basis of findings from history (including exposure to infectious TB), physical examination, and chest radiography. HIV counseling, testing, and referral is recommended because HIV infection increases the suspicion for TB and the urgency of treating LTBI. After TB has been excluded, treatment of LTBI should be considered (*6*).

The majority of healthy adults who have negative QFT-G results are unlikely to have *M. tuberculosis* infection and do not require further evaluation. However, for persons with recent contact with persons who have infectious TB, negative QFT-G results should be confirmed with a repeat test performed 8--10 weeks after the end of exposure, as is recommended for a negative TST result. Studies to determine the best time to retest contacts with negative QFT-G results have not been reported. Until more information is available, the timing of QFT-G testing should be the same as that used for the TST.

F). TREATMENT

1. Employees who have reactions or conversions will be referred to his/her private health care provider and the Inyo County Health Department. The employee will be given information on latent tuberculosis, a copy of the TST, and a copy of the CXR report to take to the local provider.

2. Symptoms suggestive of active disease (i.e., chronic cough, hemoptysis, night sweats, weight loss, unexplained fatigue) must be immediately investigated by the Employee Health RN or the Infection Control RN in conjunction with the Emergency Room physician. The employee's private health care provider and Inyo County Health Department may also be involved in the evaluation.

G). CONTACT INVESTIGATION: To be done by Inyo County Health Department

H). CHEST X-RAYS

1. Yearly chest x-rays will not be repeated for HCWs known to have had a positive TST at Northern Inyo Hospital with a previously negative chest x-ray. After this baseline chest radiograph is performed and the result is documented, repeat radiographs are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph. Instead of participating in serial testing for *M. tuberculosis* infection, HCWs with a positive test result for *M. tuberculosis* infection should receive an initial chest x-ray, and then a symptom questionnaire screen every 2 years.
2. However, new, prospective employees with a history of a positive TST and/or a positive CXR, will fill out the Tuberculosis Symptom Questionnaire to assess risk, and have a chest x-ray if not done within 12 months.
3. Chest x-rays will be done on employees with a positive TST, conversion or reaction, who previously have not had a chest x-ray.
4. If the chest x-ray of a new TST converter is positive, further work-up will be needed. The employee will not be allowed to return to work until the work-up is complete, therapy is begun and AFB smears are negative.

I). WORK RESTRICTIONS

1. There is no restriction on employment for healthy personnel with a positive skin test and documented negative Chest X-Ray, with or without treatment.
2. HCWs receiving treatment for LTBI can return to work immediately. HCWs with LTBI who cannot take or do not accept a full course of treatment for LTBI should not be excluded from the workplace. They should be counseled regarding the risk for developing TB disease and instructed to report any TB symptoms immediately to Employee Health and/or Infection Control Departments and to their primary care provider.
3. Removal from work is indicated for individuals with indications of active disease, such as those employees who have symptoms and/or a CXR suspicious for active tuberculosis.
4. Individuals with active disease may return to work if the following criteria are met:
    a. three consecutive sputum samples collected in 8-24 hour intervals that are negative, with at least one sample from an early morning specimen (because respiratory secretions pool overnight).

b. the HCW has responded to antituberculosis treatment that will probably be effective (can be based on susceptibility results).
c. The HCW is determined to be noninfectious by a physician knowledgeable and experienced in managing TB disease.

J). RESPONSIBILITY OF TREATMENT

1. Follow up and treatment of reactors/converters is to be managed by the employee's personal physician.
2. If infection occurred as a result of employment at Northern Inyo Hospital, or if it is suspected that the infection occurred as a result, Workman's Compensation will be responsible for expenses.

Definition of a positive tuberculin skin test

The definition of a positive tuberculin skin test depends on a person's prior probability of having LTBI and the person's risk of developing active TB.

≥ 5 mm of induration*

- Persons known or suspected to have HIV infection.
- Recent contacts to an active case of pulmonary or laryngeal TB.
- Persons with fibrotic changes seen on chest radiograph consistent with TB.
- Immunosuppressed individuals

≥ 10 mm of induction

- All persons except those in above

NOTE: The CDC recommends using a 15 mm cutoff for low risk reactors. However, in California, this cutoff is not recognized because California is a high incidence state and the prevalence of nontuberculous mycobacterial infections is lower than in other regions of the United States.

Tuberculin skin test conversion

TST conversion is defined as an increase of at least 10 mm induration from < 10 mm to ≥ 10 mm within two years.

Example: a TST of 4 mm that increases in size to 14 mm or more induration within 2 years would be an example of skin test conversion.

In many cases, the exact size (in mm) of the previous tuberculin skin test may not be known. In

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such cases, skin test conversion is defined as a change from a negative to positive tuberculin skin test within a 2-year period.

Above is taken from the "California Department of Health Services/California Tuberculosis Controllers Association Joint Guidelines."

References:

1. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, published by CDC.
2. Title XXII, California Health and Safety Code Ch. 1 70723 (b) (3)
3. ATD Standards Section 7.h.3.A https://www.dir.ca.gov/titles/5199.html
4. Letter from Richard O. Johnson, M.D. Health Officer Inyo County, dated 11/20/2014.
5. Letter from Occupational California department of Health Services – DHS- Feb. 28, 2007 To Dr. Tony Paz, President of California TB Controller Assn.
6. Curry International Tuberculosis Center, FAQs 12/29/2011, http://www.currytbcenter.ucsf.edu/.
7. CDC: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm/s_cid=rr5417a1_e
8. CDC: https://www.cdc.gov/tb/topic/testing/testingbcgvaccinated.htm
9. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5415a4.htm
10. http://www.ucdmc.ucdavis.edu/hr/hrdepts/hr_bulletins/Docs/EHS_TB_Surveillance_Comp_Prog.pdf
11. https://cchealth.org/healthcare-for-homeless/pdf/2017-Policy-IC406.pdf

Cross Reference P&P:

1. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
2. Tuberculosis Exposure Control Plan
3. Lippincott Procedures: Airborne Precautions

Approval	**Date**
CCOC	5/21/18
Infection Control Committee	5/22/18
Medical Executive Committee	6/5/18
Board of Directors	
Last Board of Directors Review	

Index Listings: Employee Tuberculosis Surveillance Program
Revised: 2/94, 6/97; 7/2000; 12/2002; 7/2005, 3/2006,2/2007,1/2008, 10/09, 02/12 LA; 11/14NH,3/18CO
Reviewed: 5/2011; 8/11LA; 6/13 LA; 12/4/15 NH, 1/17 NH

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Employee Tuberculosis Surveillance Program	
Scope: NIHD	Manual: CPM - Infection Control Orange (ICO), Employee Health
Source: Employee Health/Infection Prevention Spec.	Effective Date: 1/2015

CALL TO ORDER	The meeting was called to order at 5:31 pm by M.C. Hubbard, Vice President in the Northern Inyo Healthcare District (NIHD) Board Room at 2957 Birch Street, Bishop, California.
PRESENT	M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Robert Sharp, Member at Large Evelyn Campos Diaz, Chief Human Resources Officer Michelle Garcia, Administrative Assistant
ABSENT	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
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hubbard announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.
DEVELOPMENT OF PROCESS FOR FILLING BOARD VACANCIES AND ON-BOARDING NEW BOARD MEMBERS	An open discussion took place on the subject of developing a process for filling Northern Inyo Healthcare District (NIHD) Board vacancies and on-boarding new Board members. A draft process was developed that will be reviewed further and presented for approval at a future meeting of the District Board.
ADJOURNMENT	The meeting was adjourned at approximately 7:30 pm.

_____
M.C. Hubbard, Vice President

Attest: _____
Mary Mae Kilpatrick, Secretary

CALL TO ORDER	The meeting was called to order in the Northern Inyo Healthcare District Board Room at 2957 Birch Street, Bishop, California, at 5:30 pm by M.C. Hubbard, Vice President.
PRESENT	M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Robert Sharp, Member at Large Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Evelyn Campos Diaz, Chief Human Resources Officer Allison Robinson MD, Chief of Staff Sandy Blumberg, Executive Assistant
ABSENT	Tracy Aspel RN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hubbard announced 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. No comments were heard.
ADJOURNMENT TO CLOSED SESSION	At 5:32 pm Ms. Hubbard announced the meeting would adjourn to Closed Session to allow the Board of Directors to: A. Discuss Labor Negotiations; Agency Designated Representative: AALRR, Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 6:00 pm the meeting returned to open session. Ms. Hubbard reported the Board took no reportable action.
WORKFORCE EXPERIENCE COMMITTEE REPORT	Human Resources Director Alison Murray provided a report from the Workforce Experience Committee, which was established to help accomplish the workforce-related goals of the District's Strategic Plan. The first objectives of the Committee are to address Northern Inyo Healthcare District (NIHD) staff turnover and churnover rates, and to assess District employee Staff Development opportunities. Ms. Murray's presentation included information on the following: - Current completion rate for mandated employee trainings - Review of career ladders now in place within many Hospital Departments - Dollars spent on Staff Education and employee tuition assistance Ms. Murray noted a baseline staff turnover rate has been determined (16%) and the Committee's goal is to reduce that rate of turnover to 12%. The goal for staff completion of mandatory trainings has been set at

100%. It was additionally noted that regular reports from the Workforce Experience Committee will be provided for the Board of Directors on a quarterly basis.

COMPLIANCE DEPARTMENT QUARTERLY REPORT

Compliance Officer Patty Dickson provided a quarterly Compliance Report which reviewed statistics on District information breaches; research requests; investigations of compliance concerns; and employee access audits. Ms. Dickson additionally provided an informational presentation titled "*Compliance and the Role of the Board of Directors*". It was then moved by Mary Mae Kilpatrick, seconded by Robert Sharp, and unanimously passed to approve the quarterly Compliance Report as presented.

POLICY & PROCEDURE APPROVALS

Chief Executive Officer Kevin S. Flanigan MD, MBA called attention to approval of the following hospital wide Policy and Procedure approvals:

- *ICU Acuities*
- *Safe Patient Handling - Minimal Lift Program*
- *Acute/Subacute Care Services Method of Practice: Patient Coordinated Care*

It was moved by Ms. Kilpatrick, seconded by Jean Turner, and unanimously passed to approve all three Policies and Procedures as presented.

LANGUAGE ACCESS SERVICES STRATEGIC PLAN

Language Services Manager Jose Garcia presented a *Language Access Services Strategic Plan*, which is being established to help ensure effective communication and equal access to health care services for District patients with language or communication barriers, in accordance with State and Federal Law and Joint Commission standards. Mr. Garcia noted that the NIHD Language Services Call Center is now operational, and he provided an overview of interpreter service and language assistance technology available to District patients. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the *Language Access Services Strategic Plan* as presented.

POLICY & PROCEDURE: STATISTICALLY VALID SAMPLE SIZE

Chief Financial Officer John Tremble called attention to a proposed Policy and Procedure titled *Establishment of Statistically Valid Sample Sized for Business and Quality Process Analysis and Improvement*, which establishes statistically valid methods for looking at the organization's internal data. It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve the Policy and Procedure titled *Establishment of Statistically Valid Sample Sized for Business and Quality Process Analysis and Improvement* as presented.

QUARTERLY FINANCIAL AND STATISTICAL REPORT

Mr. Tremble also called attention to the financial and statistical reports for the period ending June 30 2018, noting the following:

- The 2017/2018 fiscal year proved to be a growth year, and the District billed a significantly larger number of charges than expected
- Rural Health Clinic; Inpatient; Outpatient; and Surgery volumes were

all significantly over budget for the year
- The District achieved its goal of having 90 days cash on hand by the end of the fiscal year
- The District's bottom line net profit for the year was $1,433,967

Mr. Tremble also noted the District's annual audit is taking place this week, and that volumes for the months of July and August 2018 appear to be lower. A four percent increase to the price of most patient services will be implemented in the month of August. Following review of the information provided it was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve the quarterly financial and statistical reports as of June 30 2018 as presented.

WORKFLOW AND SUGGESTED GUIDANCE FOR FILLING DISTRICT BOARD VACANCIES

Chief Human Resources Officer Evelyn Campos Diaz called attention the following:
- *Work Flow for Appointments to Fill NIHD Board Vacancies*
- Board of Directors Policy and Procedure approval: *Suggested Guidance to Fill a Board Vacancy by Appointment*

It was moved by Ms. Turner, seconded by Ms. Kilpatrick and unanimously passed to approve the *Work Flow for Appointments to Fill NIHD Board Vacancies,* and the Policy and Procedure titled *Suggested Guidance to Fill a Board Vacancy by Appointment* as presented. Director Turner thanked Ms. Campos Diaz for her hard work and many hours of effort toward the development of the process for filling and on boarding new members of the District Board.

UPDATE ON PHARMACY RELOCATION PROJECT

Doctor Flanigan stated following three years of effort to relocate the Northern Inyo Hospital Pharmacy and bring it into compliance with regulatory requirements, District leadership has determined that a Request For Proposal (RFP) should be issued in order to select a new architect for the project. Doctor Flanigan explained it is hoped that the RFP process will result in cost savings over the originally budgeted project cost by bypassing an interim Pharmacy project phase, and he noted the importance of moving forward with the project as quickly as possible. It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve terminating the existing contract for the Pharmacy relocation and issuing an RFP to select a new architect for the project.

CONSENT AGENDA

Doctor Flanigan called attention to the Consent Agenda for this meeting, which contained the following items:
- *Approval of minutes of the July 18 2018 regular meeting*
- *2013 CMS Survey Validation Monitoring, August 2018*
- *Policy and Procedure annual approvals*

It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve all three Consent Agenda items as presented.

CHIEF OF STAFF REPORT

Chief of Staff Allison Robinson, MD reported following careful review, consideration, and approval by the appropriate Committees the Medical

POLICY & PROCEDURE APPROVALS

Executive Committee recommends approval of the following hospital wide policies and procedures:

1. *Abuse Policy for Swing Bed Patients*
2. *Cepheid Xpert CT/NG PCR Assay*
3. *Coroner's Cases*
4. *Delayed Blood Bank Banding of Patients*
5. *Emergency Department Telephone Advice Information*
6. *Emergency Order and Shipment of Blood Components from UBS*
7. *Malignant Hypothermia Cart Check*
8. *Newborn Blood Glucose Monitoring*
9. *Scope of Service ICU*
10. *Sexual Assault Exam Policy*
11. *Surveillance for Hospital Acquired Infections (HAI's)*

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve all eleven hospital wide Policies and Procedures as presented.

MEDICAL STAFF RESIGNATIONS

Doctor Robinson also reported that the Medical Executive Committee recommends approval of the following Medical Staff resignations:

1. Ryan Berecky, MD (*Tahoe Carson Radiology*) - effective July 11, 2018
2. Nicholas Carlevato, MD (*Tahoe Carson Radiology*) - effective July 11, 2018

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to accept both Medical Staff resignations as requested.

MEDICAL STAFF APPOINTMENT / PRIVILEGES

Doctor Robinson additionally reported following careful review and consideration the Medical Executive Committee recommends the following Medical Staff Appointment/Privileging:

1. Kevin M. Deitel, MD (*orthopedic surgery*) - Provisional Consulting Staff, on-call only

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve the Medical Staff Appointment and Privileging of Kevin M. Deitel MD as requested.

BOARD MEMBER REPORTS

Ms. Hubbard asked if any members of the Board of Directors wished to report on any items of interest. Director Sharp reported the he, Director Hubbard, and Doctor Flanigan recently traveled to Southern Mono Healthcare District (SMHD) to meet with their leadership and hold an open discussion on possible collaboration of services in the future. The meeting was a positive experience that will hopefully constitute the first step toward developing a stronger working relationship between the two Districts. Director Turner mentioned the value of Directors reading the regular American Hospital Association publication titled *Trustee Insights*. No other comments were heard.

CLOSED SESSION

At 7:19 pm Ms. Hubbard announced the meeting would adjourn to Closed Session to allow the Board of Directors to:

A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*pursuant to Health and Safety Code Section 32106*).
B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 2 matters pending (*pursuant to Government Code Section 54956.9*).
C. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:55 pm the meeting returned to Open Session. Ms. Hubbard reported the Board took action to authorize Doctor Flanigan to execute business documents on behalf of the District

ADJOURNMENT

The meeting was adjourned at 8:58 pm.

_____
M.C. Hubbard, Vice President

Attest: _____
Mary Mae Kilpatrick, Secretary

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending July 31, 2018

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	901658.04	1125870	-224211.96	901658.04	1125870	-224211.96
Ancillary	2560635.99	2953987	-393351.01	2560635.99	2953987	-393351.01
Total Inpatient Service Revenue	3,462,294	4,079,857	(617,563)	3,462,294	4,079,857	(617,563)
Outpatient Service	9,569,247	9,125,352	443,895	9,569,247	9,125,352	443,895
Gross Patient Service Revenue	**13,031,541**	**13,205,209**	**(173,668)**	**13,031,541**	**13,205,209**	**(173,668)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	169,709	233,650	(63,941)	169,709	233,650	(63,941)
Contractual Adjustments	5,265,153	5,128,154	136,999	5,265,153	5,128,154	136,999
Prior Period Adjustments	38	(107,500)	107,538	38	(107,500)	107,538
Total Deductions from Patient Service Revenue	**5,434,900**	**5,254,304**	**180,596**	**5,434,900**	**5,254,304**	**180,596**
Net Patient Service Revenue	**7,596,641**	**7,950,905**	**(354,264)**	**7,596,641**	**7,950,905**	**(354,264)**
Other revenue	303,323	71,274	232,049	303,323	71,274	232,049
Total Other Revenue	**303,323**	**71,274**	**232,049**	**303,323**	**71,274**	**232,049**
Expenses:						
Salaries and Wages	2,232,821	2,458,844	(226,023)	2,232,821	2,458,844	(226,023)
Employee Benefits	1,754,603	1,720,497	34,106	1,754,603	1,720,497	34,106
Professional Fees	1,053,888	935,837	118,051	1,053,888	935,837	118,051
Supplies	803,594	744,152	59,442	803,594	744,152	59,442
Purchased Services	369,025	350,906	18,119	369,025	350,906	18,119
Depreciation	337,344	360,419	(23,075)	337,344	360,419	(23,075)
Bad Debts	206,733	250,000	(43,267)	206,733	250,000	(43,267)
Other Expense	612,124	426,131	185,993	612,124	426,131	185,993
Total Expenses	**7,370,132**	**7,246,786**	**123,346**	**7,370,132**	**7,246,786**	**123,346**
Operating Income (Loss)	**529,832**	**775,393**	**(245,561)**	**529,832**	**775,393**	**(245,561)**
Other Income:						
District Tax Receipts	48,743	-	48,743	48,743	-	48,743
Tax Revenue for Debt	137,596	-	137,596	137,596	-	137,596
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	-	-	-	-	-	-
Interest Income	46,909	4,530	42,379	46,909	4,530	42,379
Interest Expense	(236,292)	(238,713)	2,421	(236,292)	(238,713)	2,421
Other Non-Operating Income	4,303	-	4,303	4,303	-	4,303
Net Medical Office	(455,245)	(406,130)	(49,115)	(455,245)	(406,130)	(49,115)
340B Net Activity	(43,357)	19,726	(63,083)	(43,357)	19,726	(63,083)
Non-Operating Income/Loss	**(497,343)**	**(620,587)**	**123,244**	**(497,343)**	**(620,587)**	**123,244**
Net Income/Loss	**32,488**	**154,806**	**(122,318)**	**32,488**	**154,806**	**(122,318)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending July 31, 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	272	272	322	(50)	-16%
Total Patient Days without NB	248	248	289	(41)	-14%
Swing Bed Days	43	43	36	7	19%
Discharges without NB	84	84	95	(11)	-12%
Swing Discharges	6	6	5	1	20%
Days in Month	31	31	31		
Occupancy without NB	8.00	8	9.32	(1.3)	-14%
Average Stay (days) without NB	2.95	3	3.04	(0.1)	-3%
Average LOS without NB/Swing	2.63	3	2.81	(0.2)	-7%
Hours of Observation	912	912	8,398	(7,486)	-89%
Observation Adj Days	38	38	350	(312)	-89%
ER Visits All Visits	1,052	1,052	798	254	32%
RHC Visits	1,918	1,918	2,943	(1,025)	-35%
Outpatient Visits	3,755	3,755	3,638	117	3%
IP Surgeries	17	17	29	(12)	-41%
OP Surgery	106	106	88	18	20%
Worked FTE's	355.13	355.13	342.43	13	4%
Paid FTE's	401.34	401.34	396.07	5	1%
Hours Worked to Hours Paid%	88.5%	88.5%	86.5%	2.0%	2%
Payor %					
Medicare		39%	38%	1%	
Medi-Cal		25%	23%	2%	
Insurance, HMO & PPO		34%	37%	-3%	
Indigent (Charity Care)		0.3%	0%	0.2%	
All Other		2%	2%	-1%	
Total		100%	100%		

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending July 31, 2018

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	12,994,808	5,672,114	7,322,694
Short-Term Investments	15,199,220	15,859,495	(660,275)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	59,534,213	58,366,562	1,167,651
Less: Allowances	(46,667,708)	(46,172,939)	(494,770)
Other Receivables	979,850	4,424,796	(3,444,946)
Inventories	4,287,200	4,312,454	(25,254)
Prepaid Expenses	2,009,683	1,999,722	9,961
Total Current Assets	**49,431,294**	**45,556,234**	**3,875,060**
Internally Designated for Capital Acquisitions	0	0	-
Special Purpose Assets	100,084	100,084	-
	-	-	
Limited Use Asset; Defined Contribution Pension	1,628,154	1,541,073	87,081
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	26,117	14,391	11,726
Revenue Bonds Held by a Trustee	2,908,043	3,191,282	(283,240)
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**18,027,782**	**18,212,215**	**(184,433)**
Long Term Investments	1,100,000	1,600,000	(500,000)
Property & equipment, net of Accumulated Depreciation	76,555,107	76,789,746	(234,639)
Unamortized Bond Costs	-	-	-
Total Assets	**145,114,183**	**142,158,195**	**2,955,988**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending July 31, 2018

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,110,089	2,110,089	-
Accounts Payable	3,050,327	2,185,263	865,064
Accrued Salaries, Wages & Benefits	6,452,374	6,151,557	300,817
Accrued Interest and Sales Tax	317,577	641,372	(323,795)
Deferred Income	2,586,177	77,428	2,508,749
Due to 3rd Party Payors	1,163,149	1,163,149	-
Due to Specific Purpose Funds	(44)	-	(44)
Other Deferred Credits; Pension	4,530,000	4,521,207	8,793
Total Current Liabilities	**20,209,648**	**16,850,064**	**3,359,584**
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	530,102	534,494	(4,392)
Accreted Interest	12,304,228	12,193,679	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**85,161,809**	**85,055,652**	**106,157**
Net Assets			
Unrestricted Net Assets less Income	38,189,756	38,667,021	(477,265)
Temporarily Restricted	1,585,458	1,585,458	-
Net Income (Income Clearing)	(32,488)	(1,433,966)	1,401,478
Total Net Assets	**39,742,726**	**40,252,479**	**(477,265)**
Total Liabilities and Net Assets	**145,114,183**	**142,158,195**	**2,988,476**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Fiscal Year Ending June 30, 2019

Year to date for the month ending July 31, 2018

	-50	or	-15.5%	more IP days than in the prior fiscal year
$	(617,563)	or	-15.1%	over budget in Total IP Revenue and
$	443,895	or	4.9%	over budget in OP Revenue resulting in
$	(173,668)	or	-1.3%	over budget in gross patient revenue &
$	(354,264)	or	-4.5%	over budget in net patient revenue

Year-to-date Net Revenue was			$	7,596,641
Total Operating Expenses were:			$	7,370,132
				for the fiscal Year To Date
$	123,346	or	1.7%	over budget. Salaries and Wages were
$	(226,023)	or	-9.2%	under budget and Employee Benefits
$	34,106	or	2.0%	over budget
			79%	Employee Benefits as Percentage of Wages

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

$	118,051	or	12.6%	Professional Fees are over budget due to contract labor budgeted as employees
$	185,993	or	43.6%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending
$	(43,267)	or	-17.3%	Bad Debts are over budget due to higher volume of Outpatient services provided

Other Information:

$	529,832			Operating Income, less
$	(497,343)			loss in non-operating activities resulted in a Net
$	32,488	or	$ (122,318)	over budget.
			41.71%	Actual Contractual Percentages for Year versus
			39.79%	Budgeted Contractual Percentages including
$	(38)	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		

Non-Operating activities included:

$	(455,245)	loss	$ (49,115)	unfavorable to budget in Medical Office Activities
$	-		$ -	favorable to budget in Grants and Other Contributions

Northern Inyo Healthcare District

Preliminary Financial Indicators as of July 31, 2018

	Target	Jul-18	Jun-18	May-18	Apr-18	Mar-18	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17
Current Ratio	>1.5-2.0	2.45	2.70	2.44	2.46	2.43	2.47	2.50	2.41	2.18	2.26	2.45	2.42
Quick Ratio	>1.33-1.5	2.09	2.07	1.63	1.63	1.66	2.06	2.09	1.99	1.83	1.84	1.82	1.81
Days Cash on Hand prior method	>75	185.76	147.15	134.64	132.72	137.59	168.44	166.36	165.72	169.35	165.31	140.47	142.06
Days Cash on Hand Short Term	>75	118.59	86.06	61.83	57.21	51.38	83.49	81.30	83.05	87.18	81.28	53.95	59.26
Debt Service Coverage	>1.5-2.0	0.18	2.56	2.47	2.49	2.52	2.68	2.73	2.67	2.74	2.78	2.79	2.87
Operating Margin		6.67	5.29	5.57	5.50	5.18	5.09	4.87	5.79	5.87	7.64	7.49	8.45
Outpatient Revenue % of Total		73.43	69.96	70.10	69.97	69.49	69.74	69.53	69.25	69.52	69.46	69.13	69.83
Cash flow (CF) margin (EBIDA to revenue)		1.64	2.87	3.33	3.43	3.53	4.17	4.31	4.05	4.30	4.69	4.82	5.62
Days in Patient Accounts Receivable	<60 Days	73.10	75.40	75.40	79.80	81.50	85.60	85.90	82.80	81.80	81.40	82.10	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

Investments as of July 31, 2018

Purchase Date	Maturity Date	Institution	Broker	Rate		Principal Invested
30-Jul-18	1-Aug-18	Local Agency Investment Fund	Northern Inyo Hospital	1.94%		21,372,220.23
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	Goldman SachsBank USA NY C	Financial Northeaster Cor	2.05%		250,000.00
2-Jul-14	2-Jul-19	Barclays Bank	Financial Northeaster Cor	2.05%		250,000.00
			Short Term Investments			22,272,220.23
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		$	23,372,220.23
31-Jul-18	1-Aug-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.94%	$	1,628,153.51
			LAIF PENSION INVESTMENTS		$	1,628,153.51

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending July 31, 2018

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,670	$ 1,098,670	-
Total Board Designated Funds:	**$ 1,098,670**	**$ 1,098,670**	**$ -**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 834,044	$ 834,044	$ -
Nursing Scholarship Savings Account	$ 30,448	$ 30,448	$ -
Joint NIHD/Physician Group Savings Account	$ 100,066	$ 100,066	$ -
Total Specific Purpose Funds:	**$ 964,558**	**$ 964,558**	**$ -**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,063,228**	**$ 2,063,228**	**$ -**

POLICIES TO THE BOD
ENVIRONMENTAL

POLICY & PROCEDURES TO THE BOARD **SEPT. 2018**

ENVIRONMENTAL

TITLE	TO BOD	APPROVED
Electronic Communication (Email) Acceptable Use Policy	9/19/2018	
Emergency: Internal/External Disaster Plan	9/19/2018	
Environmental Disinfectant - Cleaning Solution	9/19/2018	
Environmental Services Cleaning Policy	9/19/2018	
Environmental Services Key Sets: All Areas	9/19/2018	
Environmental Services Key Sets: All Areas	9/19/2018	
Environmental Services Performance Improvement Plan	9/19/2018	
Environmental Services Quality Assurance Program	9/19/2018	
Equipment and Supplies: Care and Use of Daily Cleaning Supplies and Equipment	9/19/2018	
Equipment and Supplies: Care and Use of Equipment: General Guidelines	9/19/2018	
Equipment and Supplies: Care and Use of Floor Care Equipment	9/19/2018	
Equipment and Supplies: Care and Use of Upholstery Cleaning Equipment	9/19/2018	
Equipment and Supplies: Preventive Maintenance Program	9/19/2018	
Equipment and Supplies: Storage of Environmental Services Supplies and Equipment	9/19/2018	
General Administrative: Personnel Policies: Absenteeism and Lateness	9/19/2018	
General Administrative: Personnel Policies: Code of Ethics	9/19/2018	
General Administrative: Personnel Policies: Continuing Education	9/19/2018	
General Administrative: Personnel Policies: Dress Code	9/19/2018	
General Administrative: Personnel Policies: Environmental Services Organizational Chart	9/19/2018	
General Administrative: Personnel Policies: Functions of Environmental Services	9/19/2018	

EOC - Appropriate Environment/Roles and Responsibilities

Title
Maintaining Temperature & Humidity in Anesthetizing Locations EC.02.06.01EP13
Providing a Safe Environment EC.02.06.01EP1-26
Roles and Responsibilities – Competency EC.03.01.01EP2

EOC – Analyze and Develop/Monitoring and Collection

Title
MONITORING CONDITIONS EC.04.01.03EP3
Performance Improvement Activity EC.04.01.03EP3
Safety Committee EC.04.01.03EP1-2

EOC – Managing Risk

Title
Fire Safety Management Plan
Hazardous Materials & Waste Management Plan
Medical Equipment Management Plan
Safety Management Plan
Security Management Plan
Utility Systems Management Plan

CALL TO ORDER	The meeting was called to order at 12:04 pm by M.C. Hubbard, Vice President, in the Northern Inyo Healthcare District (NIHD) Board Room at 2957 Birch Street, Bishop, California.
PRESENT	M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Robert Sharp, Member at Large Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Sandy Blumberg, Executive Assistant
ABSENT	John Tremble, Chief Financial Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Allison Robinson MD, Chief of Staff
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hubbard announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.
AD HOC COMMITTEE RECOMMENDATION TO FILL DISTRICT ZONE 1 BOARD VACANCY, AND SWEARING IN OF BOARD MEMBER	On behalf of the Ad Hoc Committee formed for the purpose of selecting a candidate to fill the District Zone 1 Board of Directors vacancy of John Ungersma MD, Jean Turner was pleased to announce that the Committee recommends Mr. Peter Tracy to fill that vacancy. It was moved by Ms. Turner, seconded by Mary Mae Kilpatrick, and unanimously passed to approve appointing Mr. Peter Tracy to represent Northern Inyo Healthcare District Zone 1, with a term to expire in November of 2020. Mr. Tracy was then sworn into office.
ELECTION OF OFFICERS FOR THE REMAINDER OF THE 2018 CALENDAR YEAR	Ms. Hubbard additionally called attention to the need to appoint Board officers for the remainder of the 2018 calendar year, and made a motion that the following slate of officers be approved: - President: M.C. Hubbard - Vice President: Mary Mae Kilpatrick - Secretary: Jean Turner - Treasurer: Robert Sharp - Member At Large: Peter Tracy The motion was seconded by Ms. Kilpatrick and it was unanimously passed to approve slate of officers for the remainder of the 2018 calendar year as presented.
ADJOURNMENT	The meeting was adjourned at 12:14 pm.

_____
M.C. Hubbard, Vice President

Attest: _____
Mary Mae Kilpatrick, 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: September 4, 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. *Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners* – modification to referral agreement.
    2. *Employee Health Access of Patient Personal Medical Record*
    3. *Intravenous Medication Policy*
    4. *QuickVue Influenza A+B Test*

B. Medical Staff Appointments/Privileges (*action items*)
    1. Raul Easton-Carr, MD (*emergency medicine*) – temporary/locum tenens
    2. Farres Ahmed, MD (*diagnostic radiology*) – provisional consulting

C. 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 Adventist Health's credentialing and privileging decisions.

    1. Elizabeth Maslow, MD (*infectious disease, Adventist Health*)

D. Extension of temporary privileges (*action item*)
    1. Akash Rusia, MD (*internal medicine*) – extension of hospitalist privileges through January 31, 2019.

E. Medical Staff Resignations (*action items*)
    1. Gregory Taylor, MD (*emergency medicine*) – effective August 24, 2018
    2. Richard Ganchan, MD (*telecardiology*) – effective August 1, 2018

F. Core Privilege Forms (*action items*)
    1. Occupational Medicine (new)
    2. Internal Medicine (revised)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners	
Scope: Referring Practitioners	Manual: Medical Staff, Infusion Center
Source: Medical Staff Support Manager	Effective Date: 07/18/18

PURPOSE:
To establish a process for non-privileged practitioners to order outpatient infusion services at Northern Inyo Healthcare District (NIHD) that is in compliance with federal and state regulations.

POLICY:

A. Non-privileged referring practitioners (i.e., a practitioner who has not been credentialed or privileged by NIHD), may order outpatient infusion services at NIHD if:
    1. The practitioner is licensed, in good standing, in California;
    2. The practitioner is acting within his or her scope of practice;
    3. The practitioner is responsible for the care of the patient;
    4. The practitioner is not currently excluded from participation in Medicare, Medicaid or other state or federal health care programs.

B. Ordering practitioners will be required to remain responsible for the care of referred patients and must agree to provide necessary consultation as first call.

C. Ordering practitioners will be required to submit a signed attestation indicating their agreement to comply with this policy.

D. If questions or concerns regarding the order cannot be addressed with the ordering practitioner (should the practitioner be unreachable), the patient's case will be reviewed by the Medical Director of the Outpatient Infusion Center. If a change in management is deemed appropriate, orders will be changed and the ordering practitioner will be notified.

E. If the Medical Director of the Outpatient Infusion Center cannot be reached, the Outpatient Infusion staff may initiate the following escalating contact protocol:
    1. Primary care provider, or;
    2. Hospitalist on-call, or lastly;
    3. Emergency room physician.

F. Outpatient infusion therapy services will be provided in accordance with policies and protocols approved by the Medical Executive Committee and Board of Directors.

G. Quality evaluation and reviews of the Outpatient Infusion Center will be provided by a physician member of the Medicine and Intensive Care service.

PROCEDURE:

A. At the receipt of an outpatient infusion order from a non-privileged practitioner who is not currently on the approved referring practitioner roster, the Outpatient Infusion staff will send the attached attestation to the ordering practitioner for completion.

Title: Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners	
Scope: Referring Practitioners	Manual: Medical Staff, Infusion Center
Source: Medical Staff Support Manager	Effective Date: 07/18/18

B. If the patient's primary care provider is an NIHD privileged practitioner, an effort should be made to send a copy of the order to the primary care provider (with patient consent).
C. Once the attestation has been returned, the outpatient infusion staff is responsible for ensuring the practitioner's information is verified as outlined below:

1. *The practitioner is licensed in California* – online verification of California licensure (including active/inactive status and disciplinary action) can be found on the public Medical Board of California website, or by going to: www.mbc.ca.gov/Breeze/License_Verification.aspx

2. *The practitioner is not currently excluded from participation in Medicare, Medicaid or other state or federal health care programs* – the Office of the Inspector General (OIG) maintains a list of excluded entities and individuals, which can be found online by visiting the OIG website and querying the exclusion database, or by following this link: https://exclusions.oig.hhs.gov/. Medi-Cal maintains a suspended and ineligible provider list in a downloadable format on this website: https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

D. During normal business hours, the Outpatient Infusion Center staff may coordinate with Medical Staff Office staff to complete the verification of ordering practitioners. A copy of the signed attestation will be sent to the Medical Staff Office.

E. A list of currently verified non-privileged practitioners will be maintained by the Medical Staff Office and will be available to the Outpatient Infusion Center staff. Verifications should be repeated every two years at minimum.

REFERENCES:

1. Centers for Medicare and Medicaid Services Conditions of Participation §482.54
2. Matzka, Kathy. (2006). *The Compliance Guide to the JCAHO Medical Staff Standards.* HCPro, Inc.; 5th edition. Print.
3. Providence Sacred Heart Medical Center and Children's Hospital. (2016). "Non-Staff Practitioners Ordering Outpatient Tests and Treatments." Retrieved from: http://washington.providence.org/~/media/files/providence/hospitals/wa/phc/policies/orderingoutpatienttests_nonstaffpractitioners.pdf/

Approval	**Date**
Medical Executive Committee	7/9/18
Board of Directors	7/18/18
Last Board of Directors Review	7/18/18

Developed: 06/2018 dp
Reviewed:
Revised: 07/2018 nh
Supersedes: N/A
Index Listings: referring practitioner orders, non-staff orders

Outpatient Nursing
Fax: (760) 873-2151
Phone: (760) 873-2845 or (760) 873-2837

Northern Inyo Healthcare District (NIHD) Outpatient Infusion Center Therapy ~~Attestation Form~~ Referral Agreement for Non-Staff Ordering Practitioners

This ~~attestation~~ referral agreement must be completed by Ordering Practitioners who are not members of the NIHD Medical Staff or Allied Health Professional Staff in accordance with the *Outpatient Infusion Ordering by Non-Staff Referring Practitioners* policy.

By signing this order form, the Ordering Practitioner enters into a documented arrangement with NIHD and attests that he/she:

1. Holds a current, unrestricted California license;
2. Is acting within the scope of his/her license;
3. In conjunction with NIHD, is responsible for the care of the patients referred to the Outpatient Infusion center; ~~identified on the order form;~~ will be reachable through the phone number identified below; and will provide consultation and documentation as requested by the NIHD Infusion Center;
4. Agrees that failure to provide information or care as requested by Infusion Center staff will terminate this order and disqualify Practitioner from submitting further orders;
5. Will provide any documentation requested by the Infusion Center (e.g., history and physical, authorization for treatment ordered);
6. Has not been excluded from participation in Medicare, Medi-Cal or any other Federal or State health care program.

Failure to comply with the requirements listed may result in the Ordering Practitioner's inability to continue referrals to the NIHD Infusion Center.

_____ _____ _____
CA Licensure Primary Phone Secondary Phone

_____
Office/Practice Name and Address

_____
Name of Ordering Practitioner Signature Date

NIHD Office Use Only:

Verification of ~~Licensure~~ Agreement Completed By: _____ *Date:* _____

Please send a copy of this form to the Medical Staff Office

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Employee Health Access of Patient Personal Medical Record	
Scope: NIHD	Manual: Employee Health
Source: Quality Nurse/Infection Control Preventionist Manager	Effective Date:

PURPOSE:
To ensure that Northern Inyo Healthcare District is compliant with state and federal laws regarding separation of Employee Health records and patient medical records.

POLICY:
Workforce in the Employee Health role shall not access patients' personal medical records.

DEFINTION:
Personal medical record: Individually identifiable health information provided to, or obtained by, NIHD in its role as a health care provider, including, but not limited to, documentation of personal healthcare, routine preventive care, acute illness care, and care of chronic disease.

Employee health record: Health information provided to, or obtained by, NIHD in its role as an employer.

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

PROCEDURE:
1. Results for tests ordered by the Employee Health Department shall be provided to the Employee Health Department.
2. Employees who desire to provide specific documents from their medical record to the Employee Health Department shall complete and sign a Release of Information Authorization and present it to the Health Information Management (HIM)/Medical Records department. HIM shall provide the documents according to policy.
3. Employees who desire to obtain copies of employee health record information (such as vaccinations) shall complete and sign a Release of Information form authorizing the Employee Health Department to provide a copy of the information to the employee. Employee health shall provide the documentation as requested.

PROCESS: To provide the steps of the procedure for guidance to workforce in the Employee Health role

1. The Employee Health Nurse fills out the Employee Health Order Sheet.
2. The employee takes the order sheet to admissions.
3. Admissions registers the employee and places a face sheet in the Employee Health file (located in Admissions).
4. Lab and CXR results are set up to print out automatically through Employee Health's fax/email. If automatic printing is not available, then follow step #5.

Title: Employee Health Access of Patient Personal Medical Record	
Scope: NIHD	Manual: Employee Health
Source: Quality Nurse/Infection Control Preventionist Manager	Effective Date:

5. Using **ONLY** the visit ID/Acct # on the face sheet, obtain the labs, and/or CXR, for that employee through Paragon or One Content. Do not use the employee's name to locate the results, use only the visit ID/Acct #.

   NOTE: Any information found in the employee's **patient** file cannot be accessed without the employee's permission. If any other information is needed, and that information is located in the employee's **patient** file, then the employee needs to fill out an "Authorization to disclose health information" form. The form is then taken to Medical Records to obtain the needed documents.

REFERENCES:

1. California Hospital Association. (2017). Employee Health information, Chapter 9 Compliance Privacy Health Information Manual 8th ed. Sacramento CA: California Hospital Association.
2. Occupational Safety and Health Administration (OSHA). (n.d.). Clinicians. Retrieved from https://www.osha.gov/dts/oom/clinicians/index.html

CROSS REFERENCE P&P:

1. Post offer Physical Examination and Annual Health Screening
2. Scope of Service Employee Health
3. Responsibility and Process for Releasing Personal Health Information
4. Medical Records Release of Information
5. Release of Medical Information to Physicians and Other Health Care Provider Without Patient Authorization

Approval	**Date**
CCOC	
Infection Control Committee	8/28/18
MEC	9/4/18
Board of Directors	
Last Board of Directors Review	

Developed: 8/2018 RC
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Intravenous Medication Policy**	
Scope: Northern Inyo Hospital	Department: CPM – Medication (MED)
Source: Interim Director of Pharmacy	Effective Date:

PURPOSE:
To ensure the safe administration of intravenous (IV) medications at Northern Inyo Hospital and provide guidance for medication categories in defined areas with specific levels of care.

POLICY:
This policy is applicable to all areas of Northern Inyo Hospital where IV medications are given.

1. Code Blue Protocol is not limited by this list.
   Rationale: Certain drugs are not included on this list because of their potential for initiating a life-threatening emergency and/or of the amount of time required for monitoring. The Pharmacy & Therapeutics Committee will be responsible for approving additional medications to the attached list. The P&T Chairperson is authorized to approve exceptions that need immediate attention. Exceptions will be for a single patient only and should be referred to the P&T Committee for review and possible addition to the approved list of IV Medications.

Definitions:

IVP = Intravenous Push
IVPB = Intravenous Piggy Back is OK to give as an infusion
ICU = Intensive Care Unit
ED = Emergency Department
PACU = Post-anesthesia Care Unit

- If the High Risk Maternity/OB Labor & Delivery cell is blank, please follow the same rules specified for the Med-Surg/OB/Outpatient Clinics column.

PROCEDURE:

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Acetaminophen IV (Ofirmev	IVPB	IVPB	IVPB	
Acetazolamide [Diamox]	IVP, IVPB	IVP, IVPB	IVP, IVPB	Slow IVP 100 mg/mL at 100 mg/min. IVPB (250 to 500 mg) [50 mL] over 15 to 30 min
Acetylcysteine IV [Acetadote]	IVPB	IVPB	IVPB	
Acyclovir [Zovirax]	IVPB	IVPB	IVPB	Dilute to 7mg/mL or lower. Infuse ≥ 60 min.
Adenosine [Adenocard]	IVP	IVP	NO	Rapid IV Push over 30 sec. **Cardiac Monitoring Required**
Albumin	IVPB	IVPB	IVPB	Infuse <2-4 mL/min; 25% infuse <1 mL/min; no filter necessary
Alteplase [TPA]	IVPB	Cathflow only	Cathflow only	Dwell time for Cathflow is 20 minutes minimum
Amikacin [Amikin]	INH, IM, IVPB	INH, IM, IVPB	INH, IM, IVPB	
Aminocaproic Acid [Amicar]	IVPB	IVPB	IVPB	No faster than 1.25 g/hr Max 20 gm/24 hrs.
Aminophylline [Norphyl]	IVPB, IV PUMP	IVPB, IV PUMP	IVPB, IV PUMP	Give loading dose by IVPB whenever possible – if necessary may give 200 mg or less IV by slow push. No faster than 20 mg/min IV Push.
Amiodarone [Cordarone]	IVPB	NO	NO	OK to give if pt is at risk for extravasation. Cardiac Monitoring Required.
Ampicillin	IVPB	IVPB	IVPB	
Ampicillin/Sulbactam [Unasyn]	IVPB	IVPB	IVPB	
Argatroban	IVPB	IVPB	IVPB	Reserved for HIT
Atenolol [Tenormin]	IVP~~, IV PUMP~~	IVP~~, IV PUMP~~	IVP~~, IV PUMP~~	Slow Push, no faster than 1 mg/min. Cardiac Monitoring Required.

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Atropine [AtroPen]	IVP	IVP	IVP	Usual adult dose in CPR: 0.5 mg to 1 mg, repeated if needed. Usual total max. dose = 0.04 mg/kg (3mg)
Azithromycin [Zithromax]	IVPB	IVPB	IVPB	Dilute each 500 mg in 250 to 500 mL D5W or NS Infuse over ≥ 60 min
Betamethasone	IVP	IVP	IVP, IM	
Bumetanide [Bumex]	IV, IVPB	IVP, IVPB	IVP, IVPB	Give over 1 to 2 min IV Push
Calcium Chloride	IVPB	IVP	IVPB	~~Dilute~~Dilute in 50 mL D5W or NS and infuse no faster than over 15 to 30 min. OK if pt. has extravasation risk
Calcium Gluconate	IVPB	IVPB	IVPB	Infuse over 15 to 30 min. OK to give if pt has extravasation risk
Cefazolin	IVPB, IVP	IVPB, IVP	IVPB, IVP	
Cefepime	IVPB, IVP	IVPB, IVP	IVPB, IVP	
Cefotaxime	IVPB, IVP	IVPB, IVP	IVPB, IVP	
Cefoxitin	IVPB, IVP	IVPB, IVP	IVPB, IVP	
Ceftazidime	IVPB, IVP	IVPB, IVP	IVPB, IVP	
Ceftriaxone	IVPB, IVP, IM	IVPB, IVP, IM	IVPB, IVP, IM	Use PF 1%Lidocaine for reconstituting IM
Ciprofloxacin [Cipro]	IVPB	IVPB	IVPB	Flush line with NS before and after if using a heparin lock – will precipitate with heparin
Clindamycin	IVPB	IVPB	IVPB	
Conjugated Estrogen	IVP	IVP	IVP	Dissolve in 5 mL of packaged diluents. Avoid vigorous shaking
Cosyntropin [Cortrosyn]	IVP	IVP	IVP	IVP over 2 minutes
CroFab	IVPB	NO	NO	Reconstitute each vial with NS Only. Do not shake.
Daptomycin	IVPB	IVPB	IVPB	Reconstitute ONLY with NS
Desmopressin	IVP, IM	IVP, IM	IVP, IM	

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Dexamethasone	IVP, IVPB	IVP, IVPB	IVP, IVPB	
Dexmedetomidine [Precedex]	IVPB	~~IVPB~~NO	NO	
Diazepam	IVP	IVP	IVP	
Digoxin	IVP	IVP	NO	**Cardiac Monitoring Required**
Diltiazem	IVP, IVPB	IVPx3~~, IVPB~~	NO	~~Cardiace~~Cardiac Monitoring Required.
Diphenhydramine	IVP	IVP	IVP, IVPB	
Doxycycline	IVPB	IVPB	IVPB	stable for 48 hours if refrigerated & protected from sunlight/artificial light
Dobutamine	IVPB	~~IVPB~~NO	~~IVPB~~NO	**Cardiac Monitoring Required**
Dopamine	IVPB	NO	NO	**Cardiac Monitoring Required**
D50W	IVP	IVP	IVP	
Edrophonium Chloride [Enlon]	IVP, IM	IVP, IM	NO	
Enalaprilat	IVP	IVP	IVP	**Cardiac Monitoring Required**
Epinephrine [Adrenalin]	IVP, IVPB, SQ, IM	IVP, SQ, IM	IVP, SQ, IM	
Ertapenem	IVPB	IVPB	IVPB	
Erythromycin	IVPB	IVPB	IVPB	
Esmolol	IVP, IVPB	IVP~~, IVPB~~	NO	**Cardiac Monitoring Required**
Famotidine	IVP, IVPB	IVPB	IVPB	
Furosemide	IVP, IVPB	IVP~~, IVPB~~	IVP, IVPB	≤ 4~~6~~0 mg IVP over 2 to 5 minutes > 4~~6~~0 mg IVPB with max rate 4mg/min Continuous infusions of Furosemide must be done in the ICU
Flumazenil	IVP	IVP	IVP	
Fluconazole	IVPB	IVPB	IVPB	
Fomepizole	IVPB	IVPB	NO	All doses infused ≥ 30 minutes in at least 100 ml NS or D5W

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Fosaprepitant [Emend]	~~NO~~IVPB	~~NO~~IVPB	IVPB	
Fosphenytoin	IVP, IVPB	IVP, IVPB	NO	
Gentamicin	IVPB	IVPB	IVPB	
Glucagon	IVP	IVP	NO	
Glycopyrrolate	IM, IVP	IM, IVP	~~PO,~~ IM, IVP	Contains benzyl alcohol
Granisetron	IVP, IVPB	IVP, IVPB	IVP, IVPB	
Haloperidol decanoate	IM	IM	IM	Do Not administer Haloperidol decanoate IV.
Haloperidol lactate	IM	IM	IM	Do not administer haloperidol lactate IV. Consider Cardiac Monitoring
Heparin	IVP, IVPB, SQ	IVP, IVPB, SQ	IVP, SQ	
Hydralazine [Apresoline]	IVP	IVP	IVP	
Hydroxyzine [Atarax]	IM	IM	IM	NO IVP
Hydrocortisone [Solucortef]	IVP, IVPB	IVP, IVPB	IVP, IVPB	≤250 mg give IVP >250 mg give IVPB 500 mg max, IVPB infuse over 1 hour
Insulin Regular	IVPB, IVP, SQ	IVP, SQ	IVP, SQ	
Iron Dextran	IVP-test dose, IVPB	IVP-test dose, IVPB	IVP-test dose, IVPB	
Iron Sucrose	IVPB	IVPB	IVPB	
Imipenem/Cilastatin	IVPB	IVPB	IVPB	
Labetalol	IVP, IVPB~~BP~~	IVP~~, IVPB~~	IVP only	Consider cardiac monitoring
Levetiracetam [Keppra]	IVPB	IVPB	IVPB	
Levothyroxine	IVP, IM	IVP, IM	IVP, IM	
Levofloxacin	IVPB	IVPB	IVPB	
Lidocaine/D5W	IVPB	~~IVPB~~NO	NO	**Cardiac Monitoring Required**
Linezolid	IVPB	IVPB	IVPB	
Lorazepam	IVP	IVP	IVP	
Magnesium Sulfate	IVPB, IM	IVPB, IM	IVPB, IM	

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Mannitol	IVP, IV~~B~~PB	IVP~~, IVBP~~	NO	
Meropenem	IVPB	IVPB	IVPB	
Methylergonovine	IVP	NO	IVP – OB ONLY	
Methylprednisolone	IVP, IVPB	IVP, IVPB	IVP, IVPB	
Methylene Blue	IVP, IVPB	NO	NO	Primary use diagnostic imaging
Metoclopramide	IVP	IVP	IVP	
Metoprolol	IVP~~, IVPB~~	IVPx3~~, IVPB~~	IVP	**Cardiac Monitoring Required**
Metronidazole	IVPB	IVPB	IVPB	
Micafungin [Mycamine]	IVPB	IVPB	IVPB	
Midazolam	IVP, IVPB	IVP~~, IVPB~~	IVP~~, IVPB~~	
Moxifloxacin	IVPB	IVPB	IVPB	
Neostigmine	IVP	IVP	NO	**Cardiac Monitoring Required**
Nesiritide [Natrecor]	IVPB	~~IVPB~~NO	NO	IV Bolus dose pulled from infusion bag. Max bolus rate (2 mcg/kg) followed by 0.01 mcg/kg/min. LD may not be appropriate if SBP <110 or if patient recently treated with after load reducer. **Cardiac Monitoring Required**.
Nicardipine	IVPB	NO~~IVPB~~	NO	**Cardiac Monitoring Required**
Nitroglycerin	IVPB	~~IV~~NO~~PB~~	IVPB	Use NTG tubing, do not mix with other medication. **Cardiac Monitoring Required**
Nitroprusside	IVPB	~~IVPB~~NO	IVPB	**Cardiac Monitoring Required**
Norepinephrine	IVP, IVPB	~~IVP, IVPB~~NO	NO	**Cardiac Monitoring Required**
Naloxone	IVP, IVPB, IM, ~~SQ~~	~~YES~~IVP, IM	IVP, IM~~YES~~	
Naficillin	IVPB	IVPB	IVPB	
Octreotide	IVPB	IVPB	IVPB	

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Olanzapine	IM	IM	IM	Reconstitute with SW only. IM Only, Do not combine in a syringe with haloperidol, lorazepam, or diazepam
Palonosetron HCl [Aloxi]	IVP, IVPB	IVP, IVPB	IVP, IVPB	
Penicillin G potassium	IVPB	IVPB	IVPB	
Phenylephrine	IVPB	NO~~IVPB~~	NO	**Cardiac Monitoring Required**
Phenytoin	IVPB, IVP	IVPB, IVP	IVPB, IVP	DO NOT EXCEED 50 MG/MIN. Patients with pre-existing CV conditions and elderly use: 20 mg/min. Doses above 100 mg should be given as IVPB. Use 0.22 micron in-line filter for IVPB **Cardiac Monitoring Required**
Piperacillin/tazobactam [Zosyn]	IVPB	IVPB	IVPB	
Pitocin [Oxytocin]	IVP, IVPB	IVP, IVPB	IVP, IVPB	
Potassium Chloride	IVPB	IVPB	IVPB	**Cardiac Monitoring Required if <20 mEq/hr**
Potassium Phosphate	IVPB	IVPB	IVPB	
Procainamide HCl	IM, IV	IV, IM	NO	**Cardiac Monitoring Required**
Prochlorperazine	IM, IVP	IM, IVP	IM, IVP	
Promethazine	IM, IVPB	IM~~, IVP~~ IVPB	IM, IVPB	
Propofol	IVP, IVPB	IVP~~, IVPB~~	NO	IVP to be administered by MD or CRNA only **Cardiac Monitoring Required**
Propranolol	IVP	IVP	NO	**Cardiac Monitoring Required**
Prothrombin Complex Concentrate [KCentra]	IVPB	IVPB	NO	
Rifampin	IVPB	IVPB	IVPB	
Sodium Bicarbonate	IVPB	IVPB	NO	
Tenecteplase [TNK]	IVP	NO~~IVP~~	~~YES~~NO	IV Push bolus over 5 sec.
~~Terbutaline~~	~~IVP~~	~~NO~~	~~IVP~~	

Medication Generic [Brand] Misc.	ICU ED PACU	TELEMETRY Or Med/Surg	OB/Out-Patient Infusion Center	Comments
Thiamine	IVP, IVPB	IVP, IVPB	IVP, IVPB	Doses greater than 100mg to be given IVPB
Tobramycin	IVPB	IVPB	IVPB	
Tranexamic Acid	IVPB~~, INFIL/TOP~~	IVPB	IVPB~~YES~~	
Trimethoprim-sulfamethoxazole [Bactrim, Septra]	IVPB	IVPB	IVPB	Dilute each 5 mL in 75 to 150 mL D5W Prepare immediately prior to administration Check carefully for precipitation Do not refrigerate Infuse over 60 to 90 minutes
Verapamil	IVP	IVPx3	NO	Do not exceed 10 mg/2 min. **Cardiac Monitoring Required**
Vasopressin	IVPB	~~IVPB~~NO	NO	Dilute in NS or D5W . **Cardiac Monitoring Required**
Valproate sodium	IVPB	IVPB	IVPB	Administer IV as a 60 minute infusion (not more than 20 mg/min). Compatible in D5W, NS, or Lactated Ringers
Vancomycin	IVPB~~, PO~~	IVPB~~, PO~~	IVPB~~, PO~~	

REFERENCES:

1. Sutter Medical Center Sacramento IV Drug Administration Policy. Accessed 2018
2. University of California Medical Center IV Drug Administration Policy. Accessed 2018.
3. Highland Hospital IV Drug Administration Policy. Accessed 2018.
4. Lexicomp Drug Database. Accessed 2/2018.
5. Clinical Pharmacology Drug Database. Accessed 2/2018

Approval	Date
Pharmacy & Therapeutics Committee Review	8/16/18
CCOC	

Medical Executive Committee	9/4/18
Board of Directors	
Last Board of Directors Review	

Developed: B. Franosch and N. Vu 7.6.18
Reviewed:
Revised: P&T Committee 8/16/18
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: QuickVue Influenza A+B Test	
Scope: Outpatient Clinics	Manual: Lab- Point of Care
Source: Lab Coordinator	Effective Date:

I. INTENDED USE

The QuickVue Influenza A+B test is intended for the rapid, qualitative detection of influenza type A and type B antigens directly in nasal swab and nasopharyngeal swab specimens from symptomatic patients. The test is to be used as an aid in the rapid differential diagnosis of acute influenza type A and type B viral infection.

II. PRINCIPLE

The QuickVue Influenza A+B test is a lateral-flow immunoassay. It involves the extraction of influenza A and B viral antigens and uses highly sensitive monoclonal antibodies for detection that are specific for influenza antigens. The test is specific to influenza types A and B antigens with no known cross-reactivity to normal flora or other known respiratory pathogens.

III. MATERIALS, EQUIPMENT AND REAGENTS

- Individually packaged test strips
- Reagent solution
- Reagent tubes
- Disposable pipettes
- Sterile nasal swabs
- Positive control material (type A and type B swab)
- Negative control material
- Gloves (not provided in kit)
- Timer (not provided in kit)

IV. KIT STORAGE AND SPECIMEN STABILITY

A. Kits should be kept at room temperature (15-30°C) out of direct sunlight. Kits are stable until the expiration date printed on the outer box carton.

B. Specimen should be **tested as soon as possible** after collection. Storage of sample in a clean, dry and closed container is possible for 8 hours between 2-25°C.

Note: QuickVue Influenza A+B test performance testing swab samples diluted in transport media has NOT been evaluated and established in clinical studies.

V. SPECIMEN COLLECTION

A. Nasal Swab Sample

For optimal test performance with nasal swab specimen, **use the swabs supplied** in the kit.
It is important to obtain as much secretion as possible.

1. Insert the sterile swab into the nostril that presents the most secretion under visual inspection.
2. Using gentle rotation, push the swab until resistance is met.
3. Rotate the swab a few times against the nasal wall.

B. Nasopharyngeal Swab Sample

It is important to obtain as much secretion as possible.

1. Carefully insert the sterile swab into the nostril that presents the most secretion under visual inspection.
2. Keep the swab near the septum floor of the nose while gently pushing the swab into the posterior nasopharynx.

3. Rotate the swab several times.

VI. PROCEDURE

A. Internal Quality Control (IQC)

1. QuickVue Influenza A+B test comes with built-in procedural control features. For each patient specimen or external quality control swab tested, both levels of IQC should be observed and documented. No result should be considered valid if any IQC level does not pass.
   a. **Build-in positive control**: The appearance of a blue control line is an internal control. The appearance of the control line indicates that sufficient capillary flow occurred and that the functional integrity of the test strip was maintained.
   b. **Build-in negative control:** A clear background is an internal background negative control. If no interfering substances are in the sample and the dipstick is working properly, the background in the result area should be white to light pink within 10 minutes and not interfere with the reading of the test result.

B. External Quality Control (EQC)

1. Positive and negative controls should be run once for each untrained operator, once for each new shipment of kits (or once per lot number, if multiple lots are received at one time) and monthly for the kit lot number in use to comply with regulatory requirements.
2. Follow the steps described in C.1. to C.10.

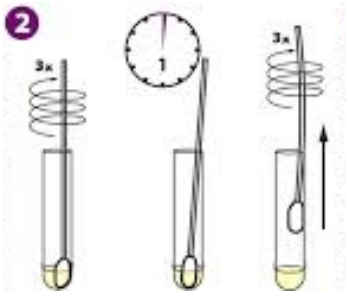
Note: External positive and negative control swabs are supplied in the kit and should be tested using the nasal/nasopharyngeal swab test procedure.

C. Assay Procedure

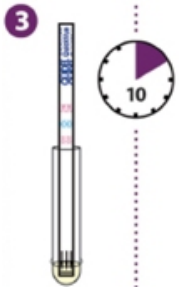
Gloves should be worn and standard precautions should be observed when handling patient specimens.

1. Dispense all of the reagent solution into the reagent tube.
2. Gently swirl the tube to dissolve its contents.

3. Place the patient swab with sample into the reagent tube.
4. Roll the swab at **least 3 times** while pressing the head against the bottom and side of the reagent tube.
5. Leave the swab in the reagent tube for **1 minute**.
6. Roll the swab head against the inside of the reagent tube as you remove it.
7. Dispose of the used swab into biohazard waste containers.

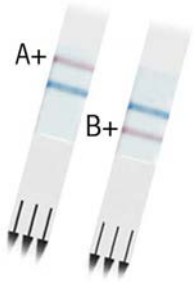


8. Remove the dipstick from the foil pouch.
9. Place the dipstick into the reagent tube with the arrows of the test strip pointing down.
Note: Do NOT handle or move the test strip until the test is complete and ready for reading.



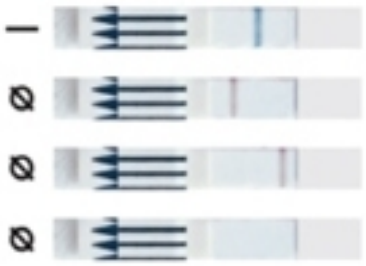
10. Read the result at **10 minutes**.
Note: Some positive results may appear sooner. Do NOT read result after 10 minutes.

D. Interpretation of Results
1. **Positive result**: Any shade of a pink to red test line, either above or below the blue control line, **AND** the appearance of a blue procedural control line indicates a positive result for the presence of influenza A and/or B viral antigen.
   a. If the red line is **ABOVE** the control line, the test results are positive for **type A**
   b. If the red line is **BELOW** the control line, the test results are positive for **type B**



2. **Negative result**: A blue procedural control line and no pink to red test line is a presumptive negative result.
Note: A negative result does NOT exclude influenza viral infection. Negative results should be confirmed by cell culture if clinically indicated.

Title: QuickVue Influenza A+B Test	
Scope: Outpatient Clinics	Manual: Lab- Point of Care
Source: Lab Coordinator	Effective Date:



3. **Invalid result**: The test result is invalid if a blue control line is NOT visible at 10 minutes. The test result is equally invalid if the background color does not clear and it interferes with the reading of the test. If either occurs, retest using a new sample and a new test strip.

NOTE: Co-infections with influenza A and B is rare. QuickVue Influenza A+B Test "dual positive" clinical specimens should be re-tested. Repeatable influenza A and B "dual positive" results should be confirmed by viral culture or an FDA-cleared influenza A and B molecular assay BEFORE reporting results.

VII. LIMITATIONS OF THE PROCEDURE

A. The contents of this kit are for use in the qualitative detection of influenza A and B antigen from nasal and nasopharyngeal swab specimens. Failure to follow the test procedure and interpretation of test results may adversely affect performance and/or produce invalid results.
B. Negative test results do not rule out possible other non-influenza viral infections.
C. Test results must always be evaluated with other data available to the provider. A negative test result might occur if the level of extracted antigen in a sample is below the sensitivity of the test or if a poor quality specimen is obtained. Additional follow-up testing using the culture method and/or molecular methods is recommended if the QuickVue test result is negative.
D. Positive test results do not rule out co-infections with other pathogens nor do they identify specific influenza A virus subtypes.
E. Children tend to shed virus more abundantly and for longer periods of time than adults. Therefore, testing specimens from adults will often yield lower sensitivities than testing specimens from children.
Note: Please refer to the package insert for a full list of test limitations

VIII. REFERENCES

1. QuickVue Influenza A+B package insert, 1350313EN00 (02/18)

Approval	**Date**
Medical Director of the Laboratory	7/12/18
CCOC	7/16/18
Medical Services/ICU Committee	7/26/18
Perinatal/Pediatrics Committee	8/17/18
Infection Control Committee	8/28/18
Medical Executive Committee	9/4/18
Board of Directors	

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: QuickVue Influenza A+B Test	
Scope: Outpatient Clinics	Manual: Lab- Point of Care
Source: Lab Coordinator	Effective Date:

Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:

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

Medical Staff Office
(760) 873-2136 voice
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TO: NIHD Medical Staff Executive Committee

FROM: Dianne Picken on behalf of Credentials Committee

DATE: August 27, 2018, 2018

RE: Credentials Committee Report

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

A. Medical Staff Appointment/Privileges and Introductory FPPEs (*action items*)

Name and Specialty	Category	Proposed FPPE Plan
Raul Easton-Carr, MD (*emergency medicine*)	Temporary/Locum Tenens	Minimum of 8 charts reviewed by Chief of ER Service or designee.
Farres Ahmed, MD (*diagnostic radiology*)	Provisional Consulting *Tahoe Carson Radiology Group*	Minimum of 8 charts reviewed by Chief of Radiology.

B. Telemedicine Staff Appointment/Privileges – credentialing by proxy (*action items*)

Name and Specialty	Distant Site	Category	Proposed FPPE Plan
Elizabeth Maslow, MD *(infectious disease)*	Adventist Health (Glendale)	Telemedicine staff	Minimum of first 2 charts reviewed by Adventist Health peer.

C. Extension of temporary privileges (*action item*)
1) Akash Rusia, MD (*internal medicine*) – extension of hospitalist privileges through January 31, 2019.

D. Completion of introductory FPPEs (*action items*)
1) Chivonne Harrigal, MD (*breast imaging*) – proctor: Stuart Souders, MD
2) Joy Engblade, MD (*internal medicine*) – EKG interpretation privileges – proctor: Asao Kamei, MD

E. Resignations (*action items*)
1) Gregory Taylor, MD (*emergency medicine*) – effective 8/24/18
2) Richard Ganchan, MD (*telecardiology*) – effective 8/1/18

F. Core Privilege Forms (*action items*)
1) Occupational Medicine (new)
2) Internal Medicine – revision

_____
Dianne Picken, Medical Staff Support Manager

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

OCCUPATIONAL MEDICINE

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 general preventive medicine/occupational medicine **OR** other accredited residency training program with three (3) years of current experience managing patients in occupational medicine services.
- Board Certified/Board Eligible in Preventive Medicine, Occupational and Environmental Medicine, Internal Medicine, or Family Medicine.

CORE PRIVILEGES
(must meet initial criteria)

Request	

☐	• Evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with occupational and environmental injuries and illnesses.
	• Evaluate, treat and manage individuals with potential and actual occupational or training-related exposure to blood-borne pathogens, other infectious pathogens, and chemical and physical hazards.
	• Physical examinations and evaluations (according to the Americans with Disabilities Act and all other appropriate state and federal guidelines), including:
	  o Pre-employment/pre-placement medical evaluations
	  o Fitness for duty
	  o Return to work evaluations
	  o Commercial driving medical exams (DOT Medical Examiner certification required)
	  o Independent Medical Evaluations (Workman's Compensation and Disability evaluations)
	• Periodic medical evaluations for surveillance of adverse health effects from hazardous exposures (asbestos, lead, ionizing radiation)
	• Interpretation of tests (spirometry, toxicologic, biological, audiometry, EKG)
	• Burn treatment, heat or chemical, for the eye/skin.
	• Soft tissue debridement of burns and wounds.
	• Wound repair/suturing of uncomplicated lacerations
	• Nail injury: removal and trephination
	• Anesthesia (local and digital block)
	• Foreign body removal (subcutaneous): ear, skin, and soft tissue
	• Initial stabilization and treatment of fracture or dislocation
	• Injection therapy (trigger point, shoulder)

SPECIAL PRIVILEGES
(require experience within last 2 years and recommendation by Chief of Medicine)

☐ Aviation medical exams (Aviation Medical Examiner certification required)	☐ Medical Review Officer – review, evaluation or interpretation of drug or alcohol testing (requires MRO certification by accredited organization)

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 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 Medicine/Intensive Care *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

INTERNAL MEDICINE

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

INITIAL CRITERIA

Education/Formal Training:

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

INPATIENT CORE PRIVILEGES

Current ACLS certification required

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

OUTPATIENT CORE PRIVILEGES

Request	
☐	• Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with general medical problems to the outpatient setting.

SPECIAL PRIVILEGES

(Requires experience within last 2 years and recommendation by Chief of Medicine)

- ☐ Anoscopy
- ☐ Arterial line placement
- ☐ Arterial puncture
- ☐ Arthocentesis - small joint
- ☐ Arthrocentesis - large joint
- ☐ Aspiration of intra-, subcutaneous cysts, furnucles, etc
- ☐ Bronchoscopy
- ☐ Buprenophine (Suboxone) – certification required
- ☐ Cancer chemotherapy (in consultation with oncologist per protocol)
- ☐ Central venous line placement
- ☐ Conscious sedation (requires tutorial and current ACLS certificate)
- ☐ Diagnostic and therapeutic paracentesis
- ☐ Diagnostic and therapeutic thoracentesis
- ☐ Diaphragm fitting
- ☐ EKG/Holter/Event Monitor interpretation
- ☐ Electrical cardioversion
- ☐ Emergency pericardiocentesis
- ☐ Emergency tracheostomy/cricothroidotomy
- ☐ Endotracheal tube placement
- ☐ I&D cutaneous abscess
- ☐ Insertion/management of PA catheters
- ☐ Insertion/management of temporary transvenous pacemaker
- ☐ IUD insertion
- ☐ IUD removal
- ☐ Liquid nitrogen treatment warts, keratosis
- ☐ Lumbar puncture
- ☐ PFT interpretation
- ☐ Removal of a non-penetrating corneal foreign body, foreign body from conjunctival sac, ear, nose, skin
- ☐ Rigid/flexible sigmoidoscopy
- ☐ Skin biopsy
- ☐ Sleep Study Interpretation (Board certified by American Board of Sleep Medicine or completion of Sleep Medicine fellowship program)
- ☐ Stress test interpretation
- ☐ Suture minor lacerations
- ☐ Therapeutic injection - small or large joint
- ☐ Toe nail avulsion
- ☐ Tube thoracotomy (chest tube placement)

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 in the following ABIM subspecialty area (must be fellowship trained & board certified/eligible): ☐ Cardiovascular Disease ☐ Interventional Cardiology ☐ Infectious Disease

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 Medicine/Intensive Care *Date*

_____ _____
Chief of Surgery *Date*

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

(Office use only)