

August 21 2019 Regular Meeting

August 21 2019 Regular Meeting - August 21 2019 Regular Meeting

Agenda, August 21 2019 Regular Meeting

District Board Agenda, August 21 2019 Regular Meeting	2
---	---

Northern Inyo Health Documents

Northern Inyo Health Bylaws	4
-----------------------------------	---

Northern Inyo Health Articles of Incorporation	15
--	----

District Board Resolution 19-06

District Board Resolution 19-06, 2013 CMS Monitoring cessation	17
--	----

Policy and Procedure, Group Intervention

Policy and Procedure Approval, Group Intervention	18
---	----

Chief of Staff Report

Medical Executive Committee Report.....	23
---	----

Medical Staff Policy and Procedure approvals, August 2019	24
---	----

Community Health Needs Assessment & Inyo County Strategic Roadmap

Inyo County Strategic Roadmap	59
-------------------------------------	----

Consent Agenda

April 30 Financial and Statistical Reports	64
--	----

District Board Minutes, July 13 2019 Special Meeting	66
--	----

District Board Minutes, July 17 2019 Regular Meeting	67
--	----

Medical Staff Services Pillars of Excellence Quarterly and Annual Reports	72
---	----

Consent Agenda Policies and Procedures, August 2019	80
---	----

District Board Minutes, August 3 2019 Special Meeting	82
---	----

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS REGULAR MEETING

**August 21, 2019 at 5:30 p.m.
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. Strategic Plan update, Workforce Experience Committee report (*information item*).
4. New Business:
 - A. Cardiac Care interventions, David Young (*information item*).
 - B. Northern Inyo Health Articles of Incorporation (*action item*).
 - C. Northern Inyo Health Bylaws (*action item*).
 - D. District Board Resolution 19-06, 2013 CDPH survey monitoring cessation (*action item*).
 - E. Policy and Procedure approval, *Group Intervention* (*action item*).
 - F. Determination of date for Town Hall meeting/Community Information Night (*action item*).
5. Chief of Staff Report, William Timbers, MD:
 - A. Policy and Procedure approvals (*action items*):
 1. *Accepting Orders from Non-Privileged Practitioners*
 2. *Administration of Drugs – Patient’s Own Medications*
 3. *Color-Coded Wristband Use*
 4. *Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants*
 5. *IV Service When NIHD IV Room is Closed*
 6. *Medication Dosing in Renal Failure*
 7. *Pharmacy Confidentiality: Storage and Destruction of PHI-Containing Documents*
 8. *Point of Care QuickVue Dipstick Strep A Test*
 9. *Unusable Drugs*
 - B. Emergency Medicine Core Privilege form update (*action item*).
 - C. 2019 Critical Indicator updates (*action items*):
 1. *Emergency Department*

2. *Rural Health Clinic*

D. Physician recruitment update (*information item*).

6. Community Health Needs Assessment and Inyo County Strategic Roadmap (*information item*).

Consent Agenda (action items)

7. Approval of minutes of the July 13 2019 special meeting

8. Approval of minutes of the July 17 2019 regular meeting

9. Approval of minutes of the August 3 2019 special meeting

10. Financial and statistical reports as of April 30, 2019

11. Medical Staff Services Quarterly and Annual reports

12. Policy and Procedure Annual Approvals

13. Reports from Board members (*information items*).

14. Adjournment to closed session to/for:

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

B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

C. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).

D. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).

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

16. 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.

BYLAWS
OF
NORTHERN INYO HEALTH,
a California nonprofit public benefit corporation

BYLAWS

OF

NORTHERN INYO HEALTH,
a California nonprofit public benefit corporation

ARTICLE I

NAME AND PRINCIPAL OFFICE

1.1 Name. The name of the corporation shall be as listed in the Articles of Incorporation, namely, Northern Inyo Health (the “Corporation”), a nonprofit public benefit corporation organized under the laws of the State of California.

1.2 Principal Office and Place of Business. This Corporation shall have and continuously maintain a registered office in Inyo County, California and may have other offices within the State of California, as the Board may from time to time determine.

ARTICLE II

PURPOSES

The primary purpose of this Corporation is to own a supplier of durable medical equipment, and the provision of other healthcare services benefitting the healthcare needs of the healthcare district residents or supporting the healthcare activities of the North Inyo Hospital in furtherance of this Corporation's charitable purposes.

In addition, this Corporation is formed for the purposes of performing all things incidental to, or appropriate in, the achievement of the foregoing primary purposes. The Corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of its primary charitable purposes.

This Corporation shall hold and may exercise all such powers as may be conferred upon a nonprofit corporation by the laws of the State of California and as may be necessary or expedient for the administration of the affairs and attainment of the purposes of the Corporation.

ARTICLE III

MEMBERSHIP

3.1 General Member. There shall be one member of this Corporation who shall be the Northern Inyo Healthcare District, a political subdivision of the State of California (the “General Member”). The General Member, and only the General Member, shall be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the California Nonprofit Public Benefit Corporation Law, and all other applicable laws. The General Member may not be expelled or suspended as the General Member without its consent. Any reference in these Bylaws to the

“member,” “Member,” “general member,” “General Member,” “corporate member,” or “Corporate Member” of this Corporation, or any similar such reference, shall mean the Northern Inyo Healthcare District, a political subdivision of the State of California. By reason of the rights or status of the General Member herein, there has been no express or implied delegation of any public agency authority from the General Member to this Corporation.

3.2 General Member Approvals. The following actions or items will require the approval of the General Member prior to implementation or becoming effective:

- (a) An amendment or restatement of the Articles of Incorporation of the Corporation;
- (b) An amendment or restatement of the Bylaws of the Corporation;
- (c) A merger, consolidation, reorganization or dissolution of the Corporation;
- (d) Any material transfer by sale, lease, debt or encumbrance, or other disposition, of any of the assets of the Corporation, real or personal, outside the ordinary course of Corporation’s business;
- (e) Any transaction that causes or is anticipated to cause a downgrade in bond rating by a standard rating agency of the General Member regardless of size of the transaction;
- (f) Contracting with an unrelated third party for all, or substantially all (fifty percent (50%) or greater), of the management of the assets or operations of this Corporation or any subsidiary or affiliate entity;
- (g) Approval of long-term or material agreements involving more than fifty thousand dollars (\$50,000), including borrowings, equity financings, capitalized leases or installment contracts, and agreements involving the purchase, sale, disposition, lease, gift, exchange, pledge or encumbrance of any asset which involve the receipt or payment of more than fifty thousand dollars (\$50,000);
- (h) Approval of the Corporation's strategic plan and business plan;
- (i) Approval of the Corporation's operating and capital budgets;
- (j) Appointment of an independent auditor and the hiring of independent corporate counsel except where a legal conflict of interest exists as determined by the General Member’s corporate counsel;
- (k) Approval of transactions of this Corporation in which a Director or officer of this Corporation has a material financial interest;
- (l) Any changes to the corporate dissolution rights (initiation of dissolution and disposition of assets) of the General Member; and

- (g) Approval of individuals for Board membership.

In addition, the General Member shall have the authority to require the prior review and approval of those activities of the Corporation which the General Member determines to be major activities.

"Major Activities" shall be those which the General Member has declared major, by written notice to this Corporation, delivered personally or deposited by registered or certified mail, return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the General Member and shall refer to this Bylaw provision granting such approval rights to the General Member. Notices received pursuant to this Section shall be recorded in the minutes of this Corporation. The General Member's approval or disapproval of such matter or matters shall be recorded in the minutes of this Corporation, and written approvals or disapprovals of the General Member shall be filed with the minutes of this Corporation.

3.3 Exercise of Membership Rights. The General Member shall exercise its membership rights through its own Board of Directors. Subject to the provisions of the General Member's own bylaws, and except as otherwise provided in these Bylaws, the Board of Directors of the General Member may, by resolution, authorize a person or committee of persons to exercise its vote on any matter to come before the membership of this Corporation. In addition, the General Member may exercise its membership rights at any regular or special meeting of the Board of Directors of the General Member. The functions required by law or by these Bylaws to be performed at the annual membership meeting or any regular or special meeting of the members of this Corporation may be performed at any regular or special meeting of the General Member's own Board of Directors.

3.4 Liabilities and Assessments. The General Member shall not be liable for the debts of this Corporation. The Board of this Corporation shall have no power to levy and collect assessments on the General Member. The provisions of this paragraph cannot be amended in any manner.

ARTICLE IV BOARD OF DIRECTORS

4.1 Responsibility. Except as otherwise provided by the Articles of Incorporation or by these Bylaws, the management of the affairs of this Corporation shall be vested in a Board of Directors (the "Board"). Specifically, the Board of Directors shall be empowered as follows:

- (a) To control and be responsible for the overall governance of the Corporation, including the provision of management and planning.
- (b) To make and enforce all rules and regulations necessary for the administration, governance, protection and maintenance of the Corporation and other facilities under its jurisdiction and to ensure compliance with all applicable laws.

(c) To review and approve annual operating and capital budgets as may be further specified herein and within financial policies adopted by the Board.

(d) To do any and all other act and things necessary to carry out the provisions of these Bylaws or of the provisions of the California Nonprofit Public Benefit Corporation Law.

4.2 Number. The Corporation shall have not less than three (3) nor more than five (5) Directors, with the exact number to be fixed within these limits by approval of the Board or the General Member, if any, in the manner provided in these Bylaws. The number may be changed by amendment of this Bylaw, or by repeal of this Bylaw and adoption of a new Bylaw, as provided by these Bylaws.

4.3 Composition of the Board. Anything to the contrary herein notwithstanding, (i) the Board of Directors shall nominate the Directors to the Board of Directors, who shall become Directors upon final approval of the General Member and (ii) in the event the Board of Directors' nominees are rejected by the General Member, the Board of Directors may nominate additional nominees until the requisite number of nominees are approved by the General Member.

4.4 Vacancies. Subject to the provisions of section 5226 of the California Corporations Code, any Director may resign effective upon giving written notice to the Chief Executive Officer, the Secretary or the Chairperson or Treasurer, unless the notice specifies a later time for the effectiveness of such resignation.

A vacancy or vacancies in the Board of Directors shall be deemed to exist in case of the death, resignation or removal of any Director, or if the authorized number of Directors is increased.

Vacancies in the Board of Directors shall be filled pursuant to Section 4.3 of these Bylaws.

Directors may be removed without cause by the General Member.

A person elected to fill a vacancy as provided by this Section shall hold office until the next meeting for nomination of Directors by the Board of Directors or until his or her earlier death, resignation or removal from office.

4.5 Voting Rights. Each voting Director shall be entitled to one (1) vote on all matters before the Board. There shall be no voting by proxy.

4.6 Organizational Meeting. As soon as reasonably possible after the formation of this Corporation, the Board of Directors shall meet for the purposes of organizing the Board, the election of officers, and the transaction of such other business as may come before the meeting.

4.7 Regular Meetings. The Board shall hold an annual meeting, and may hold additional meetings as determined by the Board, at such time and place as the Board shall from time to time determine.

4.8 Special Meetings. Special meetings of the Board for any purpose or purposes shall be called by the Secretary upon the request of the Chair, the Chief Executive Officer or any two (2) Directors.

4.9 Notice of Meetings. Notice of the time and place of any meeting shall be delivered personally, communicated by telephone or electronic mail, or sent to each Director by first-class mail, charges prepaid, addressed to the Director either at his or her address as it is shown on the records or if it is not so shown or is not readily ascertainable, to the place where the principal office of the Corporation is located. If sent by mail, such notice shall be mailed at least four (4) days prior to the meeting.

4.10 Quorum. A majority of the voting members of the Board then serving shall constitute a quorum at any meeting of the Board. The act of the majority of the voting power present at any meeting at which a quorum is present shall be considered the act of the Board.

4.11 Place. The Board shall hold its meetings at the principal office of the Corporation, or the principal office of the General Member, or such other place as the Chair or the Directors requesting the meeting may designate.

4.12 Validation of Transactions. The transactions of the Board of Directors at any meeting, however called or noticed, or wherever held, shall be as valid as though had at a meeting duly held after regular call and notice, if a quorum be present and if, either before or after the meeting, each Director entitled to vote at the meeting for that purpose not present signs a written waiver of notice, a consent to the holding of such meeting, or an approval of the minutes thereof. All such waivers, consents or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

4.13 Action Without Meeting. Any action required or permitted to be taken by the Board under the provisions of the California Corporations Code, the Articles of Incorporation, or these Bylaws may be taken without a meeting, if all members of the Board shall individually or collectively consent in writing to such action. Such action by written consent shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of such Directors. Any certificate or other document filed on behalf of the Corporation relating to an action taken by the Board without a meeting shall state that the action was taken by a unanimous written consent of the Board without a meeting, and that the Bylaws of this Corporation authorize its Directors to so act.

4.14 Quorum Initially Present. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Directors if any action is approved by at least a majority of the required quorum for such meeting, or such greater number as is required by the California Corporations Code, the Articles of Incorporation or these Bylaws.

4.15 Telephonic Meetings. Members of the Board may participate in a meeting through use of a conference telephone or similar communications equipment, so long as each Director participating in such meeting can simultaneously hear all other Directors so participating. Participation in a meeting pursuant to this Section constitutes presence in person at such meeting.

4.16 Conflict of Interest Policy. The Board shall adopt and adhere to the then current conflicts of interest policy adopted by the General Member (the “Conflicts Policy”).

4.17 Self-Dealing. Prior to conducting a business session at a meeting of the Board, Board members shall disclose and discuss their individual conflicts or potential conflicts and that of other members of the Board. Actual conflicts shall be subject to resolution pursuant to the Conflicts Policy and applicable federal and state non-profit corporation laws. In the exercise of voting rights by members of the Board, no individual shall vote on any issue, motion, or resolution which directly or indirectly inures to his or her benefit financially or with respect to which he or she has any other conflict of interest, except that such individual may be counted in order to qualify a quorum and, except as the Board may otherwise direct, may participate in the discussion of such an issue, motion, or resolution if he or she first discloses the nature of his or her interest. Board members shall adhere to the Conflict of Interest Policy enacted pursuant to Section 4.16 of these Bylaws, and the Fiduciary Policy developed and implemented by the Board.

4.18 Access to Board Records and Reports. Upon request, officers of the General Member shall have access to the Corporation’s documents for review (but not possession) that have been reviewed by the Board of Directors. Such review shall be subject to the officer executing an agreement to maintain the confidentiality (no disclosure beyond officers of the General Member) of information reviewed. Documents that are protected by legal privileges and confidentiality (e.g., personnel, peer review, legal, vendor contractual confidentiality), those containing pending competitive business transaction information shall not be subject to review. Subject to the execution of an agreement to maintain confidentiality, Board member and Board selected candidate conflict disclosure filings shall be available for review at the Corporation’s offices only to the chief executive or designated legal counsel of the General Member upon request.

4.19 Bylaw Review. Consistent with regulatory and industry standards, the Board shall periodically conduct a review of these Bylaws in order to update and improve them. At least every two (2) years, the Board shall seek the input of the General Member in connection with such a review.

ARTICLE V OFFICERS

5.1 Officers of this Corporation. The officers of the Corporation shall be a Chair of the Board, a Vice Chair of the Board, a Chief Executive Officer, a Secretary, and a Treasurer. The Corporation may also have, at the discretion of the Board of Directors, one or more assistant secretaries, one or more assistant treasurers, and such other officers as may be appointed by the

Board of Directors. Any number of offices may be held by the same person except that neither the Secretary, Treasurer, nor Chief Financial Officer may serve as the Chief Executive Officer or Chair of the Board.

5.2 Officers Elected by the Board. The Chair of the Board, Vice Chair of the Board, Treasurer, and the Secretary shall be elected annually by the Board. Nominations shall be submitted in advance of the selection by the Board of Directors or a nominating committee formed by the Board of Directors for that purpose. Each officer elected by the Board shall hold office at the pleasure of the Board and until his or her successor shall be elected and qualified to serve. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board for the unexpired term at any meeting of the Board.

5.3 Resignation or Removal. Any officer of the Board may resign at any time or be removed as follows: (a) any officer elected pursuant to Section 5.2 may be removed by the vote of the Board; and (b) any officer appointed by the Chief Executive Officer may be removed by the Chief Executive Officer.

5.4 Vacancies in Office. A vacancy in any office because of death, resignation, removal, or any other cause shall be filled in the manner prescribed in these Bylaws for regular appointments.

5.5 Chair. The Chair of the Board shall preside at all meetings of the Board. Unless the signature of the Chief Executive Officer is required by law, the Chair of the Board shall possess the same power as the Chief Executive Officer to sign all certificates, contracts, or other instruments of this Corporation when he is so authorized by the Board. The Chair of the Board shall exercise and perform such other powers and duties as may be prescribed by the Board from time to time. The Chair of the Board shall serve as the Board's liaison to the Chief Executive Officer.

5.6 Vice Chair. In the absence of the Chair of the Board or in the event of the Chair's disability, inability, or refusal to act, the Vice Chair of the Board shall perform all of the duties of the Chair and in so acting shall have all of the powers of the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or by the Chair.

5.7 Chief Executive Officer.

(a) Appointment and Removal. The Chief Executive Officer of this Corporation shall be engaged by the Board and shall serve at the pleasure of the Board, which may terminate the services of the Chief Executive Officer of this Corporation subject to any employment agreement.

(b) Responsibilities and Authority. The Chief Executive Officer shall be the general manager, administrator and Chief Executive Officer of this Corporation. The Chief Executive Officer shall be given the necessary authority and responsibility to operate this Corporation in all of its activities. The Chief Executive Officer shall be subject to such policies as may be adopted and such orders as may be issued by the Board of this Corporation or by any of its

committees to which the Board has delegated the power for such action; with respect to program execution and overall management performance, the Chief Executive Officer shall be subject to the authority of and shall report to the Board. The Chief Executive Officer shall act as the duly authorized representative of the Board of this Corporation in all matters in which the Board has not formally designated some other person to so act.

5.9 Treasurer. The Treasurer of this Corporation shall keep and maintain or cause to be kept and maintained adequate and correct account of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any Board member. The Treasurer shall be charged with safeguarding the assets of the Corporation and he or she shall sign financial documents on behalf of the Corporation in accordance with the established policies of the Corporation. He or she shall have such other powers and perform such other duties as may be prescribed by the Board from time-to-time. The Treasurer may fulfill these responsibilities and perform his or her duties through appropriate delegation, with Board oversight, to individuals or firms charged with the financial management of the Corporation.

5.9 Secretary. The Secretary shall keep or cause to be kept a book of minutes at the principal office or at such other place as the Board may order of all meetings of the Board with the time and place of holding, whether regular or special, and if special how authorized, the notice thereof given, the names of those present at the Board meetings, and the proceedings thereof. The Secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given, and the Secretary shall keep the seal of this Corporation in safe custody and shall have such other powers and perform such other duties as may be prescribed by the Board from time to time.

ARTICLE VI COMMITTEES

6.1 Establishment of Committees. Subject to the duty of the Board to exercise ultimate direction over the activities and affairs of the Corporation, the Board may authorize any special committee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board shall require, but no such committee shall have the authority to determine Corporation policy or otherwise exercise any powers of the Board with respect to the business and affairs of the Corporation.

6.2 Vacancies. Vacancies in any committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

6.3 Expenditures. Except as expressly delegated, any expenditure of corporate funds by a committee or any commitment by a committee to expend corporate funds shall require prior approval of the Board.

ARTICLE VII
GENERAL PROVISIONS

8.1 Compensation of Board Members. The members of the Board shall receive no compensation as such, except that they may be reimbursed from time to time for all expenses incurred on behalf of this Corporation.

8.2 Indemnification. To the fullest extent permitted by law, this Corporation shall indemnify its "agents", as described in Section 5238(a) of the Law, including its directors, officers, employees, and volunteers, and including persons formerly occupying any such position, and their heirs, executors, and administrators, against all expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred by them in connection with any "proceeding," as that term is used in said Section 5238(a), and including an action by or in the right of the Corporation, by reason of the fact that the person is or was a person described in that Section. "Expenses" shall have the same meaning as in said Section. Such right of indemnification shall not be deemed exclusive of any other rights to which such persons may be entitled apart from this Article 8, Section 9. To the fullest extent permitted by law and except as otherwise determined by the Board in a specific instance, expenses incurred by a person seeking indemnification in defending any "proceeding" shall be advanced by the Corporation before final disposition of the proceeding upon receipt by the Corporation of an undertaking by or on behalf of that person to repay such amount unless it is ultimately determined that the person is entitled to be indemnified by the Corporation for those expenses.

The Corporation shall have power to purchase and maintain insurance to the fullest extent permitted by law on behalf of any agent of the Corporation, against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, or to give other indemnification to the extent permitted by law.

8.3 Fiscal Year. The fiscal year of this Corporation shall end on December 31 of each year.

8.4 Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the preceding sentence, the masculine gender includes the feminine and neuter, the singular number includes the plural, the plural number includes the singular and the term "person" includes both a legal entity and a natural person.

8.5 Bylaws and Articles of Incorporation Amendment. Amendment of the Articles of Incorporation and these Bylaws may only be adopted by the approval of the Board of Directors and by the approval of the General Member of this Corporation.

SECRETARY'S CERTIFICATE

I certify that I am the Secretary of Northern Inyo Health, a California nonprofit public benefit corporation (the "Corporation"), and that the attached Bylaws of the Corporation are the current bylaws of the Corporation as adopted by the Board of Directors of the Corporation on _____, 2019, and by the General Member, the Northern Inyo Healthcare District, on _____, 2019, respectively.

Dated: _____, 2019

_____, Secretary

ARTICLES OF INCORPORATION
OF
NORTHERN INYO HEALTH

I

The name of this corporation is Northern Inyo Health.

II

A. This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the California Nonprofit Public Benefit Corporation Law for charitable purposes.

B. The primary purposes of this corporation is to own a supplier of durable medical equipment the provision of other healthcare services benefitting the healthcare needs of the healthcare district residents or supporting the healthcare activities of the North Inyo Hospital in furtherance of this corporation's charitable purposes.

C. The general purpose of this corporation is to have and exercise all rights and powers conferred on nonprofit public benefit corporations under the laws of the State of California.

III

A. This corporation is organized and operated exclusively for charitable purposes within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and successor provisions thereto (the "Code").

B. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

IV

Northern Inyo Healthcare District, a political subdivision of the State of California, is the sole member of this corporation. The corporation may also from time to time use the term "members" to refer to persons associated within, but such persons shall not be members within the meaning of Section 5056 of the California Corporations Code.

V

The property of this corporation is irrevocably dedicated to charitable purposes and no part of the net income or assets of this corporation shall ever inure to the benefit of any director, officer or member thereof or to the benefit of any private person. Upon the dissolution or winding up of the corporation, its assets remaining after payment or provision for payment of all

debts and liabilities of this corporation shall be transferred exclusively to and shall become the property of the Northern Inyo Healthcare District, a political subdivision of the State of California. If the Northern Inyo Healthcare District no longer: (a) exists; or (b) is organized and operated exclusively as a healthcare district under California law, then the assets of this corporation shall be transferred to and shall become the property of such nonprofit funds, foundations or corporations as are designated by the Board of Directors of this corporation and which: (1) have established their tax-exempt status under section 501(c)(3) of the Code; and (2) are organized and operated exclusively for religious, charitable, hospital, scientific purposes, or charitable *and* educational purposes meeting the requirements for exemption provided by Section 214 of the Revenue and Taxation Code.

VI

The name of the corporation's initial agent for service of process is:

Cathy Deubel Salenko, Esq.
Best Best & Krieger LLP
500 Capitol Mall, Suite 1700
Sacramento, California 95814

VII

The initial street and mailing address for the principle office of the corporation shall be:
Northern Inyo Healthcare District, 150 Pioneer Lane, Bishop, California 93514

DATED: August __, 2019.

Cathy Deubel Salenko, Esq., Incorporator

NORTHERN INYO HEALTHCARE DISTRICT BOARD RESOLUTION 19-06

Whereas Northern Inyo Healthcare District (District) had a Center for Medicare and Medicaid Services (CMS) site survey in March of 2013; and

Whereas that CMS site survey resulted in the identification of deficiencies; and

Whereas several of those deficiencies had a corrective action plan that required monthly reporting to the District Board of Directors; and

Whereas those reports have been consistently delivered to the Board of Directors from 2013 to 2018; and

Whereas corrective actions taken immediately after the 2013 survey have resulted in improvements as evidenced by the monitoring reports; and

Whereas other corrective actions taken since the original plan have only resulted in minimal changes in the results reported; and

Whereas the District has had surveys by The Joint Commission in 2016 and 2019; and

Whereas the 2016 and 2019 surveys by The Joint Commission have not found any deficiencies in the areas identified by CMS during the 2013 survey; and

Whereas the District has 'deemed' status;

NOW THEREFORE, BE IT RESOLVED that the Board of Directors of Northern Inyo Healthcare District hereby determines:

1. that the intent of the 2013 corrective action plan and monthly reports to the Board of Directors has achieved its goal of improvement in the areas of deficiency
2. that the District leadership shall no longer generate or report to the Board of Directors the results of the monitoring program developed as a result of the 2013 CMS site survey
3. that future corrective action plans shall have clear delineation of when a corrective action plan has been achieved and no further reporting to the Board of Directors shall be necessary

Approved: August 21, 2019

Mary Mae Kilpatrick
Northern Inyo Healthcare District Board President



Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

PURPOSE: To identify the policy and procedure for providing a Medication Assisted Treatment (MAT) Stabilization Group intervention for patients who are engaged in the MAT Program.

POLICY: Northern Inyo Health Care District (NIHD) providers recognize that Medication Assisted Treatment (MAT), in combination with counseling and/or behavioral therapies, is a holistic and evidence based best practice used to treat opioid use disorders for long-term recovery. NIHD collaborates with patients to develop individualized treatment plans. The model used for the MAT Stabilization Group is strength-based and emphasizes self-sufficiency, in an effort to empower patients to make lifestyle changes that will support long-term recovery. The group facilitator will coordinate care between primary care provider, psychiatrist/NP, and individual psychotherapy provider as needed.

PROCEDURE: When a patient is enrolled in the MAT Program they agree to participate in a Stabilization Group. The flexible curriculum used in the Stabilization Group allows patients to join at any time. The Stabilization Group is divided into three phases: Phase One meets weekly, Phase Two meets every two weeks, and Phase Three meets once a month. Patients progress through the different phases based on the clinical judgement of the behavioral health staff and the commitment level of the patient. Patients are required to repeat previous phases at any time if their need for additional support increases. During Group sessions, patients are provided psychoeducation to facilitate their physical, emotional, and mental health stabilization to support long-term recovery. Patients will both give and receive peer support throughout their stabilization process. Motivational interviewing techniques will be utilized throughout treatment. The Stabilization Group(s) will be led by a member of the behavioral health staff. The group facilitator will be responsible for providing information about addiction and recovery; responding to patient questions, helping patients relate personally to concepts discussed, facilitate group interaction, validate issues or struggles, model healthy behaviors, challenge counterproductive activities and behaviors that interfere with groups ability to achieve goals, encourage attendance in self-help groups, and motivate patients to talk directly to each other when sharing. The group facilitator is less of an “expert” and more of a skilled implementer of discussions related to recovery concerns, problems, and issues. The group facilitator will demonstrate an attitude of understanding and acceptance, utilize active and reflective listening skills to help patients explore and resolve ambivalence, and support the patient’s transformation through the stages of change.

Group Structure:

1. Groups are divided into three phases (weekly, every two weeks, once a month)
2. Groups are 30-45 minutes in length
3. Groups will have 4 basic elements:
 - a. Introductions, overview of group purpose, high/low check-in

Developed: Revised:



Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

- b. Educational/experiential presentation
- c. Discussion
- d. Wrap-Up; patient commitment to goals for coming week

Introduction/Orientation:

Purpose of group, content, process, and working conditions will be articulated. All new members will receive an introduction from facilitator. The facilitator may elect to have new patient(s) come 5 minutes early to group to acclimate them. The purpose of MAT Stabilization Group is to allow the patient to become more aware of their own problems and issues and how they relate to opiate addiction and recovery. Patients are able to give and receive support through providing feedback and sharing problems, successes, hopes, and strength. Through the group experience, group members learn the importance of mutual support, confronting negative attitudes, and managing unhealthy behaviors. Patients will also learn recovery coping skills to reduce the chances of relapse and improve functioning. The content of the group is a flexible curriculum. Topics are recovery-oriented and can be altered to address more urgent concerns of group members at any time. The group facilitator will explain the general weekly process of the group so patients are aware what is expected of them and what the program will provide. Patients will be asked to share their expectations for the group so the leader can adjust curriculum or refer patient to another resource to meet their needs. All new members will be required to sign a Group Rules Agreement acknowledging their understanding of and agreement with the rules related to participation in group therapy. Introduction is a time to introduce members and have each member say something about themselves or provide a high and low moment for the prior week. Goals of introductions are to set a positive tone, create a safe and cohesive environment for patients to learn, give and receive supportive feedback, and ask questions.

Group Expectations: Groups work best if there are certain behavioral expectations that are agreed upon. To participate in this group, members are expected to follow the behavioral guidelines below:

1. You are not allowed to come to group sessions intoxicated or high. Any member who comes to a group session intoxicated will be asked to leave and to meet with a member of the MAT Team to discuss the circumstances surrounding his/her drug use.
2. You are expected to make a commitment to attend group sessions as often as indicated in your individual treatment plan. Your consistent attendance and participation supports the strength and unity of the group, which in turn helps to support you in your recovery. If you will be late or absent, contact the group facilitator directly prior to a group session to explain why.
3. Any disruptive behavior or conduct that is disrespectful in nature, threatening, or violent will result in removal from the group and may lead to discharge from the MAT program.
4. Issues that are discussed in group sessions must stay within the group to ensure confidentiality and respect.

Developed: Revised:



Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

Groups Rules: During Group Sessions, each member agrees to the following rules:

- We arrive on time for group
- We are respectful to ourselves and others
- We turn off our cell phones
- We listen
- We avoid “cross talk”
- We use respectful language at all times (no swearing or insults)
- We do not discuss our buprenorphine dose, our cravings, or any episodes of substance use during group time
- We respect the privacy of all group members: “Who we see and what we hear stays here.”

----- (Group Rules may be adjusted to meet the needs of the group as it evolves over time.) -----

Psychoeducation Curriculum: The curriculum for the MAT Stabilization Group is designed on a flexible scaffold to address the needs of the current group members. Below is a sample outline of the topics discussed in group. The variety, organization, focus, and delivery of recovery topics can be altered at any time to accommodate the specific needs of the group members.

INTRODUCTION: Building Blocks for Developing a Recovery Program

Week 1: Setting the Foundation – Understanding the connection between Events, Thoughts, and Behavior/Emotions

Week 2: Symptoms of Opiate Addiction - Understanding the chronic, relapsing nature of addiction

Week 3: Stages of Change & Denial (pre-contemplation, contemplation, preparation, action, maintenance), evaluating the effects of your addiction, understanding denial

Week 4: Relapse Prevention - learn to cope with situations that precipitate drug use behavior, construct relapse preventive thinking and actions

Week 5: Managing Triggers & Cravings: People, Places, and Things; recognize and anticipate triggers

Week 6: Relationships in Recovery – impacts of addiction on relationships

Developed: Revised:



Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

Week 7: Establishing a Support System – my social support system

Week 8: Managing Feelings in Recovery – a multi-step approach for managing feelings in recovery

Week 9: Coping with Guilt and Shame – strategies for coping with guilt and shame

Week 10: Warning Signs of Relapse – understanding relapse process, high-risk situations, and develop strategies for coping

Week 11: Coping with High-Risk Situations – dealing with the most common relapse dangers

Week 12: Maintaining Recovery – recovery tool checklist and coping with stressful situations

Due to this being an open group, at any point in treatment patients may be ready to progress to Phase 2 or 3 of the group. The group facilitator will honor the journey the patient has made at the current group level, allow time for peers to adjust to the change in membership, offer feedback, and provide encouragement for patient. The facilitator will remind patient and group that anyone is welcome back at any time if they feel their recovery is at risk, need refresher education, or more support. This allows for putting closure on the group experience for the patient and the group. It is also a time to reflect on the impact of the group on each person and to acknowledge any feelings triggered by departure of a group member. Completing the group successfully can be an important event for group members when they see the conclusion of a difficult but successful endeavor.

REFERENCES: Curriculum was developed from various resources including Hazelden, SAMHSA, NIDA, SMART Recovery Program, Group Drug Counseling Participant Recovery Workbook, Group Treatment for Substance Abuse (second edition), Engage the Group Engage the Brain, and The Rewired Workbook.



Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

CROSS REFERENCE P&P: N/A

Approval	Date
CCOC	7/29/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised:

Supersedes:

Developed: Revised:



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: William Timbers, MD, Chief of Medical Staff
DATE: August 6, 2019
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 and Procedures (*action item*)

1. *Accepting Orders from Non-Privileged Practitioners*
2. *Administration of Drugs – Patient’s Own Medications*
3. *Color-Coded Wristband Use*
4. *Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants*
5. *IV Service When NIHD IV Room is Closed*
6. *Medication Dosing in Renal Failure*
7. *Pharmacy Confidentiality: Storage and Destruction of PHI-Containing Documents*
8. *Point of Care QuickVue Dipstick Strep A Test*
9. *Unusable Drugs*

B. Emergency Medicine Core Privilege form update (*action item*)

C. 2019 Critical Indicator updates (*action items*)

1. Emergency Department
2. Rural Health Clinic

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

~~G.F. 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.

**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

- 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/pubdoco/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	7/15/19
Board of Directors	9/19/18
Last Board of Directors Review	1/16/19

Developed: 06/2018 dp
 Reviewed:
 Revised: 07/2018 nh, 08/2018 dp, 06/2019 dp
 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
Referral Agreement for Non-Staff Ordering Practitioners**

This 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; 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 License Number	Primary Phone	Secondary Phone
-------------------	---------------	-----------------

Practice Name and Address

Name of Ordering Practitioner	Signature	Date
-------------------------------	-----------	------

NIHD Office Use Only:

Verification of Agreement Completed By: _____ Date: _____

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

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Administration of Drugs: Patient's Own Medications	
Scope: District Wide	Manual: CPM - Medication (MED), Pharmacy
Source: Director of Pharmacy	Effective Date: 4/15/17

PURPOSE:

To insure the quality and integrity of medications brought to the hospital by patients and administered by NIH personnel. To comply with Title 22 CCR 70263

POLICY:

1. ADMINISTRATION OF PATIENT'S OWN MEDICATIONS

- a. A patient's personal medications will be administered when specifically ordered by the prescribing practitioner responsible for the patient. Patients may self-administer medications only in accordance with the **“Administration of Drugs: Self-Administration”** policy and procedure.
- b. There must be a complete written order, name of the medication, strength, dose, route and frequency, by the prescriber for the nurse to administer the patient's own medications. All medications for patient administration must be positively identified by a pharmacist (**A nurse cannot do this**).
- c. Medications identified for administration in accordance with this policy shall be sent to the pharmacy for confirmation, repackaging and dispensing.
- d. Emergency ~~Room~~ Department patients will not take their own medications unless the medication is not stocked within the hospital and a physician writes an order for “patient's to take their own medication including the order requirements in part b. The pharmacist and/or physician will need to identify/verify the medication prior to administration. If an emergency patient brings in his/her own medications, physician will review and have the ED nurse enter the home medications into the Athena-EHR system.

2. IDENTIFICATION OF PATIENT'S OWN MEDICATIONS

- a. Medications brought into the facility by patients will not be administered unless the medication containers are clearly and properly labeled, the drugs have been positively identified, their quality and integrity is not questionable, and documentation of such identification is made on the Medication Administration Record.
- b. All medications (brought from home) potentially for use by the admitted patient must be furnished to the pharmacist for examination and positively identified. Prior to administration. The pharmacist should initial and add + symbol as evidence of confirmation.
- c. Patient's own drugs shall be entered on the MAR as “patient's own med” along with the name, strength, route, and dosage. Nurses will document

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Administration of Drugs: Patient's Own Medications	
Scope: District Wide	Manual: CPM - Medication (MED), Pharmacy
Source: Director of Pharmacy	Effective Date: 4/15/17

administration of patient's own medications per general administration policies.

3. **STORAGE OF PATIENT'S OWN MEDS**

- a. Patient's own medications brought in to the hospital that are not to be administered to the patient in accordance with this policy will be sent home with the patient's family or representative. Nursing staff will initially fill out the home medication list before sending the medications home with the family or patient's agent.
- b. In the event the patient's medications cannot returned home, they may be stored in the locked med cabinet.
 - i. Patient's home medications will be packaged in a sealable "Patient's Medicine Inventory" security bag and stored in a locked cabinet. The nurse will write the patient's name and ID on the face of the security bag. The nurse will, in the presence of the patient or patient's representative, count the number of bottles and list the bottle with the name of the medication as stated on the prescription label. The nurse will not open or inventory the prescription bottles but only note the number of bottles and the label on each.
 - ii. The nurse will seal the bag in the presence of the patient or patient's representative. The nurse will sign the bag and give the tear off receipt to the patient or patient's representative.
 - iii. Nursing staff will call pharmacy to inform them that home medications are in the locked cabinet.
 - iv. Upon discharge, the patient will receive his/her sealed medication bag back. Unclaimed patient meds will be destroyed after 30 days per section 5 below.

4. **USE OF PATIENT'S OWN MEDS—CONTROLLED SUBSTANCES**

Controlled substances brought from home may not be used in the Inpatient or Outpatient setting at NIHD. However, we will review any request for an exception on a case by case basis due to one of the following if in it in the patient's best interest.

- a. Pain Pump internal reservoirs
- b. Pre-existing placed Fentanyl patches that will be replaced with a district provided new patch at the conclusion of 72-hour wear.
- c. Exotic, compounded or unobtainable or non-bioequivalent substitutable medication.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Administration of Drugs: Patient's Own Medications	
Scope: District Wide	Manual: CPM - Medication (MED), Pharmacy
Source: Director of Pharmacy	Effective Date: 4/15/17

5. DESTRUCTION OF UNRETURNED DRUGS

- a. Personal drugs from expired patients and personal drugs on hand more than thirty (30) days after discharge shall be destroyed in accordance with applicable law.
- b. If in the unlikely event that drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, need to be destroyed it will be sequestered for reverse distribution agency return or if not possible recorded and destroyed by two licensed pharmacists of NIHD one being the Director of Pharmacy and the other a FTE of NIHD.
- c. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in a separate log. Such log shall be retained for at least three years.

REFERENCES:

1. The Compliance Guide to the JACHO's Medication Management Standards, Second Edition

CROSS REFERENCES:

1. Administration of Drugs and Biological
2. Controlled Substance Policy, Hospital Wide

Approval	Date
Clinical Consistency Oversight Committee	7/9/19
Pharmacy and Therapeutics Committee	6/20/19
Medical Executive Committee	8/6/19
Board of Directors	
Last Board of Directors review	

Initiated: 7/05

Revised: 9/12, 6/15, 01/17, 7/19fl

Reviewed: 10/06, 10/07, 9/08, 9/09, 9/10, 9/11, 6/15, 1/17/18

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Color-Coded Wristband Use	
Scope: Nursing Services	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 12/2008

1. Purpose

To have a standardized process that identifies and communicates patient-specific risk factors or special needs by using color-coded wristbands based upon the assessment of the patient, the patient’s wishes and medical status.

2. Objectives

- A. To reduce confusion associated with the use of color-coded wristbands by using colors standardized throughout California.
- B. To communicate patient-safety risks to all health care providers.
- C. To include the patient, family members and significant others in the communication process and promote safe care.
- D. To adopt the following risk-reduction strategies:
 - 1. A preprinted written descriptive text is used on the bands, clarifying the intent (e.g., “Allergy,” “Fall Risk” or “DNR”).
 - 2. No handwriting is used on the wristbands.
 - 3. Color-coded wristbands may only be applied or removed by a nurse conducting an assessment.
 - 4. If labels, stickers or other visual cues are used in the medical record to communicate risk factors or wristband application, those cues should use the same corresponding color and text as the color-coded band.
 - 5. Social (community) cause (social cause wristbands include, for example, “LIVESTRONG”) wristbands should not be worn by patients in the hospital. Staff should have family members take the social cause wristbands home, or remove them from the patient and store them with their other personal items. This is to avoid confusion with the color-coded wristbands and to enhance patient-safety practices.
 - 6. When a color-coded wristband is applied, the patient and family are educated regarding the wristband message.

3. General Policies

Colors used for wristbands. The following represents the only color-coded wristbands used:

- A. Clear wristbands shall be used for patient identification. The patient identification and admission identification bands may be applied by non-clinical staff in accordance with hospital policy.
- B. Purple wristbands shall be used to identify patients with a “Do Not Resuscitate” order written in the medical record in accordance with hospital policy. The letters “DNR” shall be embossed/printed on the wristbands.
- C. Red wristbands shall be used to identify patients with allergies. The list of allergies should be written in the medical record in accordance with hospital policy. Allergies should include allergies to medication(s), food, environmental allergens

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Color-Coded Wristband Use	
Scope: Nursing Services	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 12/2008

or other substances that may cause an allergic reaction in the patient. The letters “ALLERGY” shall be embossed/printed on the wristband.

- D. Yellow wristbands shall be used to identify patients with a risk of falling. Persons with a risk of previous falls, dizziness or balance problems, fatigability or confusion about their current surroundings should be assessed for potential fall risk. The letters “FALL RISK” shall be embossed/printed on the wristband.
- E. Green wristbands shall be used to identify patients with sepsis. This shall be applied when the patient meets the SOFA criteria. The letters “SEPSIS” shall be embossed/printed on the wristband.
- F. Pink wristbands shall be used to identify patients with a restricted extremity. A pink band will be placed on the affected extremity alerting staff to avoid using the limb for blood draws, IV insertions, and other medical procedures. The restricted extremity should be limited to only having one pink band loosely placed on it. All other bands should be placed on the side that is not restricted.

Application of color-coded wristbands. During the initial and reassessment procedures, allergies, DNR status and risk factors associated with falls may be identified. Assessment of potential risk is an interdisciplinary process

- A. The nurse performing the assessment is authorized to determine fall risk and patient allergies as determined by the assessment, and place the appropriate color-coded wristband on the patient. Only the nurse performing the patient assessment is designated to apply or remove color-coded wristbands. Color-coded wristbands should be used for all patients with these conditions, including all inpatient and emergency department patients
- B. The determination of a “Do Not Resuscitate” order must be consistent with hospital policy and must be documented in the patient’s medical record prior to the nurse placing the DNR wristband on the patient.
- C. Handwriting is not permitted on color-coded wristbands.
- D. It should be documented in the patient’s medical record that a color-coded wristband was applied, for specific reasons (i.e. Risk Fall, DNR and/or Allergy. **[DO NOT DOCUMENT WRISTBAND COLOR.]**)
- E. All color-coded wristbands shall be placed on the same wrist as the patient identification wristband **EXCEPT for pink wristbands, as noted above.**
- F. Upon application of the color-coded wristband, the nurse shall instruct the patient and family member(s), if present, that the wristband is not to be removed.
- G. In the event that any color-coded wristband(s) must be removed for a treatment or procedure, a nurse will remove the wristband(s). Upon completion of the treatment or procedure, risks shall be reconfirmed and new wristband(s) immediately applied by the nurse.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Color-Coded Wristband Use	
Scope: Nursing Services	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 12/2008

4. “Social (Community) Cause” Wristbands

The nurse shall examine the patient for “social (community) cause” wristbands, during the initial assessment. If “social cause” wristbands are present, the nurse will explain the risks associated with the wristbands and ask the patient to remove them. If the patient agrees, the band(s) will be removed and given to a family member to take home, or stored with the patient’s personal belongings. If the patient refuses to remove the “social cause” wristband, the nurse will request that the patient sign a refusal form acknowledging the risks associated with the “social cause” wristbands (see attached document).

5. Patient/Family Involvement and Education

Staff should assist and encourage the patient and family member(s) to be active partners in the care provided and safety measures being used. The nurse should teach all patients and family members to notify the nurse whenever a wristband has been removed and is not reapplied, or when a new band is applied and they have not been given an explanation as to the reason.

When applying a color-coded wristband(s) to a patient, the nurse shall educate the patient and family member(s) about the meaning of the wristband(s) applied, risks associated with wearing social cause wristbands in the hospital, and their role in color-coded wristbands. During assessment of the patient, the nurse shall educate and re-educate the patient and family members about the meanings of the color-coded wristband(s) applied, the risks associated with wearing social cause wristbands and why they are asked to remove them, and to notify the nurse if color-coded wristband condition(s) have changed.

6. Hand–Off in Care

The nurse shall reconfirm that the color-coded wristbands are consistent with the documentation in the medical record before invasive procedures, at transfer and during changes in level of care. The nurse shall also confirm this information is consistent with the knowledge of the patient, family members or other caregivers and what is in the patient’s chart. **Errors or omission of appropriate wristbands will be corrected immediately and an UOR completed detailing the incident.**

Color-coded wristbands are not removed at discharge. For home discharges, the patient is advised to remove the band at home. For discharges to another facility, the wristbands are left intact as a safety alert during transfer. Receiving facilities should follow their policy and procedure for the banding process.

7. DNR (Do Not Resuscitate)

The DNR color-coded wristband serves as an alert and does not take the place of an order. DNR orders must be written and verification of advanced directives must occur.

8. Staff Education

Staff education regarding color-coded wristbands will occur during the new orientation process and updated with any changes to this policy.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Color-Coded Wristband Use	
Scope: Nursing Services	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 12/2008

9. Patient Refusal

If the patient is mentally competent and refuses to wear the color-coded wristband, an explanation of the benefits of wearing the color-coded wristband and the risks of not wearing the wristband will be provided to the patient. The nurse will reinforce that this is an opportunity to participate in efforts to prevent errors, and it is his/her responsibility as part of the team. The nurse will document in the medical record patient refusals, and the explanation provided by the patient. The patient will be requested to sign a *Patient Refusal to Participate in the Wristband Process* form.

10. Surrogate Decision-maker

If the patient is not mentally competent, the appropriate surrogate decision-maker will be consulted according to hospital policy.

REFERENCES:

1. TJC CAMCAH 2016, PC.01.02.08
2. TJC CAMCAH 2016, PC.01.03.01
3. CAH State Operations Manual 12/2016, CFR 489.012

CROSS REFERENCE P&P:

1. Advanced Directives
2. Fall Risk Prevention – Perinatal
3. Fall Prevention and Management
4. Sepsis, Emergency Patient Care (Lippincott)

Approval	Date
CCOC	7/29/19
Medical Executive Committee	<u>8/6/19</u>
Board of Directors	
Last Board of Directors Review	

Developed: 12/2008 bss/jk

Reviewed: 3/15 bss

Revised: 5/11 jm; 9/12 bss; 12/17 ta; 07/19 jn

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Color-Coded Wristband Use	
Scope: Nursing Services	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 12/2008

NORTHERN INYO HOSPITAL

Patient Refusal to Participate in the Wristband Process

Patient sticker

The above-named patient refuses to (check all that apply):

Wear color-coded wristbands.

A member of the health care team has explained the benefits of the use of color-coded wristbands to me. I understand the benefits of the use of color-coded wristbands and the risks of refusing the wristbands and, despite this information, do not give permission for the use of color-coded wristbands in my care.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Color-Coded Wristband Use	
Scope: Nursing Services	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 12/2008

_____ Remove “social cause” wristbands (e.g., charity wristbands).
 A member of the health care team has explained the risks of refusing to remove the “social cause” wristbands to me. I understand that refusing to remove the “social cause” wristbands could cause confusion in my care and, despite this information, I do not give permission for the removal of “social cause” wristbands.

Reason provided (if any): _____

Date/Time

Signature/Relationship

Date/Time

Witness Signature/Job Title

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants	
Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

PURPOSE:

The Mckesson 12-Drug Panel With Adulterants Drugs of Abuse Test is a CLIA Waived Urine Toxicology rapid screening test for simultaneous and qualitative detection of Methamphetamine (MET), Amphetamine (AMP), Cocaine (COC), Morphine (MOP), Marijuana (THC), Benzodiazepines (BZO), Ecstasy/Methylenedioxymethamphetamine (MDMA), Oxycodone (OXY), Barbituates (BAR), Phencyclidine (PCP), Buprenorphine (BUP), Methadone (MTD), and their associated metabolites, in human urine.

POLICY:

1. Refer to “Training and Competency in Point of Care Testing” for NIH Point of Care Policy
2. All new lots or shipments of The Mckesson 12-Drug Panel with Adulterants Drugs of Abuse Test shall be tested with external controls, and monthly thereafter.
3. The Mckesson 12-Drug Panel with Adulterants Drugs of Abuse Test will not be used for Employment or legal drug screening.
4. The Mckesson 12-Drug Panel with Adulterants Drugs of Abuse Test will not be used in any way that violates local, state, or federal toxicology regulations.
5. All testing staff should be able to interpret results by comparing the color of a test strip to a key on the included Color Chart. Staff with color blindness should not perform this test.

INTENDED USE:

The Mckesson 12-Drug Panel With Adulterants Drugs of Abuse Test is intended for use within the Northern Inyo Hospital Medication-Assisted Treatment (MAT) Program to aid providers with determining compliance with Medication use instruction and as a preliminary indicator of possible patient substance abuse. It is only intended for preliminary analytical results and is not appropriate for Employment or Pre-employment Drug Screening. Please see the Limitations section for more details.

PRINCIPLE:

The One Step Multi-Drug Screen Test is an immunoassay based on the principle of competitive binding. Drugs which may be present in the urine specimen compete against their respective drug conjugate for binding sites on their specific antibody. During testing, a urine specimen migrates upward by capillary action. A drug, if present in the urine specimen below its cut-off concentration, will not saturate the binding sites of its specific antibody coated on the particles. The Antibody coated particles will then be captured by the immobilized drug conjugate and a visible colored line will show up in the test line region of the specific drug strip.

The colored line will not form in the test line region if the drug level is above its cut-off concentration because it will saturate all the binding sites of the antibody coated on the particles.

A drug-positive urine specimen will not generate a colored line in the specific test line region of the strip because of drug competition, while a drug-negative urine specimen or a specimen containing a drug concentration less than the cut-off will generate a line in the test region. To serve as a procedural control, a colored line will always appear at the control line region indicating that proper volume of specimen has been added and membrane wicking has occurred.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants	
Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

Each test line in the test panel contains mouse monoclonal antibody-coupled particles and corresponding drug-protein conjugates. A goat antibody is employed in each control line.

MATERIALS, EQUIPMENT, REAGENTS AND STORAGE:

Drugs of Abuse Test McKesson 12-Drug Panel With Adulterants (store between 2-30 degrees C):

- Test Cup
- Procedure Card
- Color Chart card for Adulterant Interpretation
- Desiccants
- Disposable gloves
- Package insert
- Package insert
- Security seals

Alere Professional Cup Urine Drug Controls: Negative, Positive (store between -10 to -20 degrees C or unopened between 2 and 8 degrees C, or opened and refrigerated between 2-8 degrees C for 31 days):

- Positive Control
- Procedure stand
- Negative Control
- Package insert

Not included in kits but required for test:

- Timer
- Aliquot tubes (for freezing urine controls)
- Pipette

PROCEDURE:

1. Standard precautions should be followed when collecting all patient samples. Gloves should be given to patients when collecting urine specimens.
2. External Controls:
 - A. External controls should be performed monthly or with each new shipment/lot.
 - B. Controls are best stored frozen between -10 and -20 degrees Celsius. They may be stored, unopened, between 2 and 8 degrees Celsius until the expiration date, but the Oxazepam used in the controls may deteriorate with time.
 - C. Opened controls may be aliquoted into 1 mL amounts and frozen between -10 and -20 C until the expiration date. Opened controls may be stored between 2 and 8 degrees Celsius for 31 days.
 - D. Allow controls to come to room temperature, followed by gentle swirling, before use.
 - E. Each control (positive and negative) should be added to a separate testing cup.
 - F. If using a short control sample (minimum of 1 mL), pour or pipette control sample into cup, making certain that the bottoms of all imbedded test strips are saturated with control material. Then, screw the lid back onto the testing cup.
 - G. Place the cup onto the low volume stand with the test strip portions facing down and the bottom of the cup angled lower than the top.
 - H. Testing staff should peel off label to reveal the test result. Read test result at 5 minutes. **DO NOT INTERPRET RESULT AFTER 10 MINUTES.**
 - I. Negative control should yield a result that is negative for all tested substances
 - J. Positive control should yield a result that is positive for all tested substances

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants	
Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

- K. If control results do not match expected outcomes, repeat the test with a new set of controls. If failure continues, contact NIHD lab POCT team for further instruction.
 - L. No lot or shipment of the Drugs of Abuse Test Cups should be used for patient testing until external controls have passed.
3. Specimen Collection and Preparation:
- A. After taking a Drug of Abuse, it takes a minimum of 2-7 hours for drugs and drug metabolites to appear in urine. It is advisable, therefore, to wait a minimum of 2-7 hours after suspected drug use to collect a urine specimen.
 - B. Verify all patient medication use, including OTC drugs and supplements. This can be useful in ruling out false positives.
 - C. Ensure patient is able to provide a sufficient quantity of urine. 30 mL is the minimum quantity necessary for patient testing. If the minimum quantity is not provided, the specimen should be discarded and recollected later.
 - D. Patient should urinate directly into the urine test cup if the results are to be read immediately, or the specimen may be collected in a sterile urine collection cup if the test will be read later. However, testing the specimen at a later time will invalidate the utility of the Temperature Indicator Strip, which is useful for determining if a patient came to the clinic with another person's urine.
 - E. If the provider would like to consider confirmatory testing, a second collection specimen for confirmatory testing should be provided. Please refer to specific Reference Lab requirements for confirmatory testing (eg. Labcorp Test Menu).
4. Patient Testing:
- A. Allow test cup to come to room temperature (15-30 degrees C) prior to test.
 - B. Testing staff member should be present near the restroom to receive urine DOA test cup and start the timer.
 - C. Tear open foil bag, remove test cup and disposable gloves provided for donor. Label the device with patient information (name and date of birth or Medical Record number, see NIHD specimen collection policy).
 - D. After collection is complete, the patient should close the lid and *immediately* return the cup to the testing staff member.
 - E. Testing staff should peel off label to reveal test result.
 - F. Read Adulterants strip at 2 minutes.
 - G. Read urine temperature at 2-4 minutes, if the patient has urinated directly into the testing cup.
 - H. Read test result at 5 minutes. **DO NOT INTERPRET RESULT AFTER 10 MINUTES.**
5. Result interpretation
- A. All results should be considered preliminary.
 - B. A preliminary positive test result does not always mean a person took illegal drugs and a negative test result does not always mean a person did not take illegal drugs. There are a number of factors that influence the reliability of drug tests. Certain drugs of abuse tests are more accurate than others.
 - C. **Negative:** Two lines appear. One red line should be in the control region (C) and another apparent red or pink line adjacent should be in the test region (Drug/T). This negative result indicates that the drug concentration is below the detectable level. Note, the shade

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants	
Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

of red in the test line region (Drug/T) will vary, but it should be considered negative whenever there is even a faint pink line.

- D. **Positive:** One red line appears in the control region (C). No line appears in the test region (Drug/T) This positive result indicates that the drug concentration is above the detectable level.
- E. **Invalid:** Control line fails to appear. Insufficient specimen volume or incorrect procedural techniques are the most likely reasons for the control line failure. Review the procedure and repeat the test using a new test panel. If the problem persists, discontinue using the lot immediately and contact the Point of Care Team for further instructions.
- F. At the physician’s discretion, preliminary positive tests can be confirmed by a reference lab. Patient safety and all potential clinical consequences should be taken into account before taking any actions based on preliminary results. See Limitations section for further information.
- G. **Adulterant tests (specimen validity tests):** See Color Chart to interpret each result.
 - 1) **Oxidants (OXI):** Tests for the presence of oxidizing agents such as bleach and peroxide in the urine
 - 2) **Specific Gravity (S.G.):** Tests for sample dilution. Normal levels for specific gravity will range from 1.003 to 1.030. Specific gravity levels of less than 1.003 or higher than 1.030 may be an indication of adulteration or specimen dilution.
 - 3) **pH:** tests for the presence of acidic or alkaline adulterants in urine. Normal pH levels should be in the range of 4.0 to 9.0. Values below pH of 4.0 or above 9.0 may indicate the sample has been altered.
- H. **Temperature Indicator Strip:**
 - 1) Green color on temperature indicator strip corresponds to urine temperature.
 - 2) A urine temperature significantly lower than normal human body temperature should be considered a possible indicator that the patient gave a urine specimen that is not their own if tested immediately after urine collection is performed.
 - 3) Factors such as ambient temperature and time since collection should be taken into account when determining if urine temperature reflects a recently collected specimen.

LIMITATIONS:

- 1. The Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants test cup provides only a qualitative, preliminary analytical result. A secondary analytical method should be used before any result should be considered final. Providers should exercise caution before making clinical decisions based on preliminary results. Gas chromatography/mass spectrometry (GC/MS) is the preferred confirmatory method.
- 2. There is a possibility that technical or procedural errors, as well as other interfering substances in the urine specimen may cause erroneous results. Please see the package insert included with the test cups for a detailed, but not exhaustive, list of known non-cross-reacting substances, as well as precision, specificity, and sensitivity data.
- 3. Adulterants, such as bleach and/or alum, in urine specimens may produce erroneous results regardless of the analytical method used. If adulteration is suspected, the test should be repeated with another urine specimen.
- 4. A positive result does not indicate level of intoxication, administration route, or concentration in urine.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants	
Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

5. A negative result may not necessarily indicate drug-free urine. Negative results can be obtained when drug is present but below the cut-off level of the test. See the package insert for the cut-off levels for each of the tests.
6. A negative result does not necessarily rule-out recent drug use. Drugs and their metabolites are present in urine for varying lengths of time depending on frequency of drug use and the type of drug being monitored. Frequent drug screening may be necessary to rule out drug abuse.
7. The test does not distinguish between drugs of abuse and certain medications.
8. A positive result might be obtained from certain foods or food supplements.
9. A comprehensive medication list, including supplements and OTC medications, can be useful in ruling out falsely positive results. See the package insert for known cross-reactive substances under “Analytical Specificity.”
10. The Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants test cup can be circumvented through adulteration or substitution. Observed collection can eliminate concerns of adulterants or substitution by preventing a patient from adding substances a urine or substituting another person’s urine for their own.

REFERENCES:

1. McKesson Drugs of Abuse Test Cups Multi Drug Panel with Adulterants Product Insert.
2. Substance Abuse and Mental Health Services Administration. *Clinical Drug Testing in Primary Care. Technical Assistance Publication (TAP) 32*. HHS Publication No. (SMA) 12-4668. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

CROSS REFERENCE P&P:

1. Training and Competency in Point of Care Testing

Approval	Date
CCOC	7/29/19
Medicine / ICU Committee	8/1/19
Medical Executive Committee	8/6/19
Board of Directors	
Last Board of Directors Review	

Developed: 07-22-2019

Reviewed:

Revised:

Supersedes:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: IV Service When NIH IV Room Is Closed	
Scope: Pharmacy, Administration	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date:

PURPOSE:

To delineate the use of an off-site licensed IV room for the continuance of care while the NIHD IV room is not available.

POLICY:

1. Dwayne’s Friendly Pharmacy IV room will be used under contract if NIH IV room is not available or closed for any reason.
2. Medications that qualify as immediate use will be mixed in a clean area designated by the Director of Pharmacy, also known as Pharmacist in Charge (PIC).
3. Batched medications, Chemotherapy, PCA, Epidural, TPN and PPN will be mixed at Dwayne’s Friendly Pharmacy.
4. Compounded Sterile Products (CSPs) prepared for immediate use must be started on the patient within 1 hour of mixing.
5. Immediate use CSP’s do not need to be compounded in an ISO Class 5 environment and garbing and gowning is not required. They will be mixed in a clean area.
6. During mixture for immediate use, only simple transfer of no more than 3 sterile drugs in the manufacturers containers may be involved in the compounding and no more than 2 entries into any one container may occur.
7. A copy of the current IV room license of Dwayne’s Friendly Pharmacy will be retained at NIH pharmacy during any time that Dwayne’s Friendly Pharmacy IV facility is used under this policy.
8. All personnel that will be mixing at Dwayne’s Friendly Pharmacy will be oriented to their facility
9. All ingredients for each CSP will be gathered with the appropriate labels and transported by the NIH employee to Dwayne’s Friendly Pharmacy and compounded using the same technique and record keeping as at NIH.

PROCEDURE:

Immediate Use:

1. Pharmacy technicians must work with nursing on the timing of the mixing of these medications.
2. Hand hygiene will be performed prior to mixing: Washing hands, under the fingernails, wrists and up to the elbow for 30 seconds with a facility approved agent and drying hands with a non-shedding disposable towel or sanitizing hands with application of a waterless, alcohol-based hand rub approved by the facility.
3. Follow Aseptic technique.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: IV Service When NIH IV Room Is Closed	
Scope: Pharmacy, Administration	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date:

4. Clean the preparation area with **alcohol prior to each use** appropriate agent per Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room) policy.
5. Place an expiration date of 1 hour on the label.

REFERENCES:

1. ASHP Guidelines on Compounding Sterile Preparations.
2. California Board of Pharmacy (2017). Compounding Regulations Guidance: Title CCR section 1735 et seq. and CCR section 1751 et seq. Retrieved from http://www.pharmacy.ca.gov/publications/compounding_faqs.pdf

CROSS REFERENCE POLICY:

1. Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)

Committee Approval	Date
CCOC	7/9/19
Infection Control Committee	5/28/19
Pharmacy and Therapeutics	6/20/19
Medical Executive Committee	8/6/19
Board of Directors	
Board of Directors Last Review	

Developed: 07/19
 Revised:
 Reviewed:
 Supercedes:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Medication Dosing in Renal Failure	
Scope: Pharmacy	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date: 12/15/17

PURPOSE:

To reduce medication related toxicity and adverse effects in patients with renal insufficiency/failure by making appropriate dose adjustment on renally cleared medications.

POLICY:

1. Pharmacists are authorized by the medical staff to adjust the dosages of renally eliminated medications based upon creatinine clearance rates calculated for each patient. This will apply to all medications besides chemotherapy medications which will be handled in a different manner.

PROCEDURE:

1. Upon receipt of an order for a medication that is eligible for dose adjustment, the pharmacist will determine if the ordered dose and frequency is appropriate based on estimated creatinine clearance.
2. The pharmacist will use the creatinine level and compute CRCL using Cockcroft & Gault modified equation. ~~clearance that is provided by the computer system to determine renal function. The computer system uses appropriate renal function estimators for the population that the patient fits in. Majority of patient's renal function is determined by the Cockcroft Gault equation. If the pharmacist determines another estimate for creatinine clearance is more appropriate they will use that estimate for the dose adjustment.~~
3. Appropriate dosing of the medication will be determined based on the renal dose adjustment section of product package insert or most up to date version of Lexicomp.
4. If the ordered dose of the medication is not appropriate, the pharmacist is allowed to discontinue the current order and reorder the medication at the dose defined by the above references.
5. If the medication is contraindicated based on renal function, the pharmacist is responsible for contacting the provider to suggest alternatives.
6. If the original ordered dose is not appropriate for the indication, the pharmacist must contact the provider to recommend alternative dosing.
7. The pharmacist will monitor renal function throughout patients stay in the hospital. If renal function changes throughout the stay, appropriate recommendations will be made to physician for changes in renally cleared medications.

REFERENCES:

1. Dowling, T.C., Matzke, G.R., Murphy, J.E., & Burckart, G. J. (2010). Evaluation of renal drug dosing: prescribing information and clinical pharmacist approaches. *Pharmacotherapy* (30): 776-86. (LOE 8)

CROSS REFERENCE POLICY:

1. Pharmacist Clinical Interventions

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

Title: Medication Dosing in Renal Failure	
Scope: Pharmacy	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date: 12/15/17

Approval	Date
CCOC	7/9/2019
Pharmacy & Therapeutics Committee	6/20/19
Medical Executive Committee	8/6/19
Board of Directors	
Last Board of Directors Review	

Developed: 8/24/17

Reviewed:

Revised: 7/19fl

Supersedes:

Index Listings:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pharmacy Confidentiality: Storage and Destruction of PHI-containing Documents: Storage and Destruction of PHI-containing Documents	
Scope: Departmental	Department: Pharmacy
Source: Pharmacy	Effective Date: Not Approved Yet

PURPOSE:

To ensure that HIPAA regulations are followed in the storage and destruction of Protected Health Information (PHI).

POLICY:

The pharmacy shall maintain confidentiality when storing and destroying patient-related documents (i.e., those that contain patients' names or identifying numbers, or information relating to patients' status, treatment, diagnosis, and medications). These documents include, but are not limited to, the following:

1. Orders and requests for treatments, diagnostic tests, and medications
2. Pharmacy patient profiles
3. Medication administration records
4. Parenteral nutrition "worksheets"
5. Records of medication removals from the pharmacy and floor stocks
6. Medication labels (including unused labels)
7. Medication containers labeled for patient use (including IV containers, vials, and syringes)
8. Charge and billing documents
9. Controlled substance administration records
10. Surgery schedules
11. Census records
12. Medical record audit notes
13. Minutes and records (including attachments) of meetings in which patients are discussed
14. Notes, memos, letters and any document which may contain PHI sensitive information.

STORAGE OF DOCUMENTS

1. Documents that do not require storage shall be destroyed immediately (e.g., by shredding or placing them in a bag or other container for subsequent shredding or incineration).
2. Storage of patient-related documents shall maintain the confidentiality of the data and information therein. Care shall be taken to ensure that confidential information in the documents is not available to persons inside or outside the facility who do not have a legitimate need or reason to know the information.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pharmacy Confidentiality: Storage and Destruction of PHI-containing Documents: Storage and Destruction of PHI-containing Documents	
Scope: Departmental	Department: Pharmacy
Source: Pharmacy	Effective Date: Not Approved Yet

3. Storage of patient-related documents shall comply with facility-approved policies and procedures.
4. Documents to be stored shall be placed in facility-approved storage containers.
5. The contents of document storage containers and the range of dates of the documents therein shall be clearly indicated on the containers.
6. Instructions for retention and destruction of the documents shall be clearly indicated on the containers (e.g., length of time to be retained and date to be destroyed).
7. Documents shall be retained for the longer of the time period specified by facility policy or in laws, rules, and regulations.
8. Storage sites shall be secure (e.g., a locked room or building) and approved by the facility.

DESTRUCTION OF DOCUMENTS

1. Destruction of patient-related documents shall comply with facility-approved policies and procedures.
2. Destruction shall comply with local, State, and Federal laws, rules, and regulations.
3. Destruction shall not threaten the environment.
4. Patient-related documents shall not be mixed with other facility waste.
5. Destruction of patient-related documents shall maintain the confidentiality of the data and information therein. Care shall be taken to ensure that confidential information in the documents is not available to persons inside or outside the facility who do not have a legitimate need or reason to know the information.
6. Destruction shall be complete.
7. Approved destruction procedures include incineration and shredding.

REFERENCES:

1. AHIMA. "Retention and Destruction of Health Information." (Updated October 2013).

CROSS REFERENCE:

1. NIHD Policy Patient Specific Information

Committee Approval	Date
CCOC	7/29/19
Pharmacy and Therapeutics Committee	6/20/19
Medical Executive Committee	8/6/19
Board of Directors	5/17/17
Last Board of Director review	

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Pharmacy Confidentiality: Storage and Destruction of PHI-containing Documents: Storage and Destruction of PHI-containing Documents	
Scope: Departmental	Department: Pharmacy
Source: Pharmacy	Effective Date: Not Approved Yet

Revised 10-03
Reviewed 10/05, 8/08, 9/11, 9/12, 5/17, 7/19FL
Supersedes 02-01

Draft

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Point of Care QuickVue Dipstick Strep A Test*	
Scope: Lab, Outpatient Clinics	Manual: Lab- Point of Care, Laboratory
Source: POC POCT Coordinator CLS	Effective Date: 05/16/2017

I. INTENDED USE

The QuickVue Dipstick Strep A test is intended for the rapid, qualitative detection of group A Streptococcal antigen from throat swabs. The test is to be used to aid in the diagnosis of Group A Streptococcal infection.

II. PRINCIPLE

The QuickVue Dipstick Strep A test is a lateral-flow immunoassay using Quidel's patented antibody labeled particles. The test detects either viable or nonviable organisms directly from throat swabs within five minutes.

III. MATERIALS, EQUIPMENT, AND REAGENTS

- Individually packaged dipsticks
- Gloves
- Extraction reagent A
- Extraction reagent B
- Sterile throat swabs, rayon tipped on plastic shafts
- Tubes
- Positive control material
- Negative control material
- Amies gel duo swab for follow-up culture

IV. PROCEDURE

A. Internal quality control (IQC)

1. QuickVue Dipstick Strep A test provides three levels of internal procedural controls with each test run. For each patient specimen or External QC control tested, each level of IQC should be observed. No result should be considered valid if any IQC level does not pass.
 - a. The color level of the extraction reagent changes from clear to green as the reagents are mixed together. The color change is an internal extraction reagent control and is an indication that the reagents were mixed and functioning properly
 - b. The appearance of a blue control line is an internal control. The dipstick must absorb the proper amount of sample and the dipstick must be working properly for the blue control line to appear. Additionally, the appearance of the control line indicates that capillary flow occurred.
 - c. 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 5 minutes and not interfere with the reading of the test result.

B. Collection

1. Collect throat swab specimens by standard clinical methods. Standard precautions and hand hygiene according to the NIH Infection Control Policy should be followed when performing any collection.
2. Depress the tongue with a tongue blade or spoon.
3. Use a sterile rayon tipped swab on solid plastic shaft to collect throat specimens.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

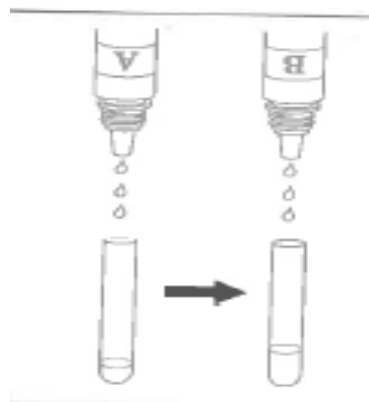
Title: Point of Care QuickVue Dipstick Strep A Test*	
Scope: Lab, Outpatient Clinics	Manual: Lab- Point of Care, Laboratory
Source: POC POCT Coordinator CLS	Effective Date: 05/16/2017

4. Taking care not to touch the tongue sides, or top of the mouth, rub the swab on the back of the throat, on the tonsils and in any other area where there is redness, inflammation, or pus.
5. Process as soon as possible after collection. Swabs may be held in any clean, dry plastic tube or sleeve up to 72 hours at room temperature.
Note: Use of charcoal or agar medium is not recommended.
6. If test is negative, a culture is recommended. Consult with ordering provider. Using an Amies gel duo or single swab, repeat steps a-c. Return swab(s) to the provided Amies gel collection tube. Order BST and send to NIH Lab for culture.

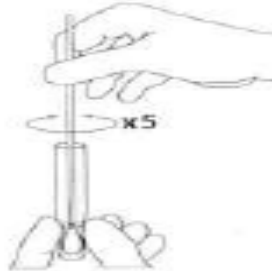
C. Assay procedure

1. Gloves should be worn when handling patient specimens.
2. Add **3 drops** of reagent A and **3 drops** of reagent B into a clean tube. Make sure to hold bottles vertically to form complete drops. This solution should turn **GREEN**.

Note: Should reagent B appear green prior to being mixed with reagent A, do NOT use. Obtain a new QuikVue Strep A kit to run test. Contact Lab POC team for follow up. POC team will contact technical support, per manufacturer's recommendations.



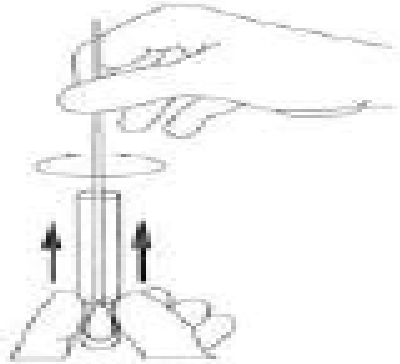
3. Immediately add the patient swab sample to the tube. Squeeze the bottom of the tube so the swab head is compressed. Rotate the swab a minimum of **5 times**.



4. Keep swab in tube for **one minute**.
5. Express all liquid from the swab against the inside of the tube. Squeeze the swab firmly as it is removed from the tube. Discard the swab.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Point of Care QuickVue Dipstick Strep A Test*	
Scope: Lab, Outpatient Clinics	Manual: Lab- Point of Care, Laboratory
Source: POC POCT Coordinator CLS	Effective Date: 05/16/2017



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



7. Read the result at **5 minutes**. Some positive results may appear sooner.

D. External QC procedure

1. External QC 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 in C.1-C.3.
3. Vigorously mix the positive control bottle. Add one drop of the control to the tube.
4. Place a clean swab in the tube.
5. Follow steps C.4-C.7.

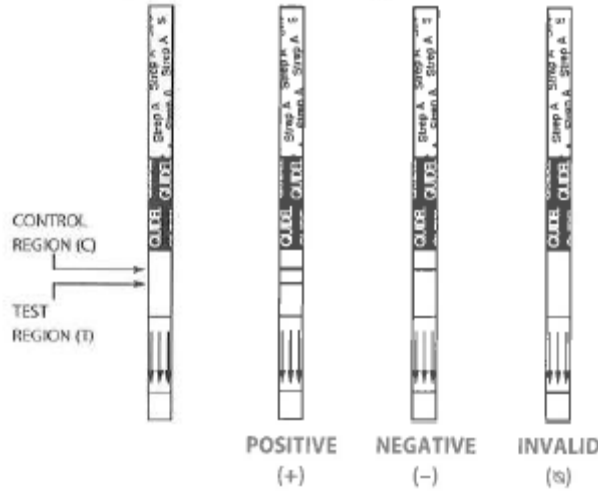
E. Interpreting results

1. **Positive result:** Any pink to purple test line along with any shade of a blue procedural control line is a positive result for the detection of Group A Streptococcus antigen.
2. **Negative result:** A blue procedural control line and no pink test line is a presumptive negative result.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Point of Care QuickVue Dipstick Strep A Test*	
Scope: Lab, Outpatient Clinics	Manual: Lab- Point of Care, Laboratory
Source: POC POCT Coordinator CLS	Effective Date: 05/16/2017

3. **Invalid result:** The test result is invalid if a blue control line is not visible at 5 minutes. If this occurs, retest using a new sample and a new dipstick.



V. LIMITATIONS OF THE PROCEDURE

- A. The contents of this kit are for use in the qualitative detection of Group A Streptococcal antigen from throat swab specimens. Failure to follow the test procedure and interpretation of test results may adversely affect performance and/or produce invalid results.
- B. The test detects both viable and nonviable Group A Streptococci and may yield a positive result in the absence of living organisms.
- C. Respiratory infections, including pharyngitis, can be caused by Streptococcus from serogroups other than Group A as well as other pathogens.
- D. The QuickVue Dipstick Strep A test will not differentiate asymptomatic carriers of Group A Streptococcus from those exhibiting Streptococcal infection
- E.** 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. Per Joint Commission recommendations, an age specific correlation study was performed on negative rapid strep tests. The correlation study demonstrated 100% correlation of negative rapid strep tests with cultures resulting as negative for Strep A. As a result of this study, additional follow-up testing of negative rapid strep tests using the culture method is not mandatory. The ordering provider has the sole discretion, after accounting for other testing results and clinical presentation, to determine if a follow up culture is necessary.

VI. REFERENCES

- 1. QuickVue Dipstick Strep A package insert, 1053407; 01/15

Approval	Date
CCOC	06-24-19
Medical Services Committee	8/1/19
Medical Executive Committee	8/6/19
Board of Directors	4/19/17

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: Point of Care QuickVue Dipstick Strep A Test*	
Scope: Lab, Outpatient Clinics	Manual: Lab- Point of Care, Laboratory
Source: POC POCT Coordinator CLS	Effective Date: 05/16/2017

Last Board of Directors Review	5/16/18
--------------------------------	---------

Developed: 3/16

Reviewed: Lab 3/17, Board of Directors 4/17, 5/16/2018

Revised: 5/18

Supersedes:

in approval

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: UNUSABLE DRUGS	
Scope: District Wide	Department: Pharmacy
Source: Director of Pharmacy	Effective Date:

PURPOSE:

To ensure that drugs which are rendered unusable are properly managed.

POLICY:

1. All discontinued patient drugs; outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels shall be returned to the Pharmacy Department for proper disposal.
2. Such returned drugs shall be stored in an isolated area in the Pharmacy Department that has been designated for the storage of such unusable drugs, until they can be destroyed in accordance with applicable law or returned to the manufacturer for proper disposal or pick up can be made.
3. Drugs listed in Schedules II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act (controlled substances) shall be destroyed or shipped to the approved agencies for destruction according to current state and federal laws.
4. All drug storage areas of the hospital shall be inspected monthly in accordance with the "Drug Storage and Inspections of Medication Areas" Policy.
5. The pharmacy staff conducting the inspection will list and remove all of these types of drugs from the area for ultimate disposition.
6. Nursing or other staff approved by license to administer medications, noting outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels, will contact the pharmacy department notifying that department of the drug's existence on his or her unit.
7. The nursing or other licensed staff member will place the unusable medication in a special container that resides on each patient care unit in a secure and separate area (generally in a designated locked cabinet) labeled "unusable medications - return to Pharmacy".
8. Medications from outside the hospital brought in by patients must not be routinely accepted for storage, and every effort should be made to return medications to family.
9. Controlled substances and scheduled drugs listed in Schedules II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act shall be destroyed or shipped to the approved agencies for destruction according to current state and federal laws.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

Title: UNUSABLE DRUGS	
Scope: District Wide	Department: Pharmacy
Source: Director of Pharmacy	Effective Date:

10. Unusable drugs may be returned to the manufacturer for credit dependent upon the manufacturer's policies and the type of medication itself:
- a. Medications that may be returned to the manufacturer will be returned per the manufacturer's instructions
 - b. Medications that are to be disposed will be sequestered and placed in the approved area of the Pharmacy Department designated for disposal company retrieval or manufacturer return
11. A record of removal from the facility will be kept which includes the name of the disposal company, the name, strength and quantity of medications for disposal, and the date the medications were removed from the Pharmacy Department.
12. The pharmacy will maintain a list of approved disposal companies after review and approval by the Pharmacy and Therapeutics Committee. To receive approval by the Pharmacy and Therapeutics Committee the company must:
- a. Supply the pharmacy department with an accounting of its medication disposal process to assure proper destruction of medications, and to assure the facility that medications released to the disposal company will not be diverted in any manner.
 - b. Have adequate quality control processes in place that verify the appropriate disposal processes are conducted successfully
 - c. Provide a sample of the company's record keeping documents to assure proper disposal and the prevention of diversion.

REFERENCES:

1. **NIHD Policy Patient Own Meds Policy**
2. **HDMA "Understanding the Drivers of Medication Returns" May 2009**

Committee Approval	Date
CCOC	5/21/19
Pharmacy & Therapeutics Committee	6/20/19
Medical Executive Committee	8/6/19
Board of Directors	1/16/19
Last Board of Directors Review	

Revised: 5/19; FL
Reviewed 10/06, 10/19, 10/11, 10/13, 5/19

Practitioner Name: _____ Date: _____
Please Print

EMERGENCY MEDICINE

Instructions: Please check box next to each set of core privileges or special privilege requested.

INITIAL CRITERIA	
Education/Formal Training:	
<ul style="list-style-type: none"> • Board Certified/Board Eligible in Emergency Medicine OR • Board Certified/Board Eligible in Family Practice with current ATLS, ACLS and PALS certification. 	
CORE PRIVILEGES	
Request	<ul style="list-style-type: none"> • Assess, work up, perform history and physical exam, and provide initial treatment to patients of any age who present to the Emergency Department with any illness, injury, condition or symptom. • Provide those services necessary to ameliorate minor illness or injuries, provide stabilizing treatment to patients presenting with major illness or injuries and to assess all patients in order to determine if more definitive services are necessary.
<input type="checkbox"/>	
SPECIAL PRIVILEGES	
<i>Please check box for each special privilege requested.</i>	
Ultrasound (Emergency)* <input type="checkbox"/> Procedural. To be utilized for localization and assistance with IV access, central lines, bladder localization and aspiration, simple subcutaneous abscess identification, foreign body identification, thoracentesis, paracentesis and nerve blocks. <input type="checkbox"/> Limited Diagnostic. Including, but not limited to abdominal/urinary, cardiac, musculoskeletal, obstetric/gynecologic, ocular, skin/soft tissue, thoracic, trauma, and vascular. <i>*Requires proof of Emergency Medicine residency training which included US training or certificate of training course with proctoring.</i>	Sedation/Analgesia** <input type="checkbox"/> Moderate sedation <input type="checkbox"/> Dissociative sedation <input type="checkbox"/> Deep sedation <i>**Requires evidence of six (6) sedations performed in the last two (2) years and completion of reading list/tutorials every two (2) years as per the Procedural Sedation policy.</i>

Acknowledgment of Practitioner:

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

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

Practitioner Signature

Date



Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

Chief of Emergency Room Service _____
Date

<i>Approvals</i>	<i>Committee Date</i>
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Emergency Room Service Critical Indicators

2019

1. Physician and Staff Concerns
2. All non-5150 Transfers
3. Formal Patient Complaints
- ~~4. AMA~~
- ~~5.4. Unscheduled Return or Admit Seen Within 72 Hours~~ with admission, transfer or death.
- ~~6.5. All Codes, and Deaths, and Critical Patients~~
- ~~7. Death Within 24 Hours of Visit 72 hours?~~
- ~~8. All Incoming Transfers~~
- ~~9.6. Suicide or Attempted Suicide in the ED~~
- ~~10. Concern Regarding Quality of Pre-Hospital Care~~

Approvals:

Emergency Room Service Committee: ~~01/09/2019~~07/10/2019

Medical Executive Committee: ~~02/05/2019~~07/15/2019

Board of Directors: ~~02/20/2019~~

Rural Health Clinic Critical Indicators

2019

1. Transfer to NIH for emergency care.
2. All admissions of RHC patients.
3. All deaths of RHC patients.
4. Documented specific procedure complication, such as:
 - a. Hemorrhage
 - b. Poor healing
 - c. Impairment of body function to a level less than that prior to the procedure and less than commonly expected as a result of the procedure
5. Cardiac or respiratory arrest.
6. Consultation with the physician in the following circumstance:
 - a. Emergent conditions requiring prompt medical intervention after the stabilization has been initiated
 - b. Any injury threatening life or limb
 - c. Any laceration requiring complicated suture close
 - d. Any fracture or injury requiring immobilization by full casting
 - e. Complicated or extensive burns
7. Upon request of the patient/family, provider staff, nursing or ancillary RHC staff, or Medical Staff member.

Approvals:

Medicine/Intensive Care Service Committee: 8/1/19

Medical Executive Committee: 8/6/19

Board of Directors:

Inyo County Strategic Roadmap

Funded by the County Medical Services Program (CMSP)

BACKGROUND

The Inyo County Healthcare Coalition met on June 24th, 2019 to review the findings from the Healthcare Coalition Needs Assessment and the Northern Inyo Healthcare District Outmigration Data, and develop priority focus areas for Community Health and Wellness efforts. This meeting has representatives from Health and Human Services (HHS) Administration, HHS- Public Health & Prevention, Northern Inyo Hospital, Southern Inyo Hospital, Wild Iris, Owens Valley Career Development Center (OVCDC), Inyo Mono Advocates for Community Action (IMACA), and Kemper Consultant Group.

OVERVIEW

This Roadmap was created to help guide our agencies priorities when developing new initiatives or pursuing funding opportunities to address broad community issues. The hope is to coalesce Inyo County’s health and wellness agencies around a series of priorities and work on them together, from our respective angles. If we leverage our combined efforts, we can perhaps move the needle on some of the identified priority issues.

IDENTIFIED PRIORITY FOCUS AREAS

1. Behavioral Health- Mental Health and Substance Use Disorder
2. Access to Services
3. TBD

ROADMAP

For each priority focus area, we will identify the following 6 elements of the roadmap:

- **Concept:**
- **Strategy(ies)**
- **Partners:**
- **Funding:**
- **Barriers:**
- **Next Steps:**

FOCUS AREA 1- Behavioral Health

Through the 2018 Community Needs Assessment, the Northern Inyo Hospital 2018 Outmigration Assessment, and stakeholder conversations, the coalition has selected behavioral health (including mental health and substance use disorder) as the first community need.

Concept: Mental Health - Depression & Anxiety

More than 20% of respondents reported depression and anxiety. This problem affects all income levels and areas although a third of the respondents who reported these conditions were low income. Two-thirds of the respondents reporting this condition were from the Bishop area.

While the county offers mental health services to Inyo County residents with serious mental illness who meet medical necessity for specialty mental health care, there are few providers of mental health services within the county to treat depression, anxiety, and other moderate mental health issues. The concept is to find ways to expand access to mental health care for those with anxiety and depression, focused on low income individuals within the Bishop area.

Strategy(ies):

- Inyo County HHS-BH is working on a referral system with Medi-Cal managed care plans to better coordinate access to mental health care for Medi-Cal enrollees who do not meet medical necessity to access county mental health services.
- HHS-BH is piloting a program in Tecopa to offer Anthem-enrolled Medi-Cal beneficiaries access to mild/moderate mental health services via Ipad. If successful, could consider rolling out in other areas.
- Other strategies??

Potential Partners: HHS, Northern Inyo Hospital and Rural Health Clinic, Southern Inyo Hospital, Toiyabe, Private Practice clinicians

Funding: Medi-Cal billing. Grant funds may be available for equipment. Donations/services from managed care plans.

Barriers: Statewide shortage of mental health professionals. Low reimbursement for Medi-Cal mental health. Prohibition of same-day billing for mental health/primary care at RHC (and Toiyabe?)

Next Steps:

- Evaluate Tecopa Ipad pilot and consider rolling out in other areas of Inyo County
- Work with CA Health and Wellness to find solutions for the CHW enrolled beneficiaries
- How do we help those who are not on Medi-Cal?
- How do we incentivize more mental health professionals to come to our area?
- Continue developing Medi-Cal referral process with HHS-BH and the Medi-Cal plans.

Concept: Substance Use and Alcohol Use Disorder and Driving Under the Influence

NIHD's outmigration data shows Inyo County underperforming compared to California and National benchmark in drug overdose deaths, excessive drinking, and alcohol-impaired driving deaths.

Strategy(ies):

- NIHD RHC is building MAT program
- HHS-BH is launching intensive outpatient treatment program
- What else are we doing/what do we want to start making a dent in this major community issue?

Potential Partners: HHS, Northern Inyo Hospital and Rural Health Clinic, Southern Inyo Hospital, Toiyabe, ICSOS, Sheriff, Bishop PD, CHP

Funding: State/federal grants around opioids, Drug Medi-Cal billing – what else is out there?

Barriers: State and federal funding centered mostly around opioids at this time. Other major issues in Inyo County include methamphetamines and alcohol. Hiring substance use counselors and personnel is very difficult. Need a way of recruiting workforce to do the work.

Next Steps:

- HHS-BH intends to continue building SUD programs
- What about workforce strategies?
- Next steps for NIHD-RHC?

FOCUS AREA 2- Access to Services

Through the survey results and conversations with stakeholders in the community coalition has decided that Access to Services is a priority focus area.

Concept: Enhance access to transportation to a variety of services to improve health and wellbeing

22% of respondents reported that it was hard to access physical health care, 10% mental health care, and 13.2 % dental care. The Northern Inyo Hospital 2018 Outmigration Assessment indicated that Inyo County is behind State and National benchmarks for access to exercise opportunities, limited access to healthy foods, and food environment index.

Strategy(ies):

Partners:

Funding:

Barriers:

Next Steps:

FOCUS AREA 3- TBD

Through the survey results and conversations with stakeholders in the community coalition has decided that XXX is a priority focus area.

Concept:

Strategy(ies)

Partners:

Funding:

Barriers:

Next Steps:

Northern Inyo Healthcare District
Income Statement - Summary
As of April 30, 2019

	Month To Date 04/30/2019	Month To Date 03/31/2019	Year To Date 04/30/2019	Year To Date 04/30/2018
	Actual	Actual	Actual	Actual
Inpatient Revenue	3,589,681.05	2,963,435.74	30,738,517.70	36,511,354.01
Outpatient Revenue	9,803,322.74	9,260,869.80	90,981,185.15	80,484,517.29
Clinic Revenue	584,113.29	704,819.73	5,598,623.10	6,769,293.52
Total Gross Patient Service Revenue	13,977,117.08	12,929,125.27	127,318,325.95	123,765,164.82
Deductions from Revenue	(7,052,302.64)	(6,895,849.64)	(66,051,446.33)	(60,362,375.13)
Other Patient Revenue	23,580.94	35,033.95	58,596.30	0.00
Total Net Patient Revenue	6,948,395.38	6,068,309.58	61,325,475.92	63,402,789.69
Income/Expense from Cost Reporting	0.00	136,456.98	3,924,518.64	5,052,491.15
Other Operating Revenue	1,020,781.70	1,743,520.17	9,607,793.23	2,142,923.41
Net Revenues from Operations	7,969,177.08	7,948,286.73	74,857,787.79	70,598,204.25
Operating Expenses				
Repairs and Maintenance	15,901.37	15,335.37	360,946.89	1,730,069.81
Leases and Rental Expenses	61,152.85	61,833.50	697,881.65	695,858.73
Salary & Wages	2,441,430.50	2,562,303.50	24,413,175.61	21,187,405.76
Benefits	1,744,594.01	1,917,304.16	17,150,685.91	16,331,518.68
Non-Benefit Expenses	5,909.97	21,979.53	137,000.29	179,091.55
Professional Fees	799,367.07	907,881.83	9,109,293.18	10,326,539.06
Supplies	862,696.65	788,557.95	8,485,445.24	7,496,234.26
Contract Services	399,837.14	466,086.47	4,279,528.44	1,428,289.56
Other Department Expenses	120,363.58	141,309.68	1,005,829.66	748,139.50
Hospital Insurance Expenses	(29,148.51)	33,686.99	286,344.39	292,839.56
Utilities	98,575.64	115,472.53	1,231,585.49	1,061,311.91
Depreciation and Amortization	315,274.19	316,569.72	3,313,622.03	3,772,456.97
Other Fees	290,465.90	466,089.99	1,741,686.39	975,679.78
Interest Expense - Operating	231,952.23	231,952.23	2,337,740.31	2,467,207.14
Total Operating Expenses	7,358,372.59	8,046,363.45	74,550,765.48	68,692,642.27
Total Net Operating Profit (Loss)	610,804.49	(98,076.72)	307,022.31	1,905,561.98
Non-Operating Revenue				
Other Income				
Tax Payer General Support	48,743.07	48,743.07	545,142.06	438,588.47
Bond/ Tax Payer Bond Support	137,595.79	137,595.79	1,393,147.87	1,286,467.50
Interpreter Services Revenue	0.00	0.00	17,826.52	0.00
Fin Chgs-Pt Ar - Int Incm-Payers	2,825.86	687.33	20,991.56	46,251.44
Interest Income	46,165.59	39,396.45	533,131.99	250,276.23
Total Other Income	235,330.31	226,422.64	2,510,240.00	2,021,583.64
Grant Revenue	57,750.00	3,508.01	2,115,871.74	1,559,430.22
Other Non-Operating Income	(9,852.00)	2,576.00	32,419.89	20,197.23
Net Medical Office Activity	(438,349.76)	(516,556.99)	(5,344,419.43)	(3,887,519.92)
340b Net Activity	42,399.84	25,130.67	263,168.34	(3,250.81)
Donations	0.00	3,000.00	9,300.00	0.00
Rental Income	4,881.41	1,750.00	30,428.93	42,235.95
Gain - Investments - Other Income	0.00	0.00	5,080.50	0.00
Netl Non-Operating Profit (Loss)	(107,840.20)	(254,169.67)	(377,910.03)	(247,323.69)
Total Net Income (Loss)	502,964.29	(352,246.39)	(70,887.72)	1,658,238.29

Northern Inyo Healthcare District
Balance Sheet
As of April 30, 2019

Assets	<u>Actual</u>
Current Assets	
Cash and Short Term Investment	11,531,401.95
PMA Partnership	379,758.00
Accounts Receivable, Net of Allowance	
Accounts Receivable	42,902,707.37
Allowances against Receivables	(23,945,356.21)
NIA Accrued Allowances	(454,581.69)
Total Accounts Receivable, Net of Allowance	<u>18,502,769.47</u>
Other Receivables	11,385,148.00
Inventory	3,860,656.01
Prepaid Expenses	1,748,076.04
Total Current Assets	<u>47,407,809.47</u>
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,098,765.26
Limited Use Assets	
DC Pension	2,688,822.65
DB Pension	13,547,735.00
PEPRA	2,967.70
Total Limited Use Assets	<u>16,239,525.35</u>
Revenue Bonds Held by a Trustee	4,387,504.20
Total Assets Limited as to Use	<u>21,725,794.81</u>
Long Term Assets	
Long Term Investment	1,054,166.52
Fixed Assets, Net of Depreciation	
Fixed Assets	124,839,779.19
Accumulated Depreciation	(49,046,950.52)
Construction in Progress	1,065,521.85
Total Fixed Assets, Net of Depreciation	<u>76,858,350.52</u>
Total Long Term Assets	<u>77,912,517.04</u>
Total Assets	<u>147,046,121.32</u>
 Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	811,088.92
Accounts Payable	2,727,351.06
Accrued Payroll and Related	8,648,725.20
Accrued Interest and Sales Tax	455,411.24
Unearned Revenue	508,574.85
Due to 3rd Party Payors	4,896,512.32
Due to Specific Purpose Funds	206,654.17
Other Deferred Credits - Pension	4,059,539.70
Total Current Liabilities	<u>22,383,055.80</u>
Long Term Liabilities	
Long Term Debt	41,839,947.15
Bond Premium	490,578.70
Accreted Interest	13,299,166.50
Other Non-Current Liability - Pension	31,778,171.00
Total Long Term Liabilities	<u>87,407,863.35</u>
Total Liabilities	<u>109,721,720.81</u>
Fund Balance	
Fund Balance	37,395,288.23
Net Income (Loss)	(70,887.72)
Total Fund Balance	<u>37,324,400.51</u>
Liabilities + Fund Balance	<u>147,046,121.32</u>

CALL TO ORDER The meeting was called to order at 10:00 am by Mary Mae Kilpatrick, President.

PRESENT Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
M.C. Hubbard, Member-at-Large
Jody Veenker, Director
Tracy Aspel, RN, BSN, Chief Nursing Officer

OPPORTUNITY FOR PUBLIC COMMENT Ms. Kilpatrick announced at this time persons in the audience may speak on any items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.

REVIEW OF BOARD OF DIRECTORS 2019 SELF ASSESSMENT At 10:01 am Ms. Kilpatrick announced that the Northern Inyo Healthcare District (NIHD) Board of Directors would review and discuss the results of their 2019 Board Self-Assessment. In-depth open discussion on this topic then took place.

ADJOURNMENT The meeting was adjourned at 2:40 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.
PRESENT	Mary Mae Kilpatrick, President Jean Turner, Vice President Robert Sharp, Secretary M.C. Hubbard, Treasurer Jody Veenker, Member at Large William Timbers MD, Chief of Staff Kevin S. Flanigan MD, MBA, Chief Executive Officer John Tremble, Chief Financial Officer Tracy Aspel RN, BSN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Kilpatrick stated at this time persons in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board. Speakers will be limited to a maximum of three minutes each, and members of the audience will have an opportunity to address the Board on every item on the agenda. Dan David, RN reported on an upcoming Opioid Summit that will be held as a collaborative effort by local healthcare providers. No other comments were heard.
STRATEGIC PLAN UPDATE, FINANCE AND MARKETSHARE	Chief Executive Officer Kevin S. Flanigan MD, MBA reported the Finance and Market Share Committee has no significant progress to report at this time. The Committee has added a physician champion to their membership, which will enhance the group's efforts going forward.
NEW BUSINESS	
ELECTION OF BOARD OFFICERS	Ms. Kilpatrick called attention to election of a member of the Northern Inyo Healthcare District (NIHD) Board of Directors to fill the vacancy of Board Treasurer. Director Robert Sharp made a motion to nominate M.C. Hubbard to fill that position and to appoint Jody Veenker to act as Member at Large. The motion was seconded by Ms. Hubbard and unanimously passed to approve.
OUTPATIENT INFUSION USE OF PASTORAL ROOM	Doctor Flanigan asked for Board approval to temporarily use Hospital space previously designated for pastoral counseling for outpatient infusion services during the Pharmacy construction project. It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the use of pastoral counseling space for outpatient infusion during the Pharmacy construction project.
DISTRICT WIDE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN	Doctor Flanigan called attention to a proposed <i>District-wide Quality Assurance and Performance Improvement Plan</i> , requesting that approval of the Plan be tabled to a future meeting in order to allow it to be made more comprehensive by combining it with the Medical Staff Quality Plan.

The revised Plan is expected to be re-submitted for Board approval in the month of September.

CHIEF EXECUTIVE
OFFICER REPORT

Doctor Flanigan asked if any members of the Board of Directors had questions on the bi-monthly Chief Executive Officer report that was submitted for review in writing. No questions were asked.

CHIEF OPERATING
OFFICER REPORT

Doctor Flanigan also asked if any members of the Board had questions on the Chief Operating Officer report submitted by Kelli Davis, MBA. No questions were asked. The Board praised the ongoing efforts of both Chief Officers.

CHIEF NURSING
OFFICER REPORT

Chief Nursing Officer Tracy Aspel RN, BSN asked if any members of the Board had questions on the bi-monthly Chief Nursing Officer report submitted for their review. The Board complimented the Emergency Department team on a successful pediatric readiness assessment, and no questions were asked.

CHIEF FINANCIAL
OFFICER REPORT

Chief Financial Officer (CFO) John Tremble provided a bi-monthly CFO report which noted the following:

- The Finance Departments have made considerable progress toward making new computer systems operational, however financial reporting challenges remain
- Accounts Receivable remain high following Athena implementation, and AR reduction is a current area of focus
- Fixed Assets have increased as a result of equipment purchases and the acquisitions of Pioneer Home Health and the Joseph House property
- The District is currently showing a loss of approximately \$70,000 for the fiscal year

Director Kilpatrick requested a written accounting of Joseph House expenses incurred and cost savings realized. Doctor Flanigan will address that request.

NIHD DEFINED
BENEFIT FUNDING
REPORT

Mr. Tremble provided an overview of the history and funding of the NIHD Defined Benefit Retirement Plan, as an item of information for the Board. The fund was closed to new participants as of January 1, 2013, and it has been underfunded in previous years. The District now projects that approximately \$6,000,000 in funding will be necessary for the next 8 years.

QUARTERLY MEDICAL
STAFF SERVICES
PILLARS REPORT

Doctor Flanigan reported the Medical Staff Services Quarterly Report will be tabled at this time, and that an annual Medical Staff Services Report will be provided at the August regular meeting.

EASTERN SIERRA
EMERGENCY
PHYSICIANS

Eastern Sierra Emergency Physicians (ESEP) partner Sierra Bourne, MD provided an ESEP quarterly report, noting the following:

- The NIHD Emergency Department (ED) is now 100 percent

QUARTERLY REPORT	staffed by local physicians <ul style="list-style-type: none">- ED physician coverage has been changed to 3 eight-hour shifts per day, which has proven to be beneficial for both patient care as well as for the physicians- The ED has seen an increase in volume- Two new ED physicians will come on board in the next month
CHIEF OF STAFF REPORT	Chief of Staff William Timbers MD reported the Medical Executive Committee requests approval of Stacey Brown MD to serve as Vice Chief of Staff for the remainder of the current fiscal year. It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to appoint Stacey Brown MD to the office of Vice Chief of Staff for the remainder of the fiscal year.
VICE CHIEF OF STAFF	
POLICY AND PROCEDURE APPROVAL	Doctor Timbers also reported following careful review and consideration the Medical Executive Committee recommends approval of the following District-Wide Policy and Procedure: <ul style="list-style-type: none">- <i>Crash Cart and Defibrillator Check Policy and Procedure</i> It was moved by Ms. Hubbard, seconded by Mr. Sharp, and unanimously passed to approve the <i>Crash Cart and Defibrillator Check Policy and Procedure</i> as presented.
MEDICAL STAFF APPOINTMENTS	Doctor Timbers additionally reported following careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following Medical Staff appointments: <ol style="list-style-type: none">1. James Fair III, MD (<i>emergency medicine</i>) - Provisional Active Staff2. Anna Rudolphi, MD (<i>emergency medicine</i>) - Provisional Active Staff It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve the appointments of Drs. Fair and Rudolphi as requested.
TEMPORARY MEDICAL STAFF PRIVILEGES	Doctor Timbers also reported the Medical Executive Committee recommends approval of the following Medical Staff Temporary Privileges (for 120 days): <ol style="list-style-type: none">1. Shiva Shabnam, MD (<i>internal medicine</i>) - Locums Temporary Staff2. Sumon Syed, MD (<i>internal medicine</i>) - Locums Temporary Staff It was moved by Ms. Hubbard, seconded by Ms. Veenker, and unanimously passed to approve the Medical Staff Temporary Privileges of Doctors Shabnam and Syed as requested.
REAPPOINTMENT TO NEW STAFF CATEGORY	Doctor Timbers additionally reported the Medical Executive Committee recommends reappointment to a new Staff category for Stefan Schunk, MD (<i>internal medicine</i>) - change from Locums/Temporary Staff to Provisional Active Staff with privileges active through December 31,

2020. It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to approve the new Staff category for Doctor Stefan Schunk as requested.

EXTENSION OF
PRIVILEGES FOR AN
ADDITIONAL 60 DAYS

Doctor Timbers also requested approval of extension of privileges for an additional 60 days for the following:

- Ruhong Ma, DO (*internal medicine/hospitalist*)
- Michael Rhodes, MD (*internal medicine/hospitalist*)

It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve the extension of privileges for Doctors Ma and Rhodes as requested.

MEDICAL STAFF
ADVANCEMENTS

Doctor Timbers additionally reported following careful review and consideration the Medical Executive Committee requests approval of the following Medical Staff advancements:

1. Farres Ahmed, MD (*radiology*) - advancement from Provisional Consulting Staff to Consulting Staff
2. Jared Kasper, MD (*radiology*) - advancement from Provisional Consulting Staff to Consulting Staff
3. Erik Maki, MD (*radiology*) - advancement from Provisional Consulting Staff to Consulting Staff

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

MEDICAL STAFF
RESIGNATIONS

Doctor Timbers also stated the Medical Executive Committee recommends acceptance of the following Medical Staff resignations:

1. Ivan Anderson, MD (*cardiology*) - effective 6/1/2019
2. Steve Dong, MD (*urology*) - effective 7/20/2019
3. Thomas Nylk, MD (*cardiology*) - effective 6/27/2019
4. Irin Pansawira, OD (*optometry*) - effective 6/30/2019
5. Jacqueline Theis, OD (*optometry*) - effective 6/30/2019
6. Cecilia Rhodus, MD (*pediatrics*) - effective 6/4/2019

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

PHYSICIAN
RECRUITMENT AND
RETENTION

Doctor Timbers also noted that physician recruitment and retention will be added to the list of Chief of Staff responsibilities going forward, and he will provide regular reports on that topic.

CONSENT AGENDA

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

- *Approval of minutes of the June 19 2019 regular meeting*

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve the minutes of the June 19 2019 regular meeting as presented.

BOARD MEMBER
REPORTS

Ms. Kilpatrick then asked if any members of the Board of Directors wished to comment on any items of interest. Director Hubbard

complimented a recent Healthy Lifestyles talk provided by Jeanine Arndal, MD and Teresa Heth, NIHD Physical Therapist. Director Turner reported that the special meeting held to review the Board of Directors annual self-assessment went very well. No other comments were heard.

ADJOURNMENT TO
CLOSED SESSION

At 6:29 pm Ms. Kilpatrick reported 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) (*Health and Safety Code Section 32106*).
- B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
- C. Conference with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d(2))*).
- D. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN

At 8:39 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 8:40 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary



Medical Staff Services

Department: Medical Staff Administration
Pillars of Excellence: FY July 1, 2018-June 30, 2019

Indicator	Baseline	Goal	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	YTD
			2018	2018	2019	2019	
			Q1	Q2	Q3	Q4	
Service							
1. Customer satisfaction							
a. Average Credentialing TAT (from receipt of complete application)	12 days	<21 days	7 d	16 d	12 d	7 d	10 d
b. Average Privileging TAT (from receipt of complete application)	30 days	<60 days	25 d	35 d	39 d	42 d	36 d
c. Percent on-time start	95%	100%	100%	86%	46%	100%	80%
2. Application times							
a. Average time for any application materials to be returned	18 days	<14 days	24 d	17 d	19 d	14 d	18 d
b. Average time for <u>complete</u> application to be returned	37 days	<45 days	43 d	23 d	28 d	33 d	32 d
Quality							
1. Credentialing/Privileging							
a. Percent processed within time frame specified in bylaws	100%	100%	100%	100%	91%	100%	97%
b. Percent of applicants granted temporary/expedited privileges	39%	<33%	25%	57%	36%	33%	37%
People							
1. Active Staff	41	N/A	39	39	42	42	
2. All Medical Staff Members and Allied Health Professionals (+ tele)	106	N/A	108	105	109	108	
3. Locums/Temporary Staff	23	N/A	5	6	9	12	
4. Resignations	13	N/A	7	4	4	5	
Finance							
1. Total initial applications processed	62/year	N/A	8	7	11	9	35
2. Number of locum tenens applications	19/year	N/A	2	3	5	4	14
3. Number of applications abandoned/discontinued	5/year	N/A	2	2	1	4*	9

*4 discontinued and an additional 4 placed on hold until further notice

LEGEND	
	Exceeds goal; 100%
	Meets goal
	Close to goal
	Does not meet goal



Medical Staff Services

Q4: FY 2019

Narrative Notes:

The medical staff office met or exceeded all metrics during the last quarter of the 2019 fiscal year, with the exception of “percent of applicants granted temporary/expedited privileges.” Lower percentages in this area mean more applicants go through the full credentialing process, which is designed to ensure applicant competency and patient safety. While expedited privileges are not typically granted without a thorough investigation into the applicant’s background, there is nonetheless an increased risk whenever privileges are granted prior to 100% completion of the credentialing process.

Annual Report - FY 2019

The Department

The medical staff services department is composed of three employees, as listed:

- Amanda Holland, Medical Staff Support Specialist
- Jason Fautz, Medical Staff Quality Analyst
- Dianne Picken, Medical Staff Support Manager

Our Medical Staff Support Specialist is our credentialing expert. With 2020 being her third year in the profession, she will be eligible to take the examination to be recognized as a Certified Provider Credentialing Specialist (CPCS). This examination is administered by the National Association of Medical Staff Services and is considered a demonstration of knowledge and professional competence in the field of credentialing.

Our Medical Staff Quality Analyst joined our team in January of 2019 and has been focused on the following performance improvement projects: review and reduction of medication-related errors, coordination and improvement of medical staff peer review, oversight of provider-specific reporting requirements, and overall implementation of lean principles in the department. As a new role, the scope of his projects continues to grow and evolve.

As the Manager in the department, my responsibilities include helping the Medical Staff rewrite and conform to their bylaws, updating policies and privileges as regulations change, and managing other projects at the direction of administration and the medical staff. Additionally, over the last year, my responsibilities have expanded to include providing administrative support in physician recruitment and retention, completing the hospitalist schedule, and chairing the Market Share Subcommittee.

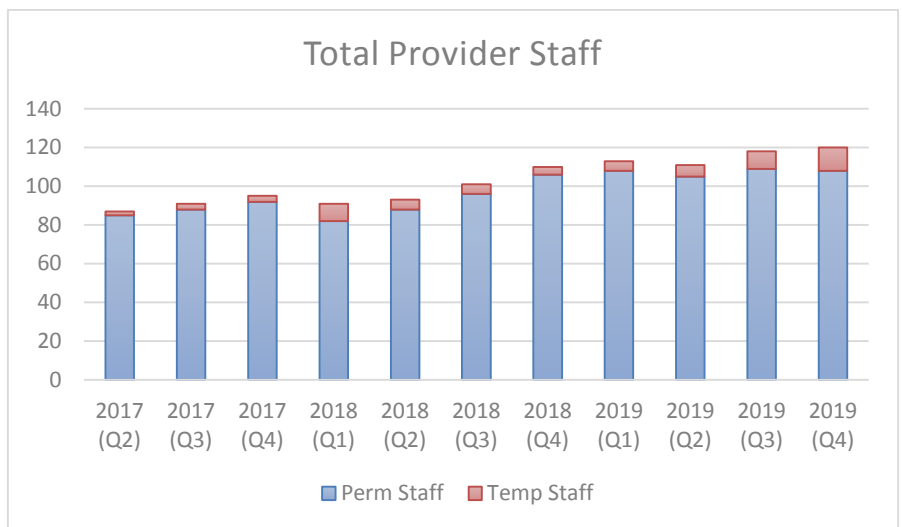
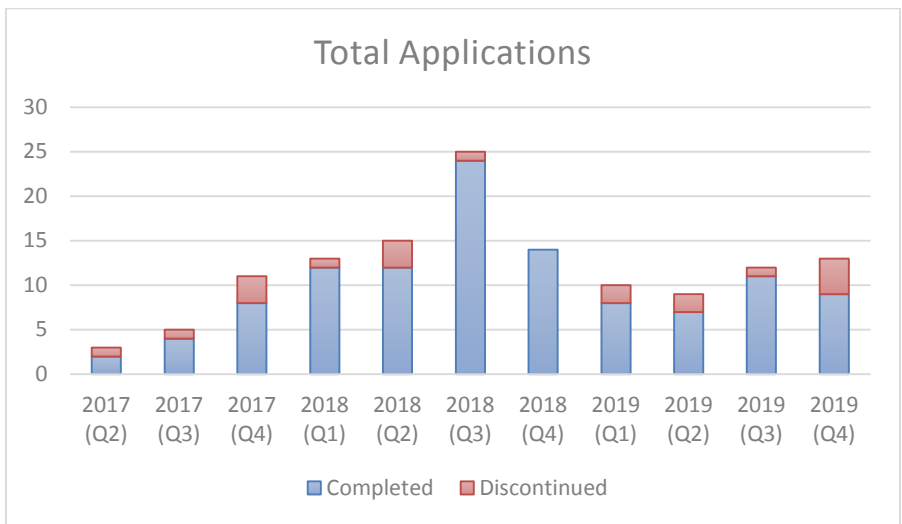


Medical Staff Services

Annual Report - FY 2019

Volumes

The following graphs trend the total number of applications and staff for the duration that the Medical Staff Pillars of Excellence have been recorded (almost 3 years). There has been a steady increase in numbers of staff over the past few years.





Medical Staff Services

Annual Report - FY 2019

Industry Benchmarking

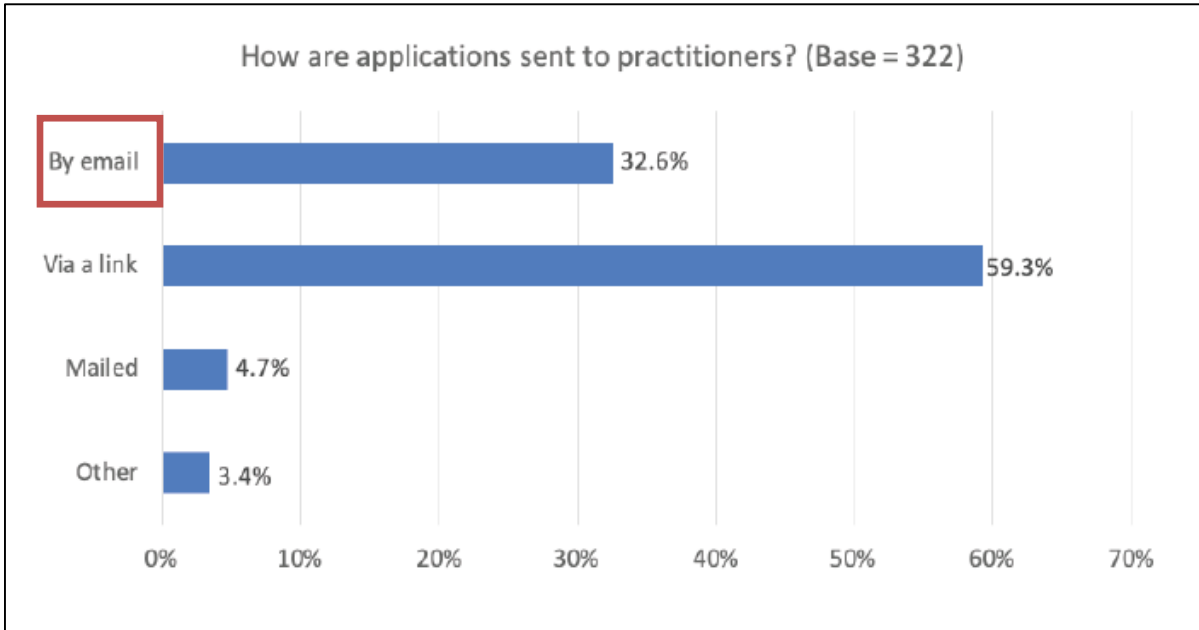
The 2019 Annual Report on Medical Staff Credentialing was recently released by Healthstream and Verity (see **Attachment 1** for the Overview of the released report, which provides a refresher on the importance of credentialing as emphasized in the recent “Dr. Death” tragedy).

This annual report is a great tool to identify how Northern Inyo Healthcare District’s Medical Staff Services department compares to others in the industry. The following graphs are taken from the results of the survey; NIHD’s answers are indicated by the **RED BOX** on the graphs:

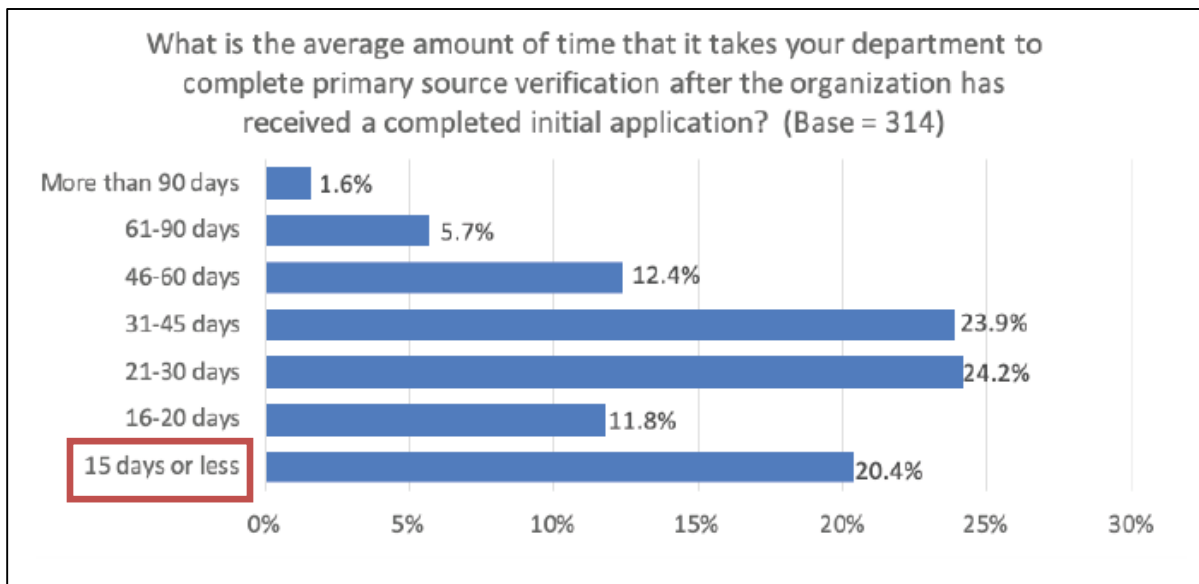


50% of the industry feels that onboarding is an area for improvement in their hospitals. NIHD has also identified this as an area for improvement. The Medical Staff Office has held preliminary meetings with the directors of our outpatient clinics to begin a work plan.

Medical Staff Services

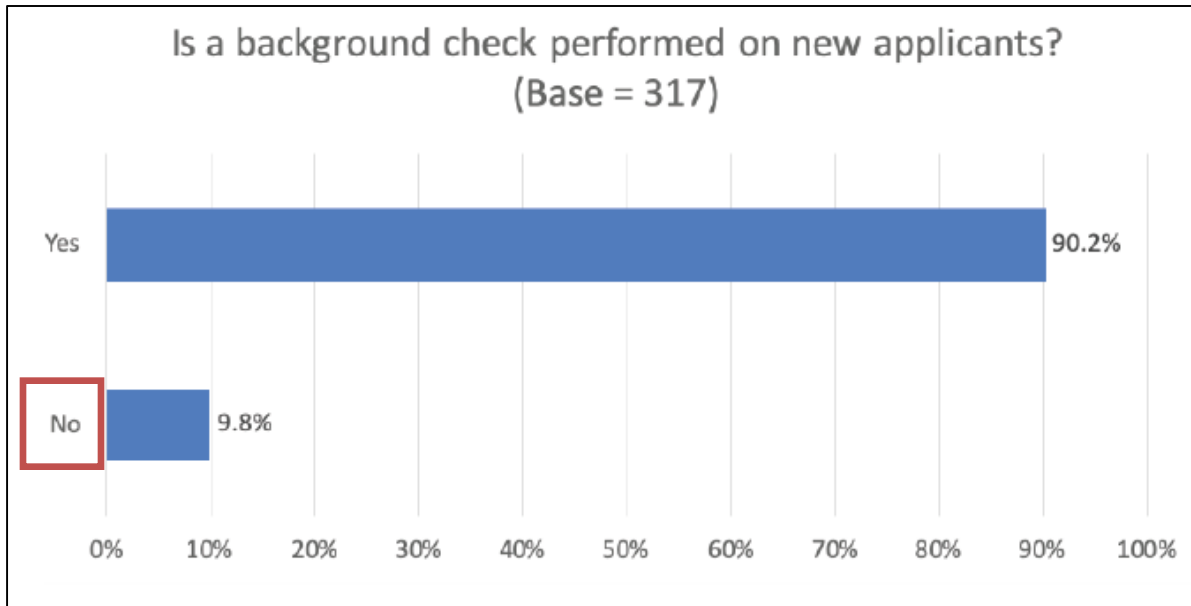


60% of survey respondents now use electronic applications for their providers sent via an electronic link. NIHD continues to send applications as attachments in emails, as do 33% of survey respondents.



The NIHD medical staff office remains competitive with industry standards, completing primary source verifications, on average, in 15 days or less.

Medical Staff Services



90% of survey respondents indicated a criminal background check is performed on all new applicants. NIHD currently asks the applicant to attest to any activity that would be found during a background check, but does not actually perform a criminal background check through a designated agency to confirm the self-reported activity.

The Future

In summary, after the evaluation of department's current roles and responsibilities and the results from the industry annual survey, the Medical Staff Services goals for the next year are to:

1. Complete the Medical Staff bylaws revision (which includes changes to strengthen our credentialing procedures)
2. Begin the process for CPCS certification of our credentialing specialist.
3. Work with various departments to strengthen the onboarding process.
4. Continue the migration to electronic processes, such as electronic applications.
5. Discuss the addition of criminal background checks with the medical staff.



Dianne Picken, MS
Medical Staff Support Manager

OVERVIEW OF SURVEY

Verity™, A HealthStream Company is proud to provide the third annual report on medical staff credentialing to the healthcare industry.

As you review the survey results, you will see evidence of much progress being made over the past three years as organizations transition from manual to electronic methods in all components of the credentialing and privileging processes. Credentialing and provider data management has clearly been in a state of change for a number of years – and while substantial improvement has been made, most organizations haven't reached the end of their journey toward automating, streamlining and improving everything related to credentialing and provider data management.

Most of the respondents to our surveys are Medical Services Professionals (MSPs). This year, there was an upswing of respondents (from 683 for the 2018 survey to 901 for this year's survey – an increase of 24%). We believe that this indicates the interest coming from the field of MSPs and the value that this data brings to their ability to compare themselves with other organizations and to determine future initiatives.

MSPs are the gatekeepers of patient safety for healthcare organizations, proclaims NAMSS (National Association Medical Staff Services), the professional organization comprised of 6000+ MSPs. What does this gatekeeper role mean in the healthcare industry? Credentialing and privileging are designed to assess the competency of providers who deliver healthcare services to an organization's patients. Most MSPs would say that their involvement in the credentialing, privileging and re-credentialing of providers (physicians, dentists, podiatrists, psychologists and additional advanced practice professionals such as nurse practitioners and physician assistants) is the critical factor in making MSPs the gatekeepers of patient safety. Patient safety is compromised when processes that enable excellent credentialing and privileging are not in place.

The extent to which patient safety can be compromised has been clearly evident to the public during the past two to three years. There have been frequent articles, and a series of popular

webcasts available on the subject of “Dr. Death” - Christopher Duntsch, a neurosurgeon who was sentenced to life in prison in Texas on February 20, 2017 after conviction for a first degree felony for the maiming of a patient during spinal fusion surgery. This surgery wasn't Christopher Duntsch's only surgical error. There were other surgeries that ended in death and/or permanent injuries to many patients. Unfortunately, the credentialing/privileging processes in place in the hospitals in Texas that allowed Christopher Duntsch to practice were not effective in preventing him to do harm to patients. And – the Texas Medical Board's action in suspension and ultimate removal of his license to practice medicine/surgery took too long in the opinion of many insiders in the healthcare industry.

Because of the Dr. Death case as well as other cases that have been made very public (for example, Dr. William Husel who was charged with 25 counts of murder related to fentanyl overdoses in Ohio on June 5, 2019) patients are in doubt about how – or even if – they are protected against incompetent or criminally-inclined physicians and other providers of care.

MSPs obtain data about providers, verify and assess the information and then manage the decision-making process of the medical staff leadership and governing body. The decision-making process determines the provider's membership (credentialing) and specific services (privileging) that may be delivered within the healthcare system. This behind the scenes work is essential when a patient is treated in a hospital emergency department or admitted to a surgical procedure or other type of treatment. Most patients don't know that this activity goes on—but they do rely on the healthcare organization to assure that when they are seen and treated, it is by currently competent providers. When patients are not happy with their treatment, lawsuits, including negligent credentialing, may be filed. Because of the notoriety of recent cases involving incompetency and criminal behavior on the part of providers, it is clear that organizations will be evaluating their processes to assure that they are comprehensive and effective in order to mitigate their financial risks as well as the risk of a damaged reputation.

Credentialing and privileging of providers has been performed by healthcare organizations for decades and has evolved from one page applications (in the 1970's) and very rudimentary verification to today's voluminous applications, privilege delineations, verification of each provider's education/training and background, and other requirements. For years, the hospital credentialing process took a minimum of six months—and it was not unusual for the process to take nine months to a year. It didn't matter because most providers received temporary privileges almost as soon as they asked for them. Today, credentialing and privileging is heavily regulated, by the state in which an organization is located, by the Centers for Medicare and Medicaid Services (CMS), and by accreditation bodies, such as The Joint Commission (the organization that accredits the majority of healthcare organizations) and the National Committee for Quality Assurance (the organization that accredits managed care organizations and has heavily influenced the hospital credentialing process). The granting of temporary privileges has been significantly reduced or eliminated in most organizations over the past ten years, and if it takes three months to get a provider credentialed, that is too long in the opinion of the organization's leaders. It should be noted that Dr. Death – Christopher Duntsch – did receive temporary privileges from at least one of the hospitals where there were horrific patient outcomes.

In the early days, MSPs were typically clerical positions. They worked in a Medical Staff Office, where the position included not only the credentialing and privileging processes, but also coordinating medical staff organization committees and taking minutes of those meetings. Much more is expected of today's MSPs. The position has become complicated partially due to the proliferation of regulatory and accreditation requirements and additional activities that have become the responsibility of the Medical Staff Services Department or Medical Staff Office (MSO). One of these activities is the onboarding process and you'll see some new data about onboarding activities in this year's report. However, credentialing and privileging remain the activities that are the most visible and consume the most resources.

In today's healthcare organizations, there may be a MSO or a CVO (a centralized verification office that performs credentialing on behalf of multiple facilities within a health system). A CVO may provide credentialing services to multiple MSOs within a health system—as well as to an enrollment department, where processes are put in place to enroll providers with multiple payers. The landscape is changing rapidly with evolving questions of the MSOs or CVOs such as: Does the organization have the right skill sets to address current responsibilities? Are today's MSPs able to take advantage of technology to streamline credentialing and privileging—and to also provide data considered to be the source of truth from the provider software to other business applications within the healthcare organization? Are today's MSPs able to credential and privilege faster—because of the need of most organizations to get their employed/contracted providers working as soon as possible? And finally – the question in the mind of many is how effective are the procedures that are used for credentialing and privileging. The circumstances around the credentialing related to Dr. Death are an impetus to many organizations to question the effectiveness their credentialing and privileging processes.

MSPs gather and present information. They do not make the credentialing and privileging decisions – those are made by the governing body of the organization after a recommendation has come to the governing body from the medical staff organization. The effectiveness of the decision-making process and related peer review activities must also be examined in light of recent events. It is not the data that is the critical issue – it is the decisions that are made by evaluating data that make the difference to our patients.

This survey was conducted independently by Verity™, A HealthStream Company. Verity™ hopes that the information provided in this report will be valuable to healthcare industry leaders and help to determine future directions for their improvement efforts.

FINANCE & ADMINISTRATION
CONSENT AGENDA POLICY AND PROCEDURE APPROVALS
AUGUST 2019

1. ASSET CONTROL
2. CAPITALIZATION OF ASSETS
3. FIXED ASSETS AND DEPRECIATION
4. ASSET MANAGEMENT

Medical Staff Policies and Procedures 2019

Anesthesia Clinical Standards and Professional Conduct
Credentialing - da Vinci Robotic Surgery
Credentialing Health Care Practitioners in the Event of a Disaster
Disclosure of Unanticipated Outcome
End of Life Option Act
Focused and Ongoing Professional Practice Evaluation
Medical Ethics Referrals and Consultations
Medical Staff and Allied Health Professional Application Fee Processing
Order Set Approval and Archiving
Pediatric and Newborn Consultation Requirements
Performance Improvement Program Anesthesia Service
Performance Improvement Program Surgical Service Physicians
Practitioner Complaint Resolution Process
Pre and Post Operative Anesthesia Visits
Professional Conduct. Prohibition of Disruptive or Discriminatory Behavior
Request for Establishment of New Privilege or Service
Scope of Anesthesia Practice

- CALL TO ORDER** The meeting was called to order at 10:00 am by Mary Mae Kilpatrick, President.
- PRESENT** Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
M.C. Hubbard, Treasurer
Jody Veenker, Member at Large
Kevin S. Flanigan, MD, MBA, Chief Executive Officer
Kelli Davis, MBA, Chief Operating Officer
Tracy Aspel, RN, BSN, Chief Nursing Officer
John Tremble, Chief Financial Officer
- OPPORTUNITY FOR PUBLIC COMMENT** Ms. Kilpatrick 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 three minutes each. No comments were heard.
- LABORATORY MEDICAL DIRECTOR POLICY** Kevin S. Flanigan, MD, MBA, Chief Executive Officer called attention to approval of a District-wide Policy and Procedure titled *Laboratory, Medical Director Delegation of Responsibilities* being established as a result of Northern Inyo Healthcare District's (NIHD's) recent Joint Commission Laboratory survey. It was moved by M.C. Hubbard, seconded by Jody Veenker, and unanimously passed to approve the proposed *Laboratory Medical Director Delegation of Responsibilities* Policy and Procedure as presented (with Director Sharp being absent from the vote).
- RE-STOCKING OF AMBULANCE SUPPLIES** Doctor Flanigan also called attention to a request by NIHD leadership to draft a policy on the subject of re-stocking supplies for local for-profit and not-for-profit ambulance services. It was moved by Jean Turner, seconded by Ms. Hubbard, and unanimously passed to authorize NIHD leadership to draft a policy on the subject of District re-stocking of ambulance supplies for local ambulance service providers as requested.
- STRATEGIC PLANNING SESSION** A strategic planning session was provided by David Sandberg with Cycle of Business, who provided an overview of strategic objectives developed at a recently-held District Board Self-Assessment. Mr. Sandberg also provided an overview of the District's strategic planning efforts to date, and established groundwork for future strategic planning meetings. It was determined that strategic planning will be addressed as part of regular meetings of the District Board going forward, and that planning will be based partially on data collected from a collaborative Community Health Needs Assessment survey with the Healthcare District's mission, vision, and values being considered as part of all future planning.

ADJOURNMENT

The meeting was adjourned at 3:02 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary