Northern Inyo Hospital

April 15 2020 Regular Meeting

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
April 15, 2020 at 5:30 p.m.
2957 Birch Street, Bishop, CA

Northern Inyo Healthcare District invites you to join this meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: At this time, persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda.
3. New Business:
   A. Financial impact of Covid 19 on NIHD *(information, possible direction to staff)*
   B. Pioneer Home Health 5 Year Action Plan (*information item*)
   C. Emergency Mutual Aid Memorandum of Understanding, Northern Inyo Healthcare District; Southern Mono Healthcare District; Southern Inyo Healthcare District; Toiyabe Indian Health Project (*action item*)
   D. Appointment of Interim Chief Medical Officer (*information item*)
   E. Approval *of Identity Theft Red Flags Rule* Policy and Procedure (*action item*)
   F. *Temporary Floating Staff* Policy (*action item*)
   G. *Temporary Telecommuting Assignment* Policy (*action item*)
   H. *Safety in the Operating Room* Policy and Procedure (*action item*)

I. *Asset Control* Policy and Procedure approval (*action item*)

J. *Asset Management Policy and Procedure* approval (*action item*)

K. *Capitalization of Assets* Policy and Procedure approval (*action item*)

L. *Fixed Assets and Depreciation* Policy and Procedure approval (*action item*)

4. Old Business:
   A. Building separation construction project update (*information item*)
5. Reports (*information items*):
   A. RHC Building update
6. Chief of Staff report, Stacey Brown, MD
   A. Medical Staff Bylaws Amendment for Disaster Privileging (*action item*)
   B. Policy and Procedure approvals (*action items*):
      1. *Credentialing Healthcare Practitioners in the Event of a Disaster*
      2. *Biological Monitoring System for Steam Sterilizers*
      3. *High-Level Disinfection of Equipment*
      4. *Steris System 1 E Processor*
      5. *Manual Jet Ventilator*
      6. *Clinic Patient No-Show, Missed Appointment, and Late Cancellation Policy*
      7. *OP Hospital No-Show, Missed Appointment, and Late Cancellation Policy*
      8. *New Line of Service Implementation Policy and Procedure*
   C. Physician recruitment update (*information item*)

   The following items were submitted for approval and tabled at the March 18 2020 District Board meeting:

   D. Annual Approvals (*action items*)
      1. Critical Indicators
         i. *ICU*
         ii. *Medical Services*
         iii. *Perinatal*
      2. Policies and Procedures
         i. *Plan to Eliminate or Substantially Reduce Medication-Related Errors*
         ii. *Standardized Procedure – Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife*
         iii. *Standardized Protocol – Emergency Care Policy for the Physician Assistant*

iv. *Standardized Procedure – Medical Screening Examination for Obstetrical Patient*

v. *Standardized Procedures for Medical Functions by RN in the Emergency Department*

3. Radiation Safety Policies

i. *ALARA Program*

ii. *DI – Area Monitoring and Controls*

iii. *DI – Radiation Protection for the Patient*

iv. *DI – Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*

v. *DI CT Radiation Safety Policy*

vi. *DI – Lead Apron/Protective Equipment Policy*

vii. *Diagnostic Imaging – C-Arm (Fluoroscope) Radiation Safety*

viii. *Diagnostic Imaging – Disposal of Radioactive Sharps*

ix. *Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear medicine personnel*

x. *Diagnostic Imaging – Nuclear Medicine New Employee/Annual Orientation*

xi. *Diagnostic Imaging – Ordering Radioactive Materials*

xii. *Diagnostic Imaging – Radioactive Material Hot Lab Security*

xiii. *Diagnostic Imaging – Radioactive Material Spills Procedure*

xiv. *Diagnostic Imaging – Radioactive Materials Delivery After-hours Policy/Procedure*

xv. *Diagnostic Imaging – Radioactive Waste Storage and Disposal*

xvi. *Dosimetry Program – Occupational Radiation Exposure Monitoring Program*

xvii. *Radiation Policy for Management of Patients with Excessive Exposure*

xviii. *Radiation Safety Committee*

xix. *Radiology Services Pregnant Personnel*

xx. *Responsibilities and Duties f Radiation Safety Committee (RSC)*

Consent Agenda (action items)

7. Approval of minutes of the March 18 2020 regular meeting
8. Financial and statistical reports as of February 2020
9. Policy and Procedure annual approvals

10. Reports from Board members (*information items*).
11. Adjournment to Closed Session to/for:
    A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
    B. Conference with Legal Counsel regarding existing litigation, Inyo County Local Agency Formation Commission and Northern Inyo Healthcare District v. Southern Mono Healthcare District (*pursuant to Government Code Section 54956.9*).
    C. Public Employee Performance Evaluation (*Government Code Section 54957(b*)) title: Chief Executive Officer.
    D. Public Employee Performance Evaluation (*Government Code Section 54957(b*)) title: Chief Financial Officer.
12. Reports from Board members (*information items*).
13. Adjournment.

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

Northern Inyo Healthcare District Impact of COVID-19 & Governor Newsom's Order

As of April 8, 2020

Timeline of Situation

- March 12, NIHD Activates Incident Command
- Patient cancellations start occurring, No Shows increase
- March 16 NIHD on budget for March revenues, patients and providers begin to agree to delay services like surgery
- March 19, 2020 – Governor Newsom Issues stay at home order, closes many businesses, work from home policy starts
- March 20 NIHD reduces to essential services – RHC drive-up screening and ER Big Room in full operation
- March 24th; CMS says they don't have authority to expand telemedicine to RHCs or hospital outpatient services (rehab, respiratory, dietician)
- March 27th, Cures Act Signed; volumes drop by 70% for most services, only inpatient and infusion are normal
- March 31st; Revenues for month are ($3.0 million) less than budget, COVID-19 response in full at NIHD; New Operational Paradigm in place
- April 6th; NIHD begins discussions on expansion of services beyond essential and planning for appropriate precautions for surgeries and other services above "essential"

COVID-19 Operational Paradigm

- NIHD Offering Essential Services Only
  - No departments totally closed
  - Patients are acute or telemedicine
    - RHC offering telemedicine on fee for service basis
    - NIA offering telemedicine through existing program
- Patients avoiding health care
  - Daily acute census for March 5.95 per day
  - Emergency room services drop to 12 per day
  - Revenues for Week ended April 7th. $1,308,302 versus budget of $3,182,895; 41% of budget
- Operational Expenses
  - Small reductions in supplies expense at end of March
  - Payroll ended 3/30/2019 was $1,259,760 plus $92,511 in taxes

Cures Act & Other Federal Help

- General Acute Care Hospitals assistance - $100 Billion; 60% in the form of a payment of $25,000 per bed; $625,000
- Delay of Sequestration Cuts - $80,000 in 2020 and another $210,000 in 2021 (estimated)
- HRSA $100 million grants; $90,000 to NIHD
- Paycheck Protection Program; NIHD ineligible
  - Cromer-Tyler Group to apply for perhaps $1 million
  - Sierra Emergency Group reviewing for eligibility
  - Discussions with Radiology Group to occur on same
  - Preparing application with Pioneer Homecare & Hospice
- FEMA Grants and Other Support
  - NIHD recording direct cost and staff assigned hours, approximately $250,000 each two weeks
  - Private Foundation support being applied for
- Medicare Cash Advance of $15.1 million application in process

Financial Situation

- February 29, 2020:
  - Year to Date Net Income $478,424
- March 31, 2020:
  - Census and outpatient revenues falls from budget to ($3.0 million) less than budget.
  - Expenses same level and salaries slightly higher than February
  - Expected Net Loss ($1,500,000) turning year negative ($1 million)
- April 30, 2020:
  - Revenues now trending down to $5,670,000 after 8 days for month
  - Expenses dropping 5% based on 3/30/20 payroll average
  - Expected loss based on $7.9 in total expenses of ($4.1 million)
  - Year to Date loss to be ($5.1 million)
- Cash trending $1.5 million of weekly receipts due to continued collections on Athena AR. Expect downturn end of April

Pioneer Home Health Care, Inc.
Five Year Action Plan
for
Responsible Growth and Financial Stability

I. Background

Pioneer Home Health Care, Inc. (PHHC) was originally created to address an unmet health care need within the communities of Inyo and Mono Counties. It is a State Licensed and Medicare Certified home health agency. This program was created in late 1990 and was licensed to begin care in early 1991. With over 85% of the patients being Medicare beneficiaries and reimbursement being paid based on costs, the agency was able to both provide a new health care service and was financially solvent as the agency grew.

In 1998, Medicare's payment methodology for home health changed radically, causing a severe challenge especially to small, rural providers, as reimbursement became based on a standardized patient episode, with very little consideration to the higher costs in the vast rural area. This program could no longer cover its own costs.

However, at the same time, as Pioneer was known to be a trustworthy home care provider, the community asked us to begin a second program – hourly attendant care in the home. With our new program's employees being paid just above minimum wage, and reimbursement coming directly from our private clients, this new Personal Care Program was able to make enough of a profit to cover the home health care losses.

Our next program, hospice care, was again created at the request of the community. This program opened its doors to patients in mid-2016. We began with donated start-up funds, however, in the four years it took before being able to begin licensed care, we required additional financial resources. Based on all national and state data, this program should be providing care to at least 12 – 15 patients at any given time, yet we have not reached this census goal. In seeking to provide this needed service to our community, we are working to educate our local physicians for earlier referrals to the program.

Year after year, there have been significant cuts to Medicare's home health reimbursement. As a result, we were no longer able to provide salaries and benefits competitive with other local health care providers and it became impossible to recruit new employees. Our ability to accept orthopedic and rehab referrals was hampered due to insufficient therapy staff. We became financially challenged, unable to grow, and unable to meet the combined home care needs of our community. A partnership was necessary. We needed an opportunity to parallel our salaries and benefits with the rest of the health care district in order to recruit, hire, and retain staff, to receive more patient referrals, and to grow all of our programs in order to better meet the total home care needs of our community. Our goal has always been financial stability while meeting these needs.

Thus began our partnering relationship with the Northern Inyo Healthcare District (NIHD). The District Board and Administration acknowledged the value of our programs, the benefit of supporting their ongoing existence, and the desire to see them grow to benefit many more members of our community. This required NIHD financial support. With that

initial support, we have been able to parallel our salaries and hire needed staff – registered nurses, physical therapist, social worker, and home care aides. We were also given the opportunity to parallel our benefits, especially our health insurance and our 401k employer match. In addition, we received the needed financial and IT support to initiate a new, seriously needed, electronic medical records system (NDoc).

All this has come at considerable financial support of the District. It is now our responsibility, with the District's continued support, to utilize all our new resources to the fullest, grow all of our programs, perhaps even add other grant-supported programs, and find a way for our community programs to financially support themselves. To this end, we have put together a 5-year financial action plan which ties into our strategic plan of 2019.

II. Goal / Plan

This plan has been created to set in writing our goal to provide all of Pioneer's programs to our community with little or no financial support from our NIHD partner within the next 5 years. While we have attempted to include the daily encounters that could stall our plan from happening sooner, it does not take into account any major disasters.

Our Action Plan is supported by our Strategic Plan which was created by our staff and approved by our corporate board in November 2019. The two main precepts of our strategic plan are to transition our administrative leadership successfully and grow our quality programs responsibly for the betterment of our community. We will list here all portions of our strategic plan that will have an impact toward our financial sustainability.

A. Embrace and support the transition of Pioneer Administrators
   1. Provide hands-on training of new administrator, and send off-site to all important workshops and conferences.
   2. Past administrator to provide ongoing advisory support to new administrator as needed/requested.

   In summary, in the initial year of 2020, there will be a salary and benefit savings of over $40,000. In 2021, that savings could be close to $50,000. However, at the some point, most likely when the home health average daily census reaches 45 and hospice average daily census reaches 8, it will be necessary to recruit and hire a licensed clinician to take on the responsibilities of Clinical Supervisor and Quality Assurance Coordinator, as the one Administrator will not be able to continue to manage all these responsibilities alone. There will be no additional costs for recruitment, as we presently have a credit with a recruitment company.

B. Grow our 3 services to meet the projected needs of our community (projections based on national average in rural areas) while demonstrating responsible fiscal management with the goal to increase referrals (see attached Projected PHHC Revenue sheet).
   1. Actively engage in daily NIHD discharge planning meetings, continuing to educate all present in the meeting regarding the services we provide for a safe transition home.
   2. Actively engage with healthcare providers of NIHD Rural Health Clinic and other local health care providers.

3. Proactively work with referral sources in Mammoth and Lone Pine; meet and educate.
4. Proactively meet and educate orthopedic office and therapy clinics locally, in Southern Inyo and in Mammoth.
5. Actively engage with out-of-area referral sources, making sure they are aware of all our programs.
6. Initiate use of Facebook/social media to engage the community and educate regarding our services.
7. Request that NIHD stop referring attendant care hours to unlicensed, "under the table" entities, which takes revenue away from PHHC while creating risk management issues for the District.
8. Train additional Certified Home Health Aides (CHHAs) through state approved 40-hour certification program update for Certified Nurse Assistants (CNAs).

C. Preserving the Medicare Rural Add-on Revenue
We do not want to completely lose the additional Medicare Rural Add-on revenue, which is presently decreasing annually by 1%, from 5% to 0% (we are currently only receiving 3% in 2020). We must enlist the full force of our providers and boards in a crusade to make sure federal legislation is passed to secure us the 5% add-on permanently.

D. Continue to expand hospice fundraisers with the help of NIHD in order to enhance publicity and support
1. Annual Spring Breakfast Buffet and Silent Auction
In 2019, this function brought in $4,586.01
2. Annual Light-Up-A-Life (LUAL) is both a fundraiser and a memorial service
In 2019, this function brought in $3,350.25
3. Annual Holiday Tree Raffle
In 2019, this function brought in $4,601.00
4. Various yard sales, raffles, etc. held through the year
5. Serious consideration is given to creating a Hospice Thrift Store. We are already looking into foundation grant sources for start-up funding. Time line to begin this plan is scheduled for 2023. Much research would be needed to consider present competition, cost of operation, amount of volunteerism available, and anticipated revenue.

E. Meet the home care needs of the patients in our community by creating and implementing a Disease Management Program to support our rural, elderly population having multiple chronic comorbidities and repeat hospitalizations.
1. Specifically define the project based on needs
   a. Use of home telehealth program/equipment for monitoring and educating our chronically ill patients
      i. Be able to keep unstable home health patients on service for at least 60 days, while minimizing clinical travel visits/costs.
      ii. Be able to increase a percentage of our current 30-day patient admission periods into 60 day admission periods. This can potentially create an

additional 40% in Medicare reimbursement. (Presently only 50% of our patients are on service for home health more than 30 days)

b. Be able to closely monitor medication regimens for patients unable to manage without support.

c. Offer home "Tuck-in" services by our Personal Care Program
   i. Meet vulnerable patients "at the door" after hospital discharge.
   ii. Make sure patients have filled their prescriptions, take their new medications as ordered, have food in the refrigerator and a good meal in front of them, making sure they will be safe until the home health nurse arrives the next day.

2. Find foundations willing to fund our project over a five-year initial period, and complete the appropriate grant writing, training and implementation.

In summary, the goal will include increasing our traditional home health admissions by 5% each year over the next five years initial grant funded program. Each new home health admission specifically for disease management through telehealth or medication management will generate additional revenue of $3,600 - $4,000 if kept on service for 60 days. We would need the addition of a part-time LVN to work under one of our RN's in order to run this program.

The "Tuck-in" program will require 1-2 additional employees on an hourly as-needed basis. Keeping high risk patients from early readmissions will show the benefit of the "Tuck-in" program. In the future, it may find further grant funding, or consider charging a fee for this service, or work with NIHD to incorporate this program into the hospital discharge plan, in addition to taking them home in the care shuttle. Collectively all these programs aid NIH in providing safe discharges home. In addition, we would be able to keep and continue to utilize all the telehealth and medication management for continued use at no added equipment cost.

III. Final Summary

This Action Plan shows a reasonable growth projection within our rural population base. Any larger numbers than these would not be reality based. It also shows the plan for increasing services and revenue. There will, obviously, be step increases in costs. While much of the overhead costs will remain relatively consistent, additional staffing needs will occur as we grow. This will likely include an additional registered nurse and physical therapist, as well as hours from a licensed vocational nurse and home care aides. At some point, additional billing help may also be needed.

We are extremely grateful to the NIHD Board and to Dr. Flanigan for acknowledging the value of our multiple home care programs and stepping in to partner with us as we grow to our full potential. We in the home care arena firmly understand our collaborative importance in the large picture of this unique community's health care needs. It is our firm collective intent to meet the home care needs of our community while practicing sincere fiscal responsibility.

Projected PHHC Revenue

Home Health Care - paid by Medicare in 30-day episodes, and assuming at least 75% will be 60-day episodes.

In 2017, our average dialy census was 12-14

In 2019, our average daily census increased to 35

	Daily Census =	Admissions =	Revenue	
2020	40	248	$ 843,200.00	(at $3,400 per episode per Home Health Gold)
2021	45	278	$ 973,000.00	(at $3,500 per)
2022	50	308	$ 1,108,800.00	(at $3,600 per)
2023	55	338	$ 1,250,600.00	(at $3,700 per)
2024	60	368	$ 1,398,400.00	(at $3,800 per)

Hospice Care - paid by all payor sources on a "per-diem" rate

In 2019, our average daily census was 3

	Daily Census	Admissions X	Length of Stay =	# of Days X	Approximate Expected Daily Rate =	Revenue
2020	5	30	30	900	$200.00	$ 180,000.00
2021	8	33	33	1089	$210.00	$ 228,690.00
2022	11	36	36	1296	$215.00	$ 278,640.00
2023	14	40	39	1560	$218.00	$ 340,080.00
2024	18	45	40	1800	$220.00	$ 396,000.00

Personal Care Program - privately paid at $25 per hour

In 2019, our average hours of care per week was 380

	Hours per Week	Revenue
2020	400	$ 10,000.00
2021	450	$ 11,250.00
2022	500	$ 12,500.00
2023	550	$ 13,750.00
2024	600	$ 15,000.00

Total PHHC Revenue Projection

2020	$ 1,033,200.00
2021	$ 1,212,940.00
2022	$ 1,399,940.00
2023	$ 1,604,430.00
2024	$ 1,809,400.00

GOALS & ACTION PLANS

2 main issues
- Transition Leadership Successfully
- Grow Responsibly

Overall Progress: 4%

1. PATIENTS

GOALS/ACTION PLANS/TASKS	OWNER	RESOURCES	DUE DATE	UPDATES	PROGRESS
1.1 Create and implement a disease management program	Select Owner	3/20/20 Foundation Grant Search now in progress Nicki/PAT Marianne	Select Date	Update	0%
1.1.1 Specifically define our project	Select Owner		Select Date	Update	0%
1.1.2 Find Foundations that will fund our project	Select Owner		Select Date	Update	0%
1.1.3 Write grants	Select Owner		Select Date	Update	0%
1.1.4 Implement programs	Select Owner		Select Date	Update	0%
1.2 Create an integrated Patient/Client approach to ensure all needs are met	Select Owner		Select Date	Update	0%
1.2.1 Create Care Coordination Plan between clinical programs and PCP for interagency referrals	Ruby Allen	Tracy Watkins Completed Communication has improved.	01/31/2020	Update	0%
1.2.2 Identify all community resources available to help our patient/client needs	Select Owner	Patric	11/30/2019	Update	0%

2. EMPLOYEES

GOALS/ACTION PLANS/TASKS	OWNER	RESOURCES	DUE DATE	UPDATES	PROGRESS
2.1 Train all staff on optimal job performance	Select	In progress on going	Select	Update	0%

	Owner		Date		
2.1.1 Keep current on Annual Competencies	Ruby Allen	completed completed	08/31/2020	Update	0%
2.1.2 Prepare for PDGM 2020 New Medicare Reimbursement System	Ruby Allen	Pat	01/31/2020	Update	0%
2.1.3 Identify and provide ongoing training needs	Ruby Allen	Blair Caraway	11/08/2019 On Going	Update	0%
2.1.4 provide an adequate orientation process for all new staff	Select Owner		11/08/2019 On Going	Update	0%
2.1.5 Continue to train on the best use of NDOC	Select Owner	Selah	11/08/2019 On Going	Update	0%
2.2 Recruit/hire qualified staff/volunteers to meet the demands of our growing organization	Select Owner		Select Date	Update	0%
2.2.1 Work with a recruiter to find RN case manager	Pat West	Hired additional RN	01/31/2020	Update	0%
2.2.2 Continue local recruitment for PCP employees • Job Fairs • CNA Students	Select Owner		11/08/2019 On Going	Update	0%
2.3 Embrace and support the transition of role and responsibilities from Pat to Ruby	Select Owner	Completed Pat Retired 2/28/20	Select Date	Update	0%
2.3.1 Establish a list of all issues to be addressed/transitioned	Pat West		Select Date	Update	0%
2.3.2 Carve out routine training time	Ruby Allen	Pat	Select Date	Update	0%
2.4 Promote a positive work environment	Select Owner		Select Date	Update	0%
2.4.1 Create monthly PCP staff gatherings (food optional) for collaboration and training	Select Owner	Have gone to a twice a mo newsletter	Select Date	Update	0%
2.4.2 Explore options R/T improved mileage reimbursement	Ruby		Select	Update	0%

for guest clinical staff	Allen		Date		
2.4.3 Bring all performance evaluations current with raises where appropriate	Pat West	Completed	Select Date	Update	0%
2.4.4 Decide on Staff Incentive	Select Owner		Select Date	Update	0%
2.5 Promote a productive work environment	Select Owner		Select Date	Update	0%
2.5.1 Optimize features of PCP scheduling capabilities	Select Owner	Tracy PCP coordinator	Select Date	Update	0%
2.5.2 Establish the best method to have access to patient schedules	Select Owner		Select Date	Update	0%
2.5.3 Create a template for the most efficient process for referrals / SOC's / billing for the HHA under PDGM	Select Owner	Ruby computer	Select Date	Update	0%
2.5.4 Introduce use of HIPPA Compliant texting	Select Owner	Secure texting Docs Ink in use by all clinical staff	Select Date	Update	0%
2.5.4.1 Utilize cell phone app for field clinicians to clock in and out	Select Owner	not sure time clock – Have gone to computer schedules of visits	Select Date	Update	0%

3. FINANCIAL

GOALS/ACTION PLANS/TASKS	OWNER	RESOURCES	DUE DATE	UPDATES	PROGRESS
3.1 Budget all expenses to minimize financial dependence on NIHD	Select Owner	Ongoing	Select Date	Update	0%
3.2 Manage PDGM patient case-mix carefully for best reimbursement	Select Owner	Ruby works w/ DSC + NIHD + all case managers	Select Date	Update	0%
3.3 Plan and implement new revenue projects	Select Owner		Select Date	Update	0%
3.3.1 Establish a hospice thrift store – Ruby	Select Owner	Nick Ruby Pat Madeleine works on Foundation search	Select Date	Update	0%
3.3.1.1 Find grant source for the start-up	Select Owner		Select Date	Update	0%

Goals

3.3.2 Research a market for local area estate donations for hospice	Select Owner Ruby Allen	Select Date	Update	0%
3.3.3 Continue annual fundraisers • Luau • Spring breakfast • Silent Auction	Select Owner Ruby Allen Delay due to COVID-19	Select Date	Update	0%

4. GROWTH

GOALS/ACTION PLANS/TASKS	OWNER RESOURCES	DUE DATE	UPDATES	PROGRESS
4.1 Improve our visible brand	Select Owner	Select Date	Update	0%
4.2 Develop and implement a cross-training program for employees	Select Owner → cancelled due to COVID-19	Select Date	Update	0%
4.3 Expand the hospice program to average 12 patients Dr. Uja - education presented to MDs 4/24/20	Select Owner	Select Date	Update	0%
4.4 Expand home health census to 60 patients (25 referrals/month)	Select Owner 4/1/20 Census @ 40	Select Date	Update	0%
4.5 Increase PCP hours to 450/week Tracy W.	Select Owner Hours Fluctuate due to COVID-19	Select Date	Update	0%
4.6 Provide CHHA training program for better CHHA availability to meet PT needs	Select Owner Ruby	Select Date	Update	0%
4.7 Continue to recruit to meet above growth for staff	Select Owner Amanda M. in training	Select Date	Update	0%
4.8 Enhance relationships with referral sources Ilahe, Ruby A.	Select Owner Have reached out to BCC, SIH, MLH offices NIHER	Select Date	Update	0%
4.8.1 Bishop Care Center Contact: New DON PAT EVERHART Ruby	Select Owner	Select Date	Update	0%
	Select	Select		

Goals

4.8.2 Dr Richardson	Completed	Select Owner	Now Signing order for Home Health clients	Select Date	Update	0%
4.8.3 Glendale Adventist Hospital	Ruby Allen	Select Owner	Discuss Referral Issues & Case manager Jasmine	Select Date	Update	0%
4.8.4 NIH						
5. QUALITY 4.8.5 Monmouth	Ruby					

GOALS/ACTION PLANS/TASKS	OWNER	RESOURCES	DUE DATE	UPDATES	PROGRESS
5.1 Pass upcoming Hospice survey	Select Owner	Completed!	Select Date	Update	0%
5.2 Train new employees (Nick and Patric) to be able to integrate into the activities of the Hospice program.	Select Owner	Orientation Completed	Select Date	Update	0%
5.3 Improve our HHA Star rating from 3 to 4	Ruby Select Owner		Select Date	Update	0%
5.4 Continue training for adequate OASIS assessment for improved patient outcomes	Select Owner	PT/RN working together on this	Select Date	Update	0%
5.5 Provide supportive training for all staff / volunteers on: • **Death and Dying** • **Mission Statement** • **Challenging Clients** • **Clinical Skills**	Select Owner	Hospice IDG meetings weekly - include education monthly + PRN	Select Date	Update	0%
5.6 Identify and close communication gaps between programs	Tracy W. Ruby A.	Select Owner	Select Date	Update	0%
5.6.1 Involve PCP representative in HH team conference on HOS IDG for shared patients	Tracy	Select Owner	Completed	Select Date	Update	0%

5.7 Contract with NIHD for a compliance officer for routine oversight of programs for HIPPA compliance	Kevin S. Flanigan, MD	Completed Patty Dixon from NIH is the new compliance officer for PHHC	11/30/2019	Done	Update 10/11/2019	100%

MONO, INYO, AND TOIYABE HEALTHCARE COALITION HEALTHCARE ENTITY EMERGENCY MUTUAL AID MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (MOU) is made and entered voluntarily into as of this 1st day of February in the year 2020, by and between:

Mammoth Hospital

Northern Inyo Healthcare District

Southern Inyo Hospital

Toiyabe Indian Health Project

Each of these healthcare entities is a party to this MOU and collectively they constitute the "Healthcare Mutual Aid Network" for the purposes of this MOU.

Nothing in this MOU is intended to create any relationship among the healthcare entities other than that of independent entities agreeing with each other solely for the purposes set forth in this MOU. Nothing in this MOU is intended to be in conflict with any obligation of the respective parties under Federal or State law.

This MOU is not a legally binding contract, but rather is a voluntary agreement based on the belief and commitment of the undersigned healthcare entities that as a result of any community emergency or disaster, which exceeds the effective response capabilities of a healthcare entity, the medical needs of the community will be best met if the healthcare entities collaborate to coordinate their response efforts, and to provide mutual aid through the procedures set forth herein, in order to optimize the utilization of available resources.

This document is intended to augment, not replace, each healthcare entity's Emergency Operations Plan (EOP). Each healthcare entity shall have full and absolute discretion to determine the extent, if any, to which it wishes to provide resources to assist another healthcare entity under this MOU. Accordingly, no healthcare entity shall be required to provide medical supplies, equipment, services, personnel or bed capacity to another healthcare entity, either during a disaster or emergency or at any other time, regardless of available capacity or other conditions at the requesting or donating healthcare entity. For the purposes of this MOU, the disaster may be an "external" or "internal" event and is subject to an affected healthcare entity's emergency management plan being fully implemented.

The terms of this MOU are intended to be incorporated into each healthcare entity's emergency management plans.

1. Definitions

As used in this MOU, these terms shall be defined as follows:

1.1 "Contractor" means a healthcare professional who provides healthcare services at a healthcare entity, but is not under the direct control of the healthcare entity and exercises independent judgment and discretion.

1.2 "Designated representative" means an individual and at least one alternative designee identified by a party as having the authority to issue, receive, and answer requests for resources pursuant to this MOU.

1.3 "Emergency" means an emergency, catastrophic event, disaster, public health crisis, or other exigency as defined in the jurisdiction(s) in which the parties are located.

1.4 "Emergency declaration" means the official declaration by an authorized government official of a state of emergency in the jurisdiction in which one or more parties is located.

1.5 "Employee" means a healthcare worker at a healthcare entity who is employed to render healthcare services under the direct control of the healthcare entity.

1.6 "Healthcare services" means the provision of medical treatment, care, advice, or other services, or supplies, related to the health of individuals or human populations.

1.7 "Healthcare professional" means an individual licensed under state law to provide healthcare services.

1.8 "Healthcare surrogate" means the parent, court-appointed legal guardian, or other individual lawfully authorized to make health care decisions for a minor or individual who lacks the legal capacity to make decisions on his or her own behalf.

1.9 "Healthcare worker" means an individual, including a healthcare professional, who provides healthcare services.

1.10 "Healthcare entity Mutual Aid Network" means the collective group of healthcare entities that are parties to the MOU.

1.11 "Lending healthcare entity" means a party that considers requests and potentially provides personnel or other resources or provides resourced beds for transferred patients pursuant to this MOU.

1.12 "License to practice healthcare service" means the state authorization of an appropriately trained healthcare professional to provide healthcare services that would otherwise be unlawful without the authorization.

1.13 "National Incident Management System (NIMS)" means the federal coordinating program overseen by the Department of Homeland Security (DHS) requiring healthcare entities to formulate emergency plans including mechanisms to facilitate mutual aid in the event of inter-jurisdictional emergencies.

1.14 "Party" means a healthcare entity that has executed this MOU.

1.15 "Prescribing Power" means the authority to dispense prescription drugs for healthcare purposes pursuant to state licenses and institutional privileges.

1.16 "Requesting healthcare entity" means a party that requests personnel or other resources or requests the transfer of patients pursuant to this MOU.

1.17 "Scope of practice" means the extent of the authorization to provide healthcare services granted by a license to practice healthcare services in the state in which the healthcare professional practices. Scope of practice may be further limited by privileging and credentialing requirements imposed by the state or the healthcare entity in which the healthcare professional practices.

1.18 "Standard of care" means the degree of prudence and skill that a healthcare professional, healthcare worker, or healthcare entity must provide to a patient based on prevailing circumstances and existing best practices.

1.19 "Volunteer health practitioner (VHP)" means a healthcare worker licensed or registered in one or more states who is not an employee or contractor of a requesting healthcare entity and who voluntarily provides healthcare services at a requesting healthcare entity, irrespective of individual compensation.

1.20 "Worker's compensation" means the government administered system for providing benefits to individuals injured or killed in the course of employment, regardless of fault.

2. General Terms

2.1 Term and Termination. The term of this MOU shall be effective from February 1, 2020, through January 31, 2021. The term of this MOU shall be renewed for subsequent 1-year periods upon the terms and conditions then in effect, unless a party gives the other parties written notice of its intention not to renew, which notice shall be given no less than thirty (30) days prior to the expiration dates of then current term. This MOU may be terminated by either party at any time for any reason upon the provision of sixty (60) days advance written notice.

2.2 Activation of the Healthcare Entity Mutual Aid Network by Emergency Declaration. An emergency declaration made by the State of California activates the terms of this MOU. The MOU does not govern the exchange of resources among the parties in non-emergency situations, but may be used to guide resource allocations during mock training exercises as agreed by the parties.

2.3 Effect of Emergency Declaration and Relation to Other Laws. An emergency declaration changes the legal environment in diverse and numerous ways that may impact the operation of this MOU. An emergency declaration may:

(a) Suspend laws and regulations applicable to hospitals and healthcare entities, including those that regulate the provision of healthcare services by healthcare workers;

(b) Require healthcare entity compliance with local, state, regional, and national emergency management agency directives and regional response efforts;

(c) Initiate temporary licensure reciprocity through which healthcare professionals licensed in one jurisdiction are allowed to practice in another jurisdiction, often pursuant to various requirements such as advance volunteer registration or affiliation with an entity that deploys Volunteer Health Practitioners (VHPs);

(d) Provide enhanced liability protections to healthcare workers or VHPs for services that they render in responding to the emergency;

(e) Extend workers compensation benefits to VHPs who would not otherwise qualify as covered employees;

(f) Change the applicable standards of care;

(g) Provide enhanced government emergency and disaster relief funding for ongoing response activities and reimbursement for rendered emergency and disaster services; and

(h) Provide increased and expedited access to public entitlement programs, including through the waiver of enrollment requirements for Medicaid and Medicare.

2.4 Federal Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA can impact the provision of healthcare services at healthcare entities, including medical triage, by requiring healthcare entities to screen and stabilize individuals requesting emergency treatment and prohibiting inappropriate transfer of patients. Under certain circumstances during declared emergencies, federal officials can suspend some of the requirements under EMTALA. If an EMTALA waiver is issued which covers one or more parties to this MOU, such parties shall immediately assess capacity to accept transferred patients and provide additional screening and stabilization services. As well, other parties should be informed as soon as possible of:

(a) the inception of the party's disaster protocol and the duration of the waiver's coverage;
(b) any plans to suspend or modify patient screening and stabilization procedures; and
(c) intended or expected needs regarding the transfer of existing patients.

2.5 Identification of Designated Representative. Each party agrees to identify a designated representative to communicate with other parties prior to and during a government-declared state of emergency and to ensure compliance with NIMS. The designated representative or designee should be available to act at all times.

2.6 Effect of NIMS Requirements. Parties should integrate Hospital Incident System (HICS) principles and NIMS principles into their Emergency Response Plan including NIMS Implementation Activities for Hospital and Healthcare Systems established by the NIMS Integration Center. Pursuant to this MOU, parties should comply with the following:

(a) *Structural requirements*. Parties should implement an Incident Command System (ICS) as prescribed by current NIMS standards, including the development of a command hierarchy, which facilitates communications between healthcare entities, government officials, and their communities. The designated representative should be identified in the ICS hierarchy.

(b) *Collaboration*. Parties should participate in Multi-Agency Coordination Systems (MACS) and promote them with the public and private sectors and nongovernmental organizations as appropriate and necessary. These agreements should be reviewed and executed annually as required by NIMS directives.

(c) *Resource typing*. To enhance emergency preparedness, parties should follow the national typing protocol as prescribed by NIMS to describe available resources using category, kind, components, metrics, and type data.

(d) *NIMS credentialing*. Parties shall comply to the maximum extent possible with NIMS requirements concerning baseline credentialing, certification, training, and education.

(e) *Leadership NIMS certification*. Party administrators and healthcare workers likely to assume a supervisory or leadership position during a government-declared state of emergency should complete prescribed NIMS compliance courses.

(f) *Compatibility of equipment and minimum requirements*. Parties should acquire equipment that will perform in accordance with minimum standards as prescribed by NIMS so that equipment is interoperable with similar equipment used by other parties in the Healthcare Entity Mutual Aid Network and other healthcare entities.

(g) *Resource tracking*. Parties should use an inventory system to track resources that may be available during a government-declared state of emergency, including any resources stored off premises. The inventory list should be accessible to the designated representative during a government-declared state of emergency.

2.7 Communications. Parties must[1] adopt a plan to enable efficient communication during declared emergencies when prevailing modes of communication may be unavailable or compromised. The plan may specify a process for utilizing alternate communication media (e.g., radio, web-based resources). Implementation and maintenance of such plans should be regularly tested in periodic exercises.

3. Mutual Assistance

3.1 Good faith obligation to provide mutual assistance. Parties should provide mutual assistance as set forth in this MOU to the extent possible. Decisions about providing mutual assistance pursuant to this MOU should be made by:

(a) Objectively assessing whether and which resources can be feasibly shared and the degree to which patients can be safely transferred or received;
(b) Clearly conveying capacity for mutual assistance to other parties; and
(c) Striving to ensure transparency, honesty, and fairness in all phases of mutual assistance.

3.2 Requesting Resources – Role of the Designated Representative. All requests for resources should be directed to the designated representative who is authorized to agree to provide requested resources. Parties should confirm receipt of verbal or written requests for mutual assistance and provide responses within 24 hours when possible.

3.3 Procedure for Communicating Requests. After an emergency declaration is made, the requesting healthcare entity's designated representative may initially request personnel or resources from the lending healthcare entity's designated representative verbally. This request should be confirmed in writing within 24 hours, or as soon as possible, and should employ NIMS data-types where possible. The requesting healthcare entity should set forth in the written request to the lending healthcare entity the following:

(a) The type and number of requested personnel and resources;
(b) An estimate of how quickly personnel and resources are needed;
(c) The location where the personnel should report or the resources should be delivered; and
(d) An estimate of how long the personnel or resources will be needed.

3.4 Transfer of Personnel. During emergencies there are often critical shortages of healthcare workers. Accordingly, the following personnel may be transferred between parties subject to limitations set forth below:

(a) *Employees*. Lending healthcare entities may allow or encourage the voluntary transfer of employees to a requesting healthcare entity under the terms of this MOU. No employee may be ordered to transfer to a requesting healthcare entity if the employee is not willing to be transferred.

(b) *Contractors*. Parties may allow the transfer of contractors to a requesting healthcare entity. All transferred contractors provide their services to the requesting healthcare entity voluntarily. Whenever

[1] As required by §482.15(c)(3).

possible, contractors with a prior or existing relationship with the requesting healthcare entity should be transferred first.

(c) *In-State VHPs*. Volunteer registration systems across the nation, including ESARVHP state-based systems, Medical Reserve Corps programs, and healthcare entity -specific registries facilitate rapid deployment of vetted VHPs to meet surge capacity needs in healthcare entities.

(d) *Inter-state VHPs*. A number of federal and state laws allow the deployment of VHPs who hold out-of-state licenses during an emergency. Similar provisions exist under the Emergency Management Assistance Compact (EMAC) and many regional MOUs.

(e) *Credentialing and privileging*. The lending healthcare entity should ensure that the records of all transferred healthcare workers comply with requirements applicable to the lending healthcare entity, including licensure and accreditation requirements for healthcare professionals. To the extent possible, the lending healthcare entity should provide the requesting healthcare entity with copies of deployed healthcare professionals' credentialing documents to facilitate the granting of emergency staff privileges.

(f) *Transfer of personnel limitations*. Resident physicians, students, or healthcare workers who are not fully trained should only be transferred with the agreement of the requesting healthcare entity, which will supervise their activities.

3.5 Scope of Practice. The requesting healthcare entity should clarify the relevant procedures concerning authorization, scope of practice, and supervision for transferred personnel that arrive at the requesting healthcare entity pursuant to the terms of this MOU. Additionally, the requesting healthcare entity should clarify the prescribing powers of transferred personnel to ensure consistency with jurisdictional prescription laws.

3.6 Transfer of physical resources. Any physical resources may be shared between parties including pharmaceuticals, medical equipment, non-medical equipment, and basic supplies. Parties should continuously monitor the availability of physical resources for potential transfer during a government-declared state of emergency.

3.7 Recall. The lending healthcare entity may recall its personnel and resources from a requesting healthcare entity through a formal request for recall. Recall requests may be made by the lending healthcare entity at any time at its discretion. Requesting healthcare entities shall honor the lending healthcare entity's request for recall at the earliest opportunity possible without significantly and irreversibly harming existing patients, and should immediately begin to arrange for the acquisition of comparable personnel or resources from other parties, agencies, or facilities.

3.8 Transfer of patients. Transferring patients during a government-declared state of emergency raises numerous medical, legal, and ethical challenges. Contingent on existing laws, the transfer of patients should be facilitated consistent with the following:

(a) *Resourced beds*. Transfer of patients should be considered in terms of "resourced beds." The designated representatives of the parties should monitor the availability and make transfer requests in terms of specific types of resourced beds.

(b) *Process for transferring existing patients*. A requesting healthcare entity seeking to transfer patients should:

(i) determine that the patient cannot receive adequate healthcare services at the requesting healthcare entity because of circumstances arising from the emergency and that the potential harm

to the patient from the transfer does not outweigh the potential harm from staying at the requesting healthcare entity considering the state of healthcare services at the requesting healthcare entity;

(ii) Seek patient consent to the transfer unless such consent is impossible due to the exigencies of the emergency or the inability of the patient, or a surrogate, to consent due to legal incapacity, incompetence, or unavailability of the healthcare surrogate;

(iii) make reasonable efforts to either directly notify the patient, the patient's healthcare surrogate, or next of kin of the transfer, including the time of transfer, and the location of the receiving healthcare entity, or share patient lists to enable these persons to locate transferred patients; and

(iv) transport the patient or ensure that appropriate transportation is provided to ensure patient safety to the extent possible given the exigencies of the emergency.

(c) *Process for transferring (pre-screened) individuals.* A requesting healthcare entity seeking to transfer individuals prior to being screened should determine that the potential benefits from the transfer outweigh the potential harms from remaining at the requesting healthcare entity considering the state of healthcare services at the requesting healthcare entity.

(d) *Surveillance and reporting.* Parties should comply with all preexisting government public health surveillance and reporting requirements to the extent possible.

(e) *Health information privacy and data access.* The parties recognize the importance of maintaining the privacy of patient identifiable health data to the extent possible consistent with national or regional health information privacy protections without compromising the provision of critical healthcare services during a government-declared state of emergency. Although these protections may be modified or waived during a government-declared state of emergency, parties must[2] agree on a procedure for securely sharing identifiable health data concerning transferred patients.

4. Liability, Costs, and Compensation

4.1 Liability of Healthcare Entities and Healthcare Workers. During an emergency, potential liability can be a major concern for healthcare entities and healthcare workers. While exposure to liability cannot be fully eradicated, it can be significantly minimized through the clear expression of the expectations of the parties. The parties recognize the following principles concerning liability:

(a) *Changing standards of care.* Emergency declarations may lead to alterations or changes in the standard of care that healthcare workers are obligated to adhere to in the treatment of patients. These changing standards of care may impact potential claims of liability to the extent that they provide varying expectations of the duties healthcare workers or healthcare entities owe to patients in the provision of personnel or resources.

(b) *Use of VHPs.* Parties may minimize their potential exposure to liability and workers' compensation costs relating to personnel by utilizing registered VHPs. VHPs may be legally protected from liability claims and

[2] As required by §482.15(c)(4).

entitled to governmental coverage for workers' compensation benefits and costs during declared emergencies (subject to specific laws). Use of VHPs may also decrease the need for the transfer of employees and contractors whose acts may not be similarly protected from liability or entitled to workers' compensation coverage via government.

(c) *Employees*. A requesting healthcare entity may normally be responsible for all liability claims, disability claims, litigation costs, and other foreseeable costs incurred by transferred employees involving third parties except in instances arising from gross, willful, or wanton misconduct of the transferred employee. Transferred employees shall not be principally liable to a requesting healthcare entity, including through indemnity actions, for their actions taken in good faith.

(d) *Contractors*. The requesting healthcare entity also shall be responsible for all liability claims, malpractice claims, disability claims, attorneys' fees and other foreseeable costs incurred by transferred contractors except in instances arising from gross, willful, or wanton misconduct of the transferred contractor. A contractor who agrees to be transferred shall not be contractually liable for failing to fully discharge the terms of employment at the lending healthcare entity provided that the lending healthcare entity agrees in writing to the transfer.

(e) *Lending healthcare entities: Vicarious liability*. A lending healthcare entity shall not be held vicariously liable for the actions of transferred employees, contractors, or VHPs, except in instances of gross, willful, or wanton misconduct of the lending healthcare entity personnel in assuring the credentials of transferees.

(f) *Failure to respond or inadequacies*. Parties are not bound to a specific course of action for which the failure to act constitutes an actionable claim for breach of contract or equitable relief, except with respect to the credentialing of transferred personnel. Execution of this MOU shall not result in any liability or responsibility for failure to respond to any request for assistance, inefficiency in answering such a request, or for the inadequacy of equipment or skills of the responding personnel.

(g) *Workers' compensation coverage*. Transferred employees and contractors shall be considered "employees" of the requesting healthcare entity for the purposes of workers compensation coverage in the event that an injury or death of the employee or contractor occurs in the scope of the work at the requesting healthcare entity.

4.2 Financial Obligation.

(a) Compensation and reimbursement for borrowed resources. A lending healthcare entity shall be reimbursed by a requesting healthcare entity for transferred personnel and resources. The lending healthcare entity shall also be reimbursed for services rendered, including salaries of the transferred personnel at their normal pay rate as if those personnel were being paid by the lending healthcare entity. Reimbursement shall be for actual costs, but shall not include ancillary expenses, such as administrative costs or loss of revenues.

(b) *Responsibility for insurance*. Parties shall maintain and demonstrate their existing professional liability, property, workers' compensation, or other insurance coverage and affirm their intention to retain such coverage at all times as a party to this MOU.

5. Miscellaneous

5.1 Amendments and Modifications. All modifications and amendments to this MOU shall be formally agreed to by the parties in writing.

5.2 Mediation and Dispute Resolution. This MOU is not intended to provide the basis for post-emergency litigation. However, to the extent that litigation could result from the acts of the parties in carrying out the MOU (e.g., claims related to actual costs of reimbursement) parties agree to submit any actionable claim to arbitration and dispute resolution (or an analogous mechanism) prior to the inception of litigation.

5.3 Good Faith Attempts to Clarify and Fulfill Understandings. In the event that a portion of this MOU is impossible to fulfill, the parties agree to attempt to comply with the remainder of the MOU to the extent possible.

5.4 Effect on Legal Rights. This MOU is in no way meant to affect any of the parties' rights, privileges, titles, claims, or defenses provided under federal or state law or common law.

In witness whereof, we have set our hands and seals that date below written.

Signed

3.24.2020
Dated

CEO
Title

Mammoth Hospital
Healthcare Entity

Kelli Davis
Signed

3-25-2020
Dated

INTERIM CEO
Title

NORTHERN INYO HEALTHCARE DISTRICT
Healthcare Entity

5. Miscellaneous

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In witness whereof, we have set our hands and seals that date below written.

Signed

24 March 2020
Dated

CEO
Title

Toiyabe Indian Health Project
Healthcare Entity

Signed

27 March 2020
Dated

CEO
Title

Southern Inyo Healthcare District
Healthcare Entity

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Identity Theft Red Flags Rule Policy	
Scope: Northern Inyo HealthCare District	Manual: Business Office
Source: Director of Revenue Cycle	Effective Date:

PURPOSE:
As an issuer of credit to recipients of its healthcare services, Northern Inyo HealthCare District (NIHD) adopts an Identify Theft Prevention Program to assist in identifying, detecting, and mitigating risks of identity theft affecting patients of the Hospital and clinics.

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

DEFINITIONS:
I. Identity theft - fraudulently using the identifying information of another person.
II. Medical Identity Theft - When an individual assumes or attempts to assume the identity of another person through fraudulent means or false pretenses and obtains or attempts to obtain medical service or goods, or to make false claims for medical services or goods.
III. Red Flag - a pattern, practice, or specific activity that indicates the possible existence of Identity Theft.

PROCEDURE:
I. <u>IDENTIFICATION OF RED FLAGS</u>
Activities involving Identity Theft generally fall within one of the following general types of red flags:
   A. Suspicious documents
   B. Suspicious personal identifying information, such as a suspicious address
   C. Unusual use of – or suspicious activity relating to – a covered account
   D. Alerts from others (e.g. customer, identity theft victim, or law enforcement)

II. <u>DETECTION OF RED FLAGS</u>

   A. NIHD has adopted the following procedures to aid in the detection of red flags for identity theft:

      i. New Patient - Obtain appropriate identifying information and insurance information. This should include the following:
         1. Full legal name
         2. Date of Birth
         3. Address
         4. Make copy of Government issued or other valid picture ID, e.g. Driver's License
         5. When applicable, make copy of patient's insurance card
         6. Verify eligibility and insurance company's information

7. Have patient sign Conditions of Admission

ii. Existing Patient
Verify and update the personal and insurance information listed

1. During each return patient visit registration have patient show valid picture ID
2. Make copy of insurance card, including existing insurance listed
3. Verify eligibility and insurance company's information, including existing insurance listed
4. Verify validity of requests for changes of billing addresses
5. Have patient sign Conditions of Admission with each patient visit registration
6. Verify identification of patients before releasing any personal information.

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

III. PREVENTION AND MITIGATION OF IDENTITY THEFT

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

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

C. Appropriate responses may include:

i. Monitoring a covered account for evidence of identity theft
ii. Contacting the patient
iii. Placing Billing Hold on account
iv. Reopening a covered account with a new account number
v. Not opening a new covered account

Title: Identity Theft Red Flags Rule Policy	
Scope: Northern Inyo HealthCare District	Manual: Business Office
Source: Director of Revenue Cycle	Effective Date:

vi. Closing an existing covered account
vii. Notifying Compliance, law enforcement, and the designated governmental hotlines; or
viii. Determining that no response is warranted under the particular circumstances.

D. Internal Notifications:
Any NIHD employee who becomes aware of a potential or actual breach of personal information should report it to their manager and/or the Compliance Department for follow-up. The Compliance Office shall be notified of all breaches.

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

IV. PROGRAM OVERSIGHT

A. This policy shall be reviewed annually.

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

REFERENCES:

1. FTC's Identity Theft Prevention Red Flag Rules-16 C.F.R. Section 681.2 (2008) Fair and Accurate Credit Transactions (FACT) Act of 2003.

Committee Approval	**Date**
Fiscal Services Meeting	11/15/19
NCOC	4/02/20
Executive Team	12/23/19
Board of Directors	
Last Board of Directors Review	

Developed: 11/21/19mt
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Temporary Floating Staff Policy**	
Scope: District Wide	Manual:
Source: Administration	Effective Date: 3/31/2020

PURPOSE:

1. To identify the process for floating staff who do not have a workload in their routinely assigned (home) department due to COVID-19.
2. To decrease the need to low-census staff from departments where census and services have decreased; to utilize available staff to provided care and/or service in other departments where need exists.

POLICY:

Floating is defined as an unscheduled temporary assignment to another department other than the employees regularly scheduled department. Floating shall occur due to staffing, departmental needs and/or other service considerations. In the event the employee feels that she/he lacks skills or competency, the employee shall inform the immediate supervisor. The supervisor and the employee shall alter such assignment if warranted.

PROCEDURE:

1. The department supervisor may float employees who are required to be onsite to another department to assist with care or service activities within his/her skill set. In so doing, the District shall use best practices in reducing risk of exposure and social distancing.

Committee Approval	**Date**
Administration	3/31/2020
Board of Directors	Pending April Board meeting

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Temporary Telecommuting Assignment Policy**	
Scope: District Wide	Manual:
Source: Administration	Effective Date: 3/19/2020

POLICY:

Northern Inyo Healthcare District (NIHD) recognizes that our employees are by definition, Healthcare Workers, and the first priority of government is continuity of service in the event of a wide spread emergency or disaster (GC §§3100-3109). In the event of such emergency or disaster, it is important that NIHD not only respond to the emergency by stabilizing the emergency, saving lives, and protecting property but also maintain continuity of government. As such, NIHD is implementing this temporary telecommuting assignment policy to ensure the highest level possible of continuity of operations in light of the current COVID-19 (coronavirus) outbreak while addressing health and safety concerns for employees.

This policy will allow Department Heads full discretion to determine if an employee is eligible to be placed in a temporary telecommuting assignment and to determine the length of the telecommuting assignment. Department Heads will be guided in their decision-making by their assessment of job duties that may be conducive to working remotely, and operational needs assessments.

Because NIHD provides essential services to members of the community, there are positions at NIHD that require the employee to be physically present in the workplace. These employees are expected to report to work as scheduled unless otherwise notified by their direct supervisor.

All employees will benefit from the impacts of this policy by way of the increased opportunities to achieve social distancing parameters recommended as a precaution against the spread of the coronavirus.

The temporary telecommuting assignments implemented by this policy are expected to be short-term. NIHD will continue to monitor guidance from health officials and may make alterations to or terminate this policy at any time at the direction of the Chief Executive Officer.

Employees should not assume eligibility for a telecommuting assignment. Nor should they assume any specified period of time for telecommuting if so assigned. Employees assigned to a temporary telecommuting assignment will receive specific written instructions and are expected to abide by the following guidelines.

PROCEDURE:

Job Responsibilities & Regular Communication

While telecommuting, to the extent possible, employees should be performing the full range of their normal job duties. Employees and supervisor should maintain communication throughout the workday, through email, by phone, video chat, or other means. Managers and supervisors will be expected to establish and communicate work expectations of employees working remotely, including setting work priorities, deadlines, and reviewing work assignments. Employees are required to log work activity in 30 minute increments in his/her Outlook calendar; daily logs are to be submitted to the supervisor at the end of the work day.

Work Schedules and Time Worked

Telecommuting employees should coordinate with their supervisor the set hours that will be devoted to performing their work. Start and end times for telecommuting employees should be communicated in

advance and should be consistent from day-to-day, as much as possible. As approved by the employee's supervisor, an employee's start time and end time may be permitted to be different from the employee's normal hours when working on-site.

Employees who are not exempt from overtime requirements under the Fair Labor Standards Act (FLSA) will be required to accurately record all hours worked. Employees should coordinate with their supervisor for any periods of time during the workday when they will not be working. Employee activity may be subject to audit by NIHD. Any overtime must be authorized in advance by the employee's supervisor. Under this policy, employees are not eligible for shift differential.

While it is anticipated the majority of work performed by the employee will be remotely (not on-site), there may circumstances in which the employee is needed to return to their normal work site. In the event such on-site attendance is required, supervisors will notify the employee, in advance, when on-site attendance is necessary.

Equipment and Tech Support

Electronic equipment needed for employees to telecommute will be supplied by NIHD to the extent resources are available. In certain circumstances and/or if sufficient resources are not available, employees may be requested to use their personal phones, computers, or other equipment. Equipment supplied by the employee, if deemed appropriate by the organization, will be maintained by the employee, except that employees shall be reimbursed for any preapproved expenses related to usage (eg Data overages). Should the employee agree to use their own equipment, NIHD will work with them to protect their personal private contact information. NIHD accepts no responsibility for damage or repairs to employee-owned equipment and reserves the right to make determinations as to appropriate equipment, subject to change at any time. Equipment supplied by NIHD is to be used for business purposes only. The employee must sign inventory Telecommuting Agreement (Attachment A) with an inventory of NIHD property authorized for telecommuting use and thereby agree to take appropriate action to protect the items from damage or theft. All NIHD-owned equipment issued to an employee must be returned immediately at the conclusion of the temporary telecommuting arrangement. Employees who had been provided with an NIHD computer prior to this temporary policy will not need to return their NIHD issued equipment.

NIHD will provide employees with appropriate office supplies (pens, paper, etc.) as deemed necessary and shall reimburse the employee for pre-approved business-related expenses that are necessary and reasonably incurred to carry out the employee's job.

Telecommuting employees will establish an appropriate work environment within his or her home for work purposes and provide the necessary workspace, such as desk, tabletop, or other location that provides optimal work productivity. Given the temporary nature of this program, employees are not expected to purchase furniture or equipment to arrange a home workspace.

Employees should seek advice from a tax advisor if they have questions concerning tax implications of working from home. NIHD is not responsible for substantiating any employee's claim of tax deductions for operation of a home office used to perform work.

Security

Title: **Temporary Telecommuting Assignment Policy**	
Scope: District Wide	Manual:
Source: Administration	Effective Date: 3/19/2020

Consistent with NIHD's expectations of information security for employees working at the office, telecommuting employees are expected to ensure the protection of NIHD information accessible from their home office. Necessary security steps include appropriate network security measures, regular password maintenance, and any other measures appropriate for the job and the environment.

Safety

Employees are expected to maintain their home workspace in a safe manner, free from safety hazards. Injuries sustained by the employee in a home office location and in conjunction with his or her regular work duties may be covered by Workers' Compensation. Telecommuting employees are responsible for notifying their supervisor of such injuries as soon as practicable. NIHD assumes no liability for injuries that occur outside the performance of the employee's duties and/or outside the employee's scheduled telecommuting hours.

Employees are prohibited from having face-to-face meetings regarding NIHD business in their homes. Rather, employees shall opt to use video or phone conferencing to maintain social distancing guidelines and personal protection. NIHD will not be liable for any injuries sustained by visitors to an employee's home worksite.

NIHD Policies and Employee Conduct

Working from home inherently changes the workplace dynamic for employees. However, employees are expected to continue to adhere to all NIHD Personnel Rules and Regulations department policies, and relevant Memoranda of Understanding. Employees with questions about the application of a policy or procedure should contact their supervisor for additional information.

Committee Approval	**Date**
Administration	3/19/2020
Board of Directors	Pending April Board meeting

Title: **Temporary Telecommuting Assignment Policy**	
Scope: District Wide	Manual:
Source: Administration	Effective Date: 3/19/2020

ATTACHMENT A

Employee Name: _____

Department/Division: _____ **Supervisor:** _____

Job Title/Position: _____

Telecommute Start Date: _____

Remote Work Location

Address: _____

_____

Phone # : _____

Alternate #: _____

Email Address: _____

Work Schedule

Hours Per Week: **Schedule Type (5/40, 9/80, 4/10):**

☐	Monday	From: _____ To: _____
☐	Tuesday	From: _____ To: _____
☐	Wednesday	From: _____ To: _____
☐	Thursday	From: _____ To: _____
☐	Friday	From: _____ To: _____
☐	Saturday	From: _____ To: _____
☐	Sunday	From: _____ To: _____

Meal Breaks: Hourly employees working full-day schedules of six hours or more, are required to include a minimum thirty (30) minute unpaid meal break into the daily work schedule, and may take two paid 10 minute rest breaks during an 8 hour and 10 hour shifts and three during a 12 hour shift.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Temporary Telecommuting Assignment Policy**	
Scope: District Wide	Manual:
Source: Administration	Effective Date: 3/19/2020

Employee & Supervisory Responsibilities

Employees and supervisor agree to maintain regular communication through email, by phone, video chat, or other means on an agreed schedule and as needed basis. Employees on temporary telecommuting assignment are expected to respond to manager/supervisor within 15 minutes of call during agreed regular work hours, with the exception of during unpaid meal breaks. Managers/supervisors shall communicate work expectations for telecommuting employees and ensure appropriate compliance with expectations.

Equipment/Supplies Inventory

Equipment/Supply	Supplied by NIHD	Supplied by Employee
Computer:	_____	_____
Cell Phone:	_____	_____
Printer:	_____	_____
Other Equipment:	_____	_____
	_____	_____

Employee Verification

I have reviewed and agree to the provisions in this Temporary Telecommuting Agreement. I verify that I have also read and understand the NIHD Temporary Telecommuting Assignment Policy, attached hereto for reference and agree to all of its terms. I further understand that the arrangement to work remotely is temporary and may be rescinded, without notice, based on needs of NIHD.

_____ _____
Employee Signature Date

_____ _____
Supervisor/Manager Date

_____ _____
Department Director Date

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Safety in the Operating Room*	
Scope: Nursing, Biomed, Medical Staff, Anesthesia, Respiratory	Manual: Anesthesia - Patient Safety (PS), Standards of Practice Independent/Interdependent, Surgery - Patient Safety (PS)
Source: DON Perioperative Services	Effective Date: 8/17/16

PURPOSE:
To identify potential hazards associated with use of electrical equipment in the operating room. To provide a safe environment for patients in the operating room.

POLICY:
Safe practice for use of all electrical equipment in the operating room shall be followed. All equipment in the operating room shall be safe for patient use.

PRECAUTIONS:
- No open flames will be tolerated in the operating room at any time.
- Electrosurgical units will be turned off when mixing Methyl Methacrylate (bone cement). Methyl Methacrylate is mixed at all times, in a mixing system attached to a suction scavenging system.
- The use of extension cords is allowed **ONLY IN EMERGENCY** situations and must be equipped with hospital grade plugs.
- No elective surgeries will be initiated during a power outage in which NIHD is without power or is on generator (back-up) power.

PROCEDURE:
1. All electrical equipment shall be inspected by a biomedical engineer before use in a clinical setting.
2. All electrical equipment shall be subject to routine periodic inspection by Biomedical Engineering in accordance with an established preventive maintenance program.
   - All electrical equipment shall be labeled with an inspection sticker indicating:
   - Date of inspection
   - Equipment identification number
3. Before electrical equipment is inserted, all outlets and switch plates shall be inspected for damage.
4. All electrical cords shall be inspected for fraying or other damage before they are used.
   - Electrical cords shall be neither too short nor too long when extended from place of use to appropriate outlet.
   - The use of extension cords shall only be used in emergency.
   - If electrical cords are too short, they should be replaced by biomed for longer cords.
5. The use of personal electrical equipment in the operating room is discouraged. All personal electrical equipment must be inspected prior to use by biomedical engineer and approved for use.
6. All loaner equipment from manufacturer must be inspected and approved safe before use in the operating room.
7. Any equipment found to be faulty will be immediately repaired before being returned to use.
8. Patient physical safety is protected at all times. Attention is given to safe procedures in transportation, positioning and moving of patients (see individual procedures).
9. Personnel safety is insured by awareness of hazards in the operating room, promotion of safe practices and education in proper safety techniques, including body mechanics.
10. In the event NIHD is switched to (back-up) generator power, the maintenance Department will notify the Administrator On Call (AOC), the House Supervisor, and Perioperative Nursing Director or Surgery Manager (who will notify the surgery and PACU staff).

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Safety in the Operating Room*	
Scope: Nursing, Biomed, Medical Staff, Anesthesia, Respiratory	Manual: Anesthesia - Patient Safety (PS), Standards of Practice Independent/Interdependent, Surgery - Patient Safety (PS)
Source: DON Perioperative Services	Effective Date: 8/17/16

ANESTHESIA MACHINE SAFETY:

1. All anesthesia machines are pin indexed and have fail safe 02 systems, pressure and disconnect alarms, gas scavenging systems, and oxygen pressure interlock systems.
2. All anesthesia machines are serviced quarterly and waste gas testing is performed by technical company service representative.
3. Anesthesia equipment is checked prior to each use by ~~anesthesiologist~~the anesthesia provider.
4. All vaporizers have pin indexed fillers and are specific for each gas to prevent error when filling.
5. All operating rooms are equipped with C02, O2 monitoring and inhalation gas monitoring capability.
6. Flammable anesthetic agents are prohibited in all operating rooms. All areas are prominently posted above the entry door "Use of Explosive Gases Prohibited."

MEDICAL GASES:

1. Medical gases should be stored in a secure area.
2. Full cylinders should be segregated from empty cylinders.
3. Medical gases should be stored in a well ventilated room in a holder or storage rack, away from heat sources.
4. Cylinders should not be stored in an egress hallway.
5. Gas cylinder valves should be closed properly to avoid leakage during storage.
6. Gas cylinders should be carried in a safe manner to prevent dropping or damage to the cylinder. Dropping of a full cylinder poses a risk of releasing compressed gas and can cause propulsion of the cylinder and subsequent injury.
7. Gas cylinders used during patient transport should be secured to the transport cart, or bed holders. Cylinder should not be placed on top of the bed next to the patient.
8. Gas Cylinders must be clearly identified as to type of gas, and have a unique pin-index. Gas Cylinders have standardized colors for identification and the pin-index system prevents connecting the wrong gas to the delivery system.
9. Before use, gas cylinders should be checked for:
    - Appropriate label.
    - Appropriate pin-index safety system connector.
    - Appropriate color coding.
10. Compressed medical gas tank valves should be opened fully during use to prevent excessive heat buildup through the regulator. Temperatures can increase more quickly if the valve is only partially opened.
    - A flash fire may occur if combustible materials such as dirt or oil are present at the gas outlet.
11. Fittings on medical gas cylinders and hoses should not be altered under any circumstances.

HAZARDOUS CHEMICALS:

1. Refer to Material Safety Data Sheet Information for every potentially hazardous chemical.
2. When using chemicals, personnel should read and follow all instructions provided on the container label or found on the MSDS provided by the manufacturer of the chemical.

Title: Safety in the Operating Room*	
Scope: Nursing, Biomed, Medical Staff, Anesthesia, Respiratory	Manual: Anesthesia - Patient Safety (PS), Standards of Practice Independent/Interdependent, Surgery - Patient Safety (PS)
Source: DON Perioperative Services	Effective Date: 8/17/16

3. Chemicals should not be combined.

- Methyl Methacrylate bone cement is used for orthopedic procedures. Methyl Methacrylate is a respiratory, eye and skin irritant.
  - Methyl Methacrylate fumes should be extracted from the environment and the fumes absorbed through activated charcoal.
  - Vacuum mixers with fume extraction should be used to reduce the fume levels.
  - Eye protection should be worn to prevent contact with eyes.
  - Follow manufacturer's recommendation for mixing cement.
  - A second pair of gloves should be worn when handling methyl methacrylate and should be discarded after use.
  - Methyl methacrylate may be absorbed through the skin and penetrate many plastic and latex compounds, leading to dermatitis. The liquid portion should not come in contact with gloves.
  - Methyl methacrylate is hazardous waste and should be disposed of per state, local and federal requirements.
  - **NOTE:** Electrosurgical machines must be turned off during the mixing of methyl methacrylate to prevent possible combustion.

FIRE SAFETY:
- Fire is always a risk to both patients and healthcare workers in the operating room.
- Ignition sources should be controlled.
- Refer to policy on Fire Safety in the Operating Room.

BLANKET AND SOLUTION WARMING CABINETS:
- The danger of thermal burns from heated blankets or solutions is increased in the perioperative setting because patients are unconscious or sedated and cannot feel the increase in temperature or communicate their discomfort.
- Attention to the temperature of warming cabinets is important. Even when solutions and blankets do not feel warm to staff members, heat continues to build up in these items and can be transferred to patients.
- Refer to policy on Warming Cabinets for Solutions and Blankets.

RELATIVE HUMIDITY:
Relative Humidity in the Operating Room is monitored both electronically and manually on a continual basis. The goal is to have relative humidity in the range of 30% to 60%, although there have been times when this goal has not been achievable.
The Centers for Medicare and Medicaid Services (CMS) is issuing a categorical LSC waiver permitting new and existing ventilation system supplying hospital and critical access hospital (CAH) anesthetizing locations to operate with a relative humidity greater than 20 percent, instead of greater than 30 percent in these locations. They also recommend that relative humidity not exceed 60 percent. There must be written documentation stating that the facility has elected to use the waiver. A copy of this waiver is maintained in the maintenance department.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Safety in the Operating Room*	
Scope: Nursing, Biomed, Medical Staff, Anesthesia, Respiratory	Manual: Anesthesia - Patient Safety (PS), Standards of Practice Independent/Interdependent, Surgery - Patient Safety (PS)
Source: DON Perioperative Services	Effective Date: 8/17/16

At the entrance conference for any survey assessing LSC compliance, the facility that has elected to use this waiver must notify the survey team. Facilities must monitor relative humidity in anesthetizing locations and take corrective actions when needed to ensure relative humidity remains at or above 20 percent.
The Relative Humidity is monitored electronically every hour on the Building Control Management Computer. This log is printed off monthly and the information is given to the Surgical Clerk, The Performance Improvement Coordinator and maintained in the Maintenance Department.
The Relative Humidity is monitored manually by Operating Room Personnel prior to each surgical procedure and is documented in the patient record. If the Relative Humidity is less than 20%, the surgeon who is performing the procedure is to be notified and the decision to continue with the procedure is based on his/her judgment.
A list of the supplies and equipment that are stored in the OR Rooms will be used to check manufacturer recommendations for humidity requirements/ actions should the humidity fall below 30% for an extended period. Package integrity should be checked routinely as supplies are opened and supplies discarded if integrity is compromised.

DOCUMENTATION:

- Identification numbers of cautery equipment used for patient care shall be documented on the operative record.
- Records and equipment manuals for the maintenance and biomedical engineering departments are kept on file in their respective departments and copy is kept on file in the Operating Room Nurse Manager's office.
- The Relative Humidity is monitored electronically every hour on the Building Control Management Computer. This log is printed off monthly and the information is given to the Surgical Clerk, The Performance Improvement Coordinator and maintained in the Maintenance Department.
- Any equipment that has failed and needs service is to be labeled with an **OUT OF SERVICE** sign and maintenance and biomedical engineer notified ASAP.
- The relative humidity in the OR is documented in the patient record by the circulating RN prior to the start of the case.
- Any potential patient hazard is to be noted on a QA Review (incident report) and Operating Room Nurse Manager is to be notified. Equipment is to remain out of service as noted above.

REFERENCE: Centers for Medicare and Medicaid Services (CMS) (REF; S&C: 13-25-LS & ASC)
Current and Relevant JCAHO and Title 22 Standards
AORN Standards of Care

Approval	**Date**
CCOC	11/18/2019
Safety Committee	2/12/2020
Surgery Tissue Committee	1/22/2020
MEC	2/4/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Safety in the Operating Room*	
Scope: Nursing, Biomed, Medical Staff, Anesthesia, Respiratory	Manual: Anesthesia - Patient Safety (PS), Standards of Practice Independent/Interdependent, Surgery - Patient Safety (PS)
Source: DON Perioperative Services	Effective Date: 8/17/16

Board of Directors	
Last Board of Director review	

Developed: 1/00
Reviewed:
Revised: 01/0; 6/11; 2/15AW, 7/15BS, 6/16AW, 11/19 AW
Supersedes:
Index Listings: Safety in operating room/ Anesthesia safety, Humidity safety

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Asset Control	
Scope: Administration	Department: Purchasing
Source: Director of Purchasing	Effective Date: 9/1/2019

Purpose:
To ensure effective asset controls.

Policy:
Purchasing will coordinate with the Accounting department to ensure that capital assets are identified at purchase and accounted for at disposal.

Procedure:

1. When Purchasing has completed the order process for a capital purchase it will assign a property number for each piece of equipment.
2. Purchasing will use pre-printed property tags for each asset item and forward them to Receiving.
3. Upon receipt, Purchasing will attach the property tag(s) to the item(s) and receive as per policy. The packing slip for capital assets will be forwarded to Purchasing for inclusion in the file.
4. Receiving will also notify the Accounting department of the receipt. The Accounting department will update the asset register.
5. Purchasing will notify the Accounting department of the disposal of any assets.

Committee Approval	**Date**
Finance Leadership	3/18/2020
Administration – Executive Committee	8/5/2019
Board of Directors	

Revised: **8/5/19**
Reviewed: **8/5/19**
Supersedes: **12/5/14**

NORTHERN INYO HEALTHCARE DISTRCIT
POLICY AND PROCEDURE

Title: Asset Management	
Scope: Administration	Department: Purchasing
Source: Director of Purchasing	Effective Date: 9/1/2019

Purpose:
To ensure the assets are properly managed throughout the facility.

Policy:
Accounting will maintain an Asset Management System with the assistance of Purchasing.

Procedure:

1. The Accounting department will establish and maintain an Asset Management System to record, track and depreciate all hospital capital assets.
2. The Purchasing department will assist with the maintenance of the Asset Management System through appropriate purchasing and receiving actions as follows:
    a. For each capital asset purchased, Purchasing will assign a property number and forward the property number tag to Receiving. Purchasing will note the tag number on the purchase order.
    b. Receiving will inspect and receive the capital asset. Receiving will affix the property number tag to the equipment as per the receiving policy for capital equipment. If items are delivered directly to the user area, the ordering department will contact Receiving and notify them that the delivery is in progress. Receiving will also provide all serial numbers and property numbers for entry into the Asset Management System.
    c. Receiving will notify the Accounting department that the capital asset has been received and will include all pertinent data including serial numbers. This may be accomplished through a hard copy of the purchase order or invoice.
3. The Purchasing department will assist with the maintenance of the Asset Management System through asset tracking as follows:
    a. Departments shall coordinate the transfer of any capital asset to another department through Purchasing.
    b. Purchasing will ensure that any service contracts are transferred and that the responsible service company is notified of the move.
    c. Purchasing will notify Finance and Biomedical Engineering (if applicable) of the transfer.
4. The Purchasing department will assist with the maintenance of the Asset Management System through appropriate disposition actions as follows:
    a. Assets will be sold or discarded according to the organization policy on excess equipment.
    b. Purchasing will forward a copy of the asset disposition form to the Accounting department.

Title: Asset Management	
Scope: Administration	Department: Purchasing
Source: Director of Purchasing	Effective Date: 9/1/2019

5. Theft or damage. In the event that an asset is stolen or destroyed, the responsible department must notify security and complete a security report. The department must also notify the Accounting department so the asset can be removed from the books.
6. Asset tracking:
    a. The Accounting department will facilitate that assets are inventoried at least annually. This can be accomplished on a single annual inventory or through inventories of individual departments on a monthly basis.
    b. The Accounting department will produce a report of assets by department. Each department will get the report annually for their area. Each department will verify that each asset is still in their possession. If an asset is no longer present, the department will indicate what happened to it.
7. Each year prior to the time for submission of capital budget requests, the Accounting department will produce a report of all assets, which have exceeded or are within two years of their expected useful lives. Departments should use this report as a resource in preparing their capital budget request.

Committee Approval	**Date**
Finance Leadership	3/18/2020
Administration	8/5/2019
Board of Directors	

Revised: 8/5/19
Reviewed: 8/5/19
Supersedes: 12/5/14

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Capitalization of Assets	
Scope: Administration	Department: Accounting
Source: Controller	Effective Date: 9/1/2019

PURPOSE:

To establish minimum criteria dollar amount for capitalizing assets according to OSHPD requirements.

POLICY:

1. Fixed Assets such as Land, Land Improvements, Hospital Buildings, Fixed Equipment and Major Movable Equipment will be capitalized using criteria established by guidelines suggested by the Office of Statewide Health Planning and Development.

2. NIH will follow OSHPD guidelines with the exception of using a lower dollar amount for capitalizing assets as follows:

3. Land, Land Improvements, Buildings, and Fixed Equipment will be capitalized at $3,000 per distinct item.

4. Major Movable Equipment will be capitalized at $3,000 per distinct item. A distinct item is defined as a piece of equipment that functions on its own including all the normal parts needed for effective operation. An example is: most items require a power cord. If the equipment requires the separate purchase of the power cord, that cord would be considered part of the distinct item for determination if an item meets the capital threshold of $3,000 per distinct item.

5. Equipment which does not meet the $3,000 threshold; will be considered Minor Equipment and expensed to the department who primarily uses the equipment. Minor Equipment will not have an asset tag assigned, but should have a Bio-Medical tag affixed.

Approval	**Date**
Finance Leadership	3/18/2020
Administration	8/5/19
Board of Directors	
Last Board of Director review	3/15/17

Revised 8/5/19
Reviewed 8/5/19
Supersedes 3/15/2017

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Fixed Assets and Depreciation**	
Scope: Administration	Department: Accounting
Source: Fiscal Services Manager	Effective Date: 9/1/2019

PURPOSE:

To ensure that asset depreciation is performed within the California, Office of Statewide Health Planning and Development (OSHPD) guidelines published in the Accounting and Reporting Manual for California Hospitals.

POLICY:

1. Northern Inyo Hospital will use the following minimum criteria dollar amounts for depreciation:
   - 1200 Property-Land $3,000
   - 1210 Property-Land Improvements $3,000
   - 1221 Property-Hospital Buildings $3,000
   - 1225 Property-Fixed Equipment $3,000
   - 1241 Property-Major Movable Equipment $3,000

2. Once a purchase has been designated to be an asset, it will be coded into the above general ledger categories and depreciated.

3. Assets will be booked and depreciation started only when the asset is put into use.

4. In the event of purchase before use, assets and building projects will be booked into the Construction in Progress general ledger accounts (also determined using OSHPD guidelines).

5. These accounts will be reconciled monthly and moved to the appropriate property account upon completion.

6. The straight-line deprecation method is used at Northern Inyo, with ½ year depreciation during the year of purchase, and the final ½ year depreciation during the final year of life for the asset.

7. The life of all assets will be determined using the Estimated Useful Live of Depreciable Hospital Assets published by the American Hospital Association.

8. If an asset is disposed of before the final year of depreciation, the final ½ year only will be taken and the balance of book value is written off.

9. Property and depreciation will be maintained in detail on a property database that will be reconciled annually to the corresponding general ledger accounts and audited.

Committee Approval	**Date**
Finance Leadership	**3/18/2020**
Administration	**8/5/2019**
Hospital Board of Directors	

Revised: **8/5/19**
Reviewed: **8/5/19**
Supersedes: **12/17/03**

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: Stacey Brown, MD, Chief of Medical Staff
DATE: April 7, 2020
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. Medical Staff Bylaws Amendment for Disaster Privileging (*action item*)

B. Policies and Procedures (*action items*)
   1. *Credentialing Healthcare Practitioners in the Event of a Disaster*
   2. *Biological Monitoring System for Steam Sterilizers*
   3. *High-Level Disinfection of Equipment*
   4. *Steris System 1E Processor*
   5. *Manual Jet Ventilator*
   6. *Clinic Patient No-Show, Missed Appointment, and Late Cancellation Policy*
   7. *OP Hospital No-Show, Missed Appointment, and Late Cancellation Policy*
   8. *New Line of Service Implementation Policy and Procedure*

C. Physician recruitment update (*information item*)

The following items were submitted for approval and tabled at the March 2020 Board meeting:

D. Annual Approvals (*action items*)
   1. Critical Indicators
      i. ICU
      ii. Medical Services
      iii. Perinatal
   2. Policies and Procedures
      i. *Plan to Eliminate or Substantially Reduce Medication-Related Errors*
      ii. *Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife*
      iii. *Standardized Protocol - Emergency Care Policy for the Physician Assistant*
      iv. *Standardized Procedure - Medical Screening Examination for Obstetrical Patient*
      v. *Standardized Procedures for Medical Functions by RN in the Emergency Department*
   3. Radiation Safety Policies
      i. *ALARA Program*
      ii. *DI – Area Monitoring and Controls*
      iii. *DI – Radiation Protection for the Patient*
      iv. *DI – Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*
      v. *DI CT Radiation Safety Policy*
      vi. *DI – Lead Apron/Protective Equipment Policy*
      vii. *Diagnostic Imaging – C-Arm (Fluoroscope) Radiation Safety*
      viii. *Diagnostic Imaging – Disposal of Radioactive Sharps*

ix. *Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear medicine personnel*
x. *Diagnostic Imaging – Nuclear Medicine New Employee/Annual Orientation*
xi. *Diagnostic Imaging – Ordering Radioactive Materials*
xii. *Diagnostic Imaging – Radioactive Material Hot Lab Security*
xiii. *Diagnostic Imaging – Radioactive Material Spills Procedure*
xiv. *Diagnostic Imaging – Radioactive Materials Delivery After-hours Policy/Procedure*
xv. *Diagnostic Imaging – Radioactive Waste Storage and Disposal*
xvi. *Dosimetry Program – Occupational Radiation Exposure Monitoring Program*
xvii. *Radiation Policy for Management of Patients with Excessive Exposure*
xviii. *Radiation Safety Committee*
xix. *Radiology Services Pregnant Personnel*
xx. *Responsibilities and Duties of Radiation Safety Committee (RSC)*

3.8 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and the district is unable to handle the immediate patient needs, the following may grant disaster privileges to volunteer practitioners in accordance with the process outlined in the applicable medical staff policy:

(a) the chief of staff;

(b) any physician member of the medical executive committee;

(c) any service chief;

(d) any active medical staff member; or

(e) designee of any of the above.

The volunteer practitioner shall be required to submit identification and other such required documentation for verification as further detailed in policy. The medical staff shall oversee the performance of all volunteer practitioners. Once the care of disaster victims can be adequately assumed by the members of the regular medical staff, then disaster privileges of the volunteer will be terminated as further detailed in policy.

Approvals:
-Bylaws: 4/3/2020
-MEC 4/3/2020
-Med Staff 4/8/2020

NORTHERN INYO HEALTHCARE DISTRICT MEDICAL STAFF
POLICY AND PROCEDURE

Title: Credentialing Healthcare Practitioners in the Event of a Disaster*	
Scope: NIHD	Department: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 2/15/2017

PURPOSE:
The purpose of this policy is to outline the credentialing procedure by which a practitioner can be granted temporary privileges in a disaster at Northern Inyo Healthcare District (NIHD).

POLICY:
1. In the event of a disaster or emergency where the District's emergency management plan has been activated and the District is unable to handle the immediate patient care needs, the medical staff may grant disaster privileges to individuals seeking to volunteer or offer their services after the policy applicability has been met and the procedure outlined in this document has been followed.
2. The following medical staff members listed in order of highest to lowest rank are authorized to grant disaster privileges as further described in this document:
    a. Chief of Staff
    b. Physician member of the Medical Executive Committee
    c. Any service chief
    d. Any active medical staff member
    e. Designee of any of the above
3. In the event of similar ranking individuals being available, preference would be given to the medical staff member with the practice most appropriate to the background or training of the practitioner seeking disaster privileges.
4. Practitioners granted disaster privileges are expected, to the best of their abilities and under extenuating circumstances, to provide the standard of care commiserate with their designated clinical role under the supervision of a paired medical staff member or Advanced Practice Provider. This may include, but is not limited to clinical care, documentation, availability for call, procedures, and consultation with supervising providers when necessary.

DEFINITIONS:
1. **Disaster** – an emergency that, due to its complexity, scope, or duration, threatens an organization's capabilities and requires additional and sometimes outside assistance to sustain patient care, safety, or security functions.
2. **Volunteer Healthcare Practitioner** – a licensed independent practitioner or other individual required by law and regulation to have a license, certification, or registration who is presenting to assist in patient care during a disaster. This individual may have existing privileges at NIHD or may be a volunteer not currently privileged at NIHD. Additionally, licensed locum tenens practitioners from a staffing agency, for the purpose of this policy, are also defined as volunteer healthcare practitioners regardless of whether the practitioner is being compensated for the work performed.

APPLICABILITY:
1. This policy and procedure is applicable only when the following has occurred:
    a. NIHD declares a disaster and activates its emergency operations plan.
    b. The Medical Executive Committee (MEC) recognizes the disaster situation as one in which this policy applies. The MEC may choose to convene a special meeting for this purpose or conduct a vote through electronic means. If the nature of the disaster is such that any delay caused by first obtaining a vote of the MEC could

Title: Credentialing Healthcare Practitioners in the Event of a Disaster*	
Scope: NIHD	Department: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 2/15/2017

reasonably cause patient harm, the highest ranking on-site medical staff member may recognize the disaster situation. That staff member may grant disaster privileges to volunteering practitioners as per the procedure detailed below. This decision must then be approved by the MEC within 24 hours.

PROCEDURE:

1. Recruitment of Volunteer Healthcare Practitioners
    a. If a Service Chief or on-site responsible physician (e.g., hospitalist or emergency medicine physician on-duty) determines that he/she is unable to cover care in his/her service during a disaster and needs additional immediate assistance, a medical staff member or appropriate District personnel (e.g., Incident Command member, House Supervisor, or medical staff office personnel) can begin contacting possible volunteer healthcare practitioners. Reasonable efforts should be made, under the circumstances, to first contact existing NIHD practitioners with appropriate privileges, followed by existing NIHD privileged practitioners who may qualify for disaster privileges or actively-practicing locum tenens practitioners of an appropriate specialty, prior to contacting or accepting other outside volunteer practitioners.
    b. Volunteer healthcare practitioners may also be proactively recruited in the course of disaster staffing preparations when the nature of the disaster allows it. In this case, the medical staff office or appropriate medical staff member with responsibilities in determining staffing for the service may contact possible volunteer healthcare practitioners to determine availability.
    c. All District departments and supervisory personnel shall be instructed to direct all volunteering health care practitioners that present to the District to a member of the Incident Command Center, medical staff office personnel, or an on-site responsible medical staff member for possible disaster privileging.

2. Identification Documentation Required
    a. The volunteer healthcare practitioner shall be required to produce a valid government-issued photo identification with a signature (e.g., driver's license or passport).
    b. If the practitioner is not currently privileged at NIHD, he or she will also be required to produce at least one of the following in addition to a government-issued photo identification:
        i. a current license to practice medicine, or other certification or registration, issued by a state, federal, or regulatory agency; or
        ii. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
        iii. identification indicating that the individual has been granted authority, by a federal, state or municipal entity, to render patient care, treatment, or services in disaster circumstances; or

iv. a signed statement by a current District department leader or medical staff member with personal knowledge regarding the practitioner's identity and ability to act as a qualified practitioner during a disaster.

c. If possible, copies of these documents should be made (or notation of the current hospital or medical staff member with personal knowledge). If it is not possible to make copies, the identification information (including full name, address, license number, issuing agency, etc.) shall be recorded.
d. If such identification documents are not readily accessible, the medical staff member will be responsible for making the final decision whether to allow the volunteer practitioner to participate in disaster care.
e. The identification information on the Request for Disaster Privileges form shall be completed by the volunteering healthcare practitioner.

3. Verifications
   a. If the practitioner is currently privileged at NIHD, the medical staff office will confirm their credentials file is up to date and will perform primary source verification of licensure as soon as feasible, but no later than 72 hours after the time that the practitioner presents him/herself. No other primary source verification is necessary provided that the credentials file is up to date.
   b. Volunteering practitioners without current NIHD privileges shall be requested to indicate his/her malpractice carrier (if any) and the name of the hospital(s) where he/she currently holds privileges (if applicable). Primary source verification of licensure, certification or registration, insurance, and hospital affiliations shall be made as soon as the disaster is under control, or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. A query to the National Practitioner Data Bank (NPDB) and Office of Inspector General (OIG) shall also be submitted, unless technologically not possible. In the event this information cannot be verified, emergency approval of disaster privileges may still be granted pending verification.
   c. If primary source verification of licensure, certification or registration cannot be completed within 72 hours of the volunteer's arrival due to extraordinary circumstances, it is performed as soon as possible. The following must be documented:
      i. Reason(s) the verification could not be performed within the 72 hours.
      ii. Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services.
      iii. Evidence of the attempt to perform primary source verification as soon as possible.

4. Approval of Disaster Privileges
   a. The available information shall be reviewed by the highest ranking available individual(s) authorized to grant emergency approval of disaster privileges. The highest ranking available individual(s) shall interview the volunteer to determine the appropriate scope of assigned responsibilities, and make a recommendation based on the available information.

b. If approved for disaster privileges, approval will be documented on the Request for Disaster Privileges form.

5. Supervision Required
   a. The volunteer practitioner shall be partnered with a member of the medical staff or Advanced Practice Provider (APP) staff. Whenever possible, the partner shall be of similar specialty.
   b. As appropriate and under the circumstances, the medical staff member or APP staff member will oversee the performance of the volunteer practitioner through direct observation, mentoring, or medical record review. Partnering information shall be recorded with the other information regarding the volunteer practitioner. More than one practitioner may be partnered with a single medical staff member or APP.
   c. The volunteer practitioner shall be issued a temporary identification badge (if available) indicating his/her name, status as an approved volunteer practitioner, notation of his/her partner, and when relevant, the specific area(s) of the District in which the practitioner shall be permitted to render care. Current NIHD practitioners may use his/her existing NIHD hospital identification badge in addition to a temporary badge (if available) which identifies he or she is approved for temporary disaster privileges in the specific patient care area.

6. Review and Termination of Privileges
   a. A decision whether to continue the volunteer practitioner's assigned disaster responsibilities is to be made within 72 hours of the practitioner's arrival.
   b. Any such disaster privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster privileges shall be terminated immediately if any information is received that suggests the volunteer healthcare practitioner is not capable of rendering services as approved.
   c. Once the care of disaster victims can be adequately assumed by an appropriate member of the regular medical staff or APP staff with existing privileges for that service, then the volunteer practitioner's privileges will be terminated. An individual who has had privileges terminated pursuant to this section shall be eligible to have disaster privileges reinstated, should circumstances warrant.
   d. Disaster privileges may be terminated by the assigned partner or any of the grantors listed in this policy.
   e. The District will make every effort to recognize and thank the services provided by the volunteer healthcare practitioners once the disaster is over.

REFERENCES:

1. The Joint Commission (2016) CAMCAH EM 02.02.13 and EM 02.02.15
2. California Medicaid Services §485.623 Condition of Participation: Emergency Services
3. "Disaster Privileging." Northwell Health. Policy retrieved March 26, 2020. https://medicine.hofstra.edu/pdf/policy/disaster-privileging.pdf

NORTHERN INYO HEALTHCARE DISTRICT MEDICAL STAFF
POLICY AND PROCEDURE

Title: Credentialing Healthcare Practitioners in the Event of a Disaster*	
Scope: NIHD	Department: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 2/15/2017

CROSS REFERENCE P&P:

1. Request for Disaster Privileges form (attached)

Approval	**Date**
Bylaws Committee	4/3/20
Medical Staff	4/8/20
Medical Executive Committee	4/3/20
Board of Directors	
Last Board of Directors Review	

Developed:
Revised: 1/14/2016; 2/2/2016; 12/21/2016 dp
Revised: 4/2/2020 dp
Index Listings: emergency credentialing, disaster credentialing, disaster privileges

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

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

NORTHERN INYO HEALTHCARE DISTRICT
REQUEST FOR DISASTER PRIVILEGES FORM

1. IDENTIFYING INFORMATION

a. Name: _____

b. Specialty/Special Skills: _____

_____

_____

c. Date of Birth: _____

d. SSN: _____

e. Sex: ○ M ○ F

f. Address: _____

_____

_____

Address Type: ○ Home ○ Business

g. Telephone: _____

h. Other telephone: _____

2. AFFILIATIONS

a. Hospitals where you hold privileges (if any):

i. _____

ii. _____

iii. _____

3. MALPRACTICE

a. Malpractice Insurance Carrier: _____

i. Policy number, if known: _____

4. SIGNATURE

_____ (SIGN) _____(DATE)

VERIFICATIONS

1. CURRENT PRIVILEGES

Is the volunteer practitioner currently privileged/credentialed at Northern Inyo Healthcare District?

○ YES ○ NO

If yes, is the credentials file up-to-date? ○ YES ○ NO

Other details/comments: _____

_____

2. IDENTIFICATION AND LICENSURE/REGISTRATION

Photo ID	**Type & Number:**	**Exp:**
License	**Type & Number:**	**Exp:**
Other Registration:	**Type & Number:**	**Exp:**
Affirmation of Identity	**Capacity:**	**Affirmed by (name and signature):**

3. PRIMARY SOURCE VERIFICATIONS

a. National Practitioner Data Bank (NPDB)

i. Query submitted by: _____

ii. Date/Time received: _____

iii. Findings: _____

b. Office of Inspector General (OIG)

i. Query submitted by: _____

ii. Date/Time received: _____

iii. Findings: _____

c. Other:

_____

_____

_____

APPROVALS

1. DISASTER PRIVILEGES APPROVED BY (select and print name):

- ☐ Chief of Staff _____
- ☐ Physician Member of MEC _____
- ☐ Service Chief _____
- ☐ Active Medical Staff Member _____
- ☐ Designee _____

2. TIME AND DATE APPROVED:

_____ _____ _____

Signature Date Time

3. 72 HOURS FROM WHEN PRIVILEGES GRANTED: _____

4. PARTNER ASSIGNMENT:

_____

5. SCOPE OF DISASTER RESPONSIBILITIES/PRIVILEGES:

_____

_____

_____

_____

_____

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Biological Monitoring System for Steam Sterilizers	
Scope: Sterile Processing	**Manual: Infection Control- Patient Care (ICP), Sterile Processing**
Source: DON Perioperative Services	Effective Date: 6/25/10

PURPOSE
To confirm the sterility of loads and the efficiency of the sterilizing process utilizing biological means.

PROCEDURE
Sterile Processing:

- Each morning sterile processing personnel will place a biological test pack in the third load of both #1 and #2 autoclaves. This test is to be performed with a loaded autoclave not an empty chamber. The results are entered in the log book, noting the date, time, sterilizer number, load and results of the test.
- The biological indicator should be placed in a 4-minute load. If the third load of the day is to be a 10minute load, then an additional biological indicator should be placed in the first 4-minute load processed in each autoclave to assure kill at a lower time.
- Label the Biological Pack with pertinent process information (load #, autoclave #, date) via label gun
- Place the properly labeled biological pack on the bottom rack closest to the drain in the steam autoclave.(as per manufacturer instructions) **THIS TEST IS TO MONITOR A LOADED CHAMBER**.
- Every day a control "Verify" Biological indicator will be dated and placed in the Biological incubator in Sterile Supply with same lot number as Biologicals to be used that day.
- This test is done on a daily basis and with all implantable products. All testing results are entered in the logbook noting date, time, sterilizer number, load and results of the test.
- All unused controls are to be disposed of in red biologic waste containers.

Operating Rooms:
To check the Operating Room autoclave, a Biological test pack is autoclaved in the sterilizer at 270 degrees for 4 minutes and then incubated in the sterile processing department. This test is done on a usage basis (when the autoclave is going to be used).

- Place biologic test pack, with date and autoclave # on outside, on the bottom shelf closest to the drain.
- Autoclave for 4 minutes at 270 degrees.
- Allow cooling to room temperature.
- Take to sterile processing to be crushed, incubated and monitored.
- Document information on the Load Record Envelope for surgery.

If there is evidence of bacterial growth in the test after 40 minutes the results are immediately reported to the Perioperative/Sterile Processing Director of Nurses or her designee.

Items in the load are retrieved from any departments they may have been distributed to, using the Steam Load Record Envelope for retrieval.

REFERENCES:
IAHCSMM Central Service Technical Manual, 2007
TJC: IC.02.02.01
Title 22: 70831, 70833
AORN Recommended Practices for Sterilization
AAMI ST79: 2017

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Biological Monitoring System for Steam Sterilizers	
Scope: Sterile Processing	**Manual: Infection Control- Patient Care (ICP), Sterile Processing**
Source: DON Perioperative Services	Effective Date: 6/25/10

Approval	**Date**
CCOC	12/16/19
Infection Control	2/25/20
MEC	4/7/20
Board	
Last Board of Director review	

Developed:
Reviewed:
Revised: 02/01 BS 6/25/10 BS, 9/12 BS, 4/2015 BS, 1/20aw
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: High Level Disinfection of Equipment	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: DON Perioperative Services	Effective Date: 5/12/2011

PURPOSE:
Sterilization or high level (chemical) disinfection shall be used to prevent transmission of microorganisms.

POLICY:
Disinfection is divided into three levels; high, intermediate and low. A high level disinfectant can be sporicidal as well as bactericidal and viricidal if contact time is sufficient. If endoscopes (colonoscopes, gastroscopes, cystoscopes, ureteroscopes, and bronchoscopes) cannot be sterilized in an autoclave, V-Pro, or System 1E, High Level Disinfection with OPA (ortho-phthalaldehyde) can be utilized.

The V-Pro or Steris Sterilization system1E shall be utilized for the sterilization of endoscopes both flexible and rigid (if applicable), and other heat sensitive equipment (i.e. instruments or equipment that cannot be sterilized in an autoclave). If the V-Pro or System 1E are unavailable then the High Level Disinfection with OPA (ortho-phthalaldehyde) will be utilized as an alternative for endoscopes until the V-Pro or Steris system 1E is back in service. Manufacturer instructions for use (IFU) must be followed to ensure proper disinfection

Cleaning and disinfection process will occur prior to storage

PROCEDURE:

STERILIZING OF ENDOSCOPES / PROBES:
Refer to manufacturer information on cleaning of individual scopes to be processed.

1. Don PPE (Personal Protective Equipment) including gown, gloves, and face shield or goggles.
2. Prepare enzymatic solution per label on container in distilled water.
3. PROTECTIVE CAP MUST BE IN PLACE BEFORE IMERSION OF FLEXIBLE SCOPES if applicable **.**
4. Wash off outside of endoscope / probe with enymatic solution, including handle and cord to light source. **NOTE**: Removal of all protein material is necessary for adequate penetration of disinfection solution and sterilization.
5. Leak testing should be performed as instructed for individual scopes / probes.
6. ENDOSCOPES should be flushed properly following manufacturer recommendations.
7. Biopsy forceps and accessories (ie; grasping forceps etc.) are to be cleaned in enzol solution as above assuring that all protein material is removed from the instrument using soft brush if necessary, then rinse thoroughly in distilled water. Autoclavable accessories, such as pink handled biopsy forceps or retrieval forceps and suction adaptors are sterilized by autoclaving for 4 minutes at 270 degrees in the flash autoclave after cleaning. Push button valves may be autoclaved or processed in the Steris.
8. Process (sterilize) scope in V-Pro or Steris system 1E following policy / procedure and manufacturer instructions.
9. After completion of disinfection/sterilization process, blow scope channels with medical air and inject alcohol to facilitate drying process.

10. Label scope with yellow tag indicating:

- Date
- Steris #
- Cycle
- Technician initials

11. Hang scope in scope cabinet. If not used in 12 days, scope is to be reprocessed In addition: cystoscopes, ureteroscopes, and bronchoscopes should be reprocessed immediately prior to use

HIGH LEVEL DISINFECTION OF SCOPES / PROBES AS AN ALTERNATIVE METHOD TO STERILIZATION:

EQUIPMENT:

- Instrumentation to be sterilized or chemically disinfected
- Enzymatic solution (Enzol)
- Distilled water (in Sterile Processing this is plumbed into the sink in the decontamination room)
- Timer
- OPA for chemical disinfection / GUS – glutaraldehyde user station

OPA PRECAUTIONS:

- Should be used in a well-ventilated area: OPA vapors have an unpleasant odor and may be irritating and cause headache, chest discomfort, and symptoms of bronchitis
- GUS filter needs to be changed per manufacturer (IFU) Instructions for Use
- Instruments must be rinsed thoroughly in distilled water or tissue reaction may occur
- Avoid contact with skin and eyes – Protective equipment must be worn at all times including gown, gloves, and face shield or goggles

PROCEDURE:

1. Don PPE (Personal Protective Equipment).
2. Use premixed OPA solution. Pour into container specified for cold disinfection (blue container). Record the date the container was opened on the container label and the expiration date. Discard the used solution at the end of each day by neutralizing solution with Glute Out before pouring down the drain.
3. If using an open bottle check expiration date and strength of solution by using "Cold Sterilog Strip", following manufacturer instructions on bottle.
4. Have instruments as dry as possible before immersing in the OPA glutaraldehyde solution.
5. If soaking endoscopes, attach scope to leak tester and turn it on before immersing for leak test. **BE SURE TO LEAK TEST THE SCOPE BEFORE IMMERSION**. A scope that has a leak detected should have applied ~~will have~~ continuous positive pressure while immersed and leak testing is in progress. This will help avoid introduction of contaminated water in the inner lining of the scope.
6. Immerse cleaned instrument in OPA solution and follow recommended manufacturer soak time.

Title: High Level Disinfection of Equipment	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: DON Perioperative Services	Effective Date: 5/12/2011

7. Endoscopes must have all channels filled with OPA solution using manual scope cleaning tubing and 60cc syringe and be sealed by leaving syringes attached and plugs in where valves were removed.
8. Rinse thoroughly and flush channels **three times** with sterile distilled water, adequate rinsing is necessary to prevent residual toxic effects of chemicals. A final rinse of 70% Isopropyl Alcohol solution can be used to speed the drying process and reduce the numbers of any organisms present.
9. Dry instrument thoroughly and blow out all channels with air supply located in decontamination room. Instruments should be thoroughly dry prior to storage. A device that is not completely dried provides an ideal situation for rapid colonization of bacteria. Make sure that cap is taken off and hang in designated scope cabinet for storage.
10. After completion of disinfection/sterilization process, blow scope channels with medical air and inject alcohol to facilitate drying process.
11. Label scope with yellow tag indicating:
    - Date
    - Steris #
    - Cycle
    - Technician initials
12. Hang scope in scope cabinet. If not used in 12 days, scope is to be reprocessed. In addition: cystoscopes, ureteroscopes, and bronchoscopes should be reprocessed immediately prior to use.

For OPA Exposure or Spill:

EYES: flush thoroughly with water and get medical attention immediately.

SKIN: flush thoroughly with water, if irritation persists, get medical attention.

INHALATION: remove to fresh air, if symptoms persist, get medical attention.

INGESTION: do not induce vomiting, drink copious amounts of milk and get medical attention.

Notify supervisor.

LARGE SPILLS:
Add POLYFORM -F granules around the perimeter of the spill to dike the liquid and prevent spreading. From the upwind side, cover the entire area from edge to edge at a ratio of about 1:1, completely covering the spill and taking care to avoid vapors and splashing. DO NOT MIX – ALLOW TO STAND. Sweep up material using dustpan and brush provided in kit and dispose of neutralized waste in the regular trash. Dispose of container after use. **Use Spill Kit.**

SMALL SPILLS:
Spray with diluted 50% solution (diluted with water) of Formalex solution, let stand 3-5 minutes and wipe up with paper towel. Rinse with water and wipe up. Products used to wipe up can be disposed of in regular trash.
DISPOSAL OF SOLUTION AFTER OUTDATE:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: High Level Disinfection of Equipment	
Scope: Sterile Processing	Manual: Infection Control- Patient Care (ICP), Sterile Processing
Source: DON Perioperative Services	Effective Date: 5/12/2011

All OPA solution that is outdated shall be disposed of according to Manufacture and OSHA standards using universal precautions for protection from splashes. Glycine can be added to the OPA to dilute it prior to disposal.

ANY QUESTIONS OR CONCERNS PLEASE REFER TO MANUFACTURER LITERATURE.

REFERENCE: AORN Recommended Practices for Safe Environment of Care, 2018
AORN Recommended Practices for High Level Disinfection, 2018
AORN Recommended Practices for Cleaning and Processing Flexible Endoscopes & Accessories, 2018
AAMI ST91:2015

Approval	**Date**
CCOC	2/24/20
Infection Control	2/25/20
MEC	4/7/20
Board of Directors	10/21/15
Last Board of Director review	1/16/19

Developed:
Reviewed: 5/12/2011 BS, BS 9/12
Revised: 02/01 BS 8/09/2010; 5/2015 BS, 1/20aw
Supersedes:
Index Listings: Cleaning and Chemical Disinfection of Equipment /OPA / Cold Sterilization Chemical Disinfection

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Steris System 1E Processor	
Scope: Sterile Processing/Surgery	Manual: Infection Control- Patient Care (ICP), Sterile Processing, Surgery
Source: Perioperative Director of Nurses	Effective Date:

PURPOSE: See the Operator's Manual for use. This describes the policy statements for operation and maintains proper working knowledge for the SYSTEM 1E™ Liquid Chemical Sterilant Processing System**.**

OVERVIEW:
The System 1E uses a peracetic acid liquid sterilant to chemically sterilize manually cleaned immersible, reuseable, critical and semi-critical heat-sensitive medical devices including: endoscopes and their accessories.
Approval for use of the SYSTEM 1E should be ascertained; manufacturer instructions for reprocessing any device should be reviewed prior to using the SYSTEM 1E chemical sterilization.

DEFINITIONS:
Qualified Personnel is an NIH employee with appropriate training and product, process, and quality knowledge regarding the operation of the SYSTEM 1E™ Liquid Chemical Sterilant Processing System**.** This includes ***Surgery RN, Surgical Scrub Technical and Central Supply Technician***
Decontaminate is the use of physical and chemical means to remove, inactivate or destroy blood borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface(s) or item is rendered safe for handling, use, or disposal.
PPE (Personal Protective Equipment) - attire worn to protect employees from potentially infectious disease or chemical or other exposure. The following items are included: disposable hat, eye protection, disposable mask, gown, apron, gloves, and shoe covers

POLICY STATEMENTS:
- All reusable surgical instruments shall be cleaned and then either high level disinfected or liquid chemically sterilized, rendering them safe for handling, preventing cross contamination, and reducing the opportunity for healthcare associated infection (nosocomial) to patients and staff.
- Written departmental guidelines and/or manufacturers' written instructions regarding the care and cleaning of medical devices must be available and followed.
- Users of the SYSTEM 1E Processor must be Qualified Personnel and demonstrate competency and knowledge in the safe and proper use of all cleaning equipment and chemicals and adhere to established dress codes and the Universal Precautions policy.
- Hospital personnel will utilize appropriate PPE when operating equipment.
- The SYSTEM 1E integrity is checked daily. An operator-initiated Diagnostic Cycle is performed daily and validated with a "PASSED" printout prior to running a sterilization cycle. If the Diagnostic Cycle fails – a Failed Diagnostic

Title: Steris System 1E Processor	
Scope: Sterile Processing/Surgery	Manual: Infection Control- Patient Care (ICP), Sterile Processing, Surgery
Source: Perioperative Director of Nurses	Effective Date:

Cycle printout will result and the problem must be corrected and a successful Diagnostic Cycle must be completed prior to use for sterilization. The printouts of the Diagnostic Cycles and printouts for each load are saved. If a printout from the SYSTEM 1E Processor is missing for a load, the load must be reprocessed.

PROCEDURE(s): See the Operator's Manual for:

- Warnings and Cautions
- Safety Information
- Illustrations
- Device Processing Instructions
- Operation of the Processor
- Quality Assurance
- Maintenance
- Monitoring
- Inservice

REFERENCES:

SYSTEM 1E™ Liquid Chemical Sterilant Processing System Operator Manual –T6500 Rev C
ANSI/AAMI ST91:2015
ANSI/AAMI ST79:2017
AORN Recommended Practices: Sterilization and Disinfection, pages 466-467
AORN Recommended Practices: Cleaning and Processing Flexible Endoscopes
AORN Recommended Practices: High Level Disinfection

Approval	**Date**
CCOC	12/16/19
Infection Control Committee	02/25/20
MEC	04/07/20
Board of Directors	
Last Board of Director review	1/16/19

Developed: 7/18/2012 PM
Reviewed:
Revised: 5/2015 BS, 11/19aw

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Manual Jet Ventilator	
Scope: Respiratory Care	Manual: Respiratory Care
Source: Manager of Cardiopulmonary	Effective Date:

PURPOSE:
To provide temporary transtracheal ventilation in specific emergency situations of upper airway obstructions.

POLICY:
The manual jet ventilator is to be used in conjunction with a transtracheal catheter or cricothyrotomy needle that is inserted through the cricothyroid membrane. Ventilation is accomplished by the manual, intermittent jetting of oxygen through the catheter for subsequent lung inflation.

PROCEDURE:
Indications
1. The main indication is an inability to ventilate or oxygenate a patient by alternative means-such as endotracheal intubation or bag valve mask ventilation.

Contraindications
1. **Total** airway obstruction because there is no means of exhalation.
2. These devices are not intended for infant or neonatal use.

Potential Complications
1. Subcutaneous emphysema
2. Barotrauma
3. Esophageal perforation
4. Reflex cough with each ventilation
5. Catheter kinking
6. Aspiration of products such as blood or mucous
7. Pneumothorax
8. Pneumomediastinum
9. Tracheal injury
10. Hypercapnia

Equipment
1. High Pressure Oxygen Source
2. Manual Jet Ventilator
3. Transtracheal Percutaneous Catheter
4. ETCO2 monitoring
5. Pulse Oximetery

Performance check for Manual Jet Ventilator
The user of this device should verify proper operation by checking the regulator after each use or approximately every six months, whichever occurs the soonest.

To do so, dial the regulator in to reach a pressure of 50 psi. When the gauge is steady, depress the plunger several times to open the line and to make sure that oxygen is flowing. Verify that the gauge returns to 50 psi after the plunger is no longer depressed.

Repeat at 40 psi, 30 psi, 20 psi, 10 psi and at 0 psi. When at 0, there should be no oxygen traveling through the unit.

Directions for use

1. Connect the O2 fitting on the high-pressure hose assembly to a high-pressure oxygen source (not to exceed 50psi, via quick connect).
2. Place the luer lock end of the small-bore tubing in one hand and hold the on/off valve in the other.
3. Depress the plunger several times to ensure proper function of the device.
4. Pull out the regulator knob and turn it until the gauge reads the desired pressure. Push the knob back in to "lock in" the pressure setting.
5. After the transtracheal catheter has been inserted and secured, connect it to the luer lock end of the small-bore tubing with the device connected, watch the patient's chest rise as you trigger the oxygen flow by pressing the button.

The lungs will inflate very quickly. Stop oxygen flow after the chest wall rises adequately. Monitor the pressure gauge. Typical pressures used are:

- In the pediatric patient < 5 years start by setting the delivery pressure to 20 psi or less
- In the pediatric patient aged 5-12 years start by setting the delivery pressure to 30 psi
- In a patient aged >12 start at 50 psi

Use I:E ratio of 1:4 to 1:5, with a breath rate of 10 to 12/minute for most children. With partial upper airway obstruction, use the ratio of 1:8 to 1:10 with a breath rate of 5 to 6/minute to reduce the risk of pulmonary barotrauma. Adjust these ratios based on clinical monitoring, including adequacy of chest wall rise, oximetry, end-tidal CO2 (sidestream (nasal) end-tidal CO2 monitoring should be attempted) if possible, blood gas measurements, and chest radiography. Titrate pressure and inspiration/expiration times as best possible to maintain adequate ventilation and oxygenation.

Prolonged percutaneous transtracheal ventilation (PTV) is associated with excessive inspiratory workload, hypercapnia, barotrauma, and catheter dislodgement with subcutaneous emphysema. Thus, a definitive airway (ie, endotracheal tube or tracheostomy) should be obtained as soon as possible after PTV is established. Emergent anesthesiology and otolaryngology consultation may be required, especially in patients with traumatic injury to the face and/or neck.

Allow the Patient to Exhale

The catheter is too small to permit the patient to exhale through it, which is why it is essential that the airway above the cricothyroid membrane must be at least partially open to allow exhalation. You must let the lungs deflate before you trigger inhalation again. As you can see in the above suggested ventilator ratios, paying attention to exhalation times is critical.

You risk tension pneumothorax if the patient cannot exhale or is not given enough time to exhale. Never press the trigger unless you are watching the patient's chest.

Title: Manual Jet Ventilator	
Scope: Respiratory Care	Manual: Respiratory Care
Source: Manager of Cardiopulmonary	Effective Date:

If the patient's chest gets large and they are truly obstructed from above they are not going to be able to exhale so you don't want to overinflate the lungs you may have to periodically disengage the ventilator and allow the patient to exhale, you can provide some gentle pressure to the patient's chest to help facilitate that exhalation.

Cleaning Recommendations

On/Off valve, high pressure hose assemble and gauge exterior

Can be wiped with bactericidal or virucidal wipe. DO NOT Autoclave, immerse in fluids, disassemble valve, use bleach, or sterilize.

Small bore tubing assemble

Single patient use. Replace tubing between patients and if in-line filter becomes occluded during use.

REFERENCES:

1. May The Force Be With You Christine Whitten MD, author: Anyone Can Intubate: A Step by Step Guide, 5th Ed. and pediatric airway a step by step guide. September 2012
2. https://www.wikem.org/wiki/Pediatric_jet_ventilation October 2019
3. Instrumentation Industries, Inc. Manual Jet Ventilator, Installation and Usage Directions, August 2017
4. https://www.youtube.com/watch?v=a4I0MEwtXFY January 2018

CROSS REFERENCE P&P:

1. https://procedures.lww.com/lnp/view.do?pId=4877893
2. https://procedures.lww.com/lnp/view.do?pId=3260314

Approval	**Date**
Respiratory Care Committee	12/16/19
CCOC	12/16/19
ED Committee	03/11/20
Medical Executive Committee	04/07/20
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Clinic Patient No-Show, Missed Appointment, and Late Cancellation Policy	
Scope: Northern Inyo Healthcare District Clinics	Manual: Rural Health Clinic, Northern Inyo Associate Clinics
Source: Charge Capture Manager	Effective Date:

PURPOSE:

To provide guidance to NIHD staff who follow up on patient scheduling issues, no-show or missed appointments and late cancellations. Facilitating patient satisfaction and optimum patient outcomes is the result of managing patient scheduling, no-shows, missed appointments and late cancellations.

POLICY:

It is the policy of Northern Inyo Hospital District (NIHD) to monitor and manage appointment no-shows and late cancellations. Our goal is to provide excellent care to each patient in a timely manner. If a situation arises where a patient needs to cancel a scheduled appointment, they are requested to call at least 24 hours in advance of the appointment or as soon as is reasonably possible. The district's goal of meeting patient's need for care is based upon each department's capacity for appointments. The patient's cancellation notification allows departments to utilize appointments for other patients in need of medical attention.

DEFINITIONS:

1. A scheduled appointment is a set time dedicated to the patient to ensure that patients are not overbooked causing long wait times. This appointment guarantees that the medical provider has the appropriate amount of time to evaluate and determine treatment for each patient.
2. A no-show or missed appointment is any scheduled appointment in which the patient does not arrive for the appointment or arrives more than 10 minutes late and is therefore unable to be seen by the provider.
3. A late cancellation is any appointment cancelled less than 24 hours before the scheduled appointment time.

PROCEDURE:

1. Each patient is notified of the "No-Show, Missed Appointment and Late Cancellation" process when they schedule their first appointment.
2. Appointments are confirmed in person with an appointment card, by phone, email, or text 24 hours prior to the first appointment.
3. The patient is provided a copy of the "No-Show, Missed Appointment and Late Cancellation Form", upon check in at their first appointment. Patients are asked to sign a copy of the 'Missed Appointment Form'.
4. The provider is notified by designated staff of all missed appointments. Providers or their designee should review the medical record for critical concerns to determine whether a patient is waiting for test results, has not completed a course of treatment or requires follow-up care.
5. An attempt to contact a patient who has missed or cancelled an appointment(s) should be made to assist them in rescheduling or determining why they choose not to reschedule (unless the provider documents that it is unnecessary to follow up with the patient).
6. Document all attempts made to contact the patient in either the scheduler or medical record.
7. The provider will determine under what circumstances a registered letter should be sent following 3 unsuccessful attempts to reschedule the appointment. Document and retain the receipt of the letter in the medical record.
8. Record missed or cancelled appointments for new patients in the appointment scheduler (EHR or appointment book) or in the medical record for existing patients. Do not obliterate, delete or erase no-shows or cancelled appointments.

Title: Clinic Patient No-Show, Missed Appointment, and Late Cancellation Policy	
Scope: Northern Inyo Healthcare District Clinics	Manual: Rural Health Clinic, Northern Inyo Associate Clinics
Source: Charge Capture Manager	Effective Date:

9. For patients who chronically no-show or cancel appointments, send a (registered) letter stating that failure to keep appointments and follow the advice of their provider may put them at medical risk.
10. If the missed appointment(s) are in a specialty clinic, after 3 missed appointments and contact attempts, the patient may need to see their primary care physician or specialist to get a new referral for the service if it is determined that the service is still medically necessary.
11. Under the above circumstances, the primary care provider or their designee will make the determination of medical necessity.
12. If the missed appointment(s) are in the Rural Health Clinic, the Women's Health Clinic or the Internal Medicine Clinic and are chronic, the primary care provider will review the patient's medical record and will make a determination as to the course of action.

REFERENCES:

1. Beta Healthcare Group, Physician Healthcare Practices, Sample 9/8/2015
2. UNC Health Care, No-Show, Late & Cancellation Policy: UNC Hospitals Neurology Clinic
3. Healthcare Business Insights, Checklist for Reducing Appointment No-Shows, Decision Resources, Inc. 2019
4. Toiyabe Indian Health Project, Inc., Cancellation, No Show and Late Arrival Policy, May 2017

CROSS REFERENCE P&P:

1. RHC "No Show" Failed Appointment Policy

Committee Approval	**Date**
Financial Leadership Team Meeting	2/25/2020
Compliance	2/26/2020
Non-Clinical Consistency Oversight Committee	4/2/2020
Medical Executive Committee	4/7/2020
Executive Team Meeting	
Board of Directors	

Developed: 11/2019
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: OP Hospital No-Show, Missed Appointment, and Late Cancellation Policy	
Scope: Northern Inyo Healthcare District Hospital Outpatient Service Departments	Manual: Diagnostic Imaging, Laboratory, Cardiopulmonary, Dietary, Rehabilitation and OP Perinatal Services
Source: Charge Capture Manager	Effective Date:

PURPOSE:

To provide guidance to NIHD staff who follow up on patient scheduling issues, no-show or missed appointments and late cancellations. Facilitating patient satisfaction and optimum patient outcomes is the result of managing patient scheduling, no-shows, missed appointments and late cancellations.

POLICY:

It is the policy of Northern Inyo Hospital District (NIHD) to monitor and manage appointment no-shows and late cancellations. Our goal is to provide excellent care to each patient in a timely manner. If a situation arises where a patient needs to cancel a scheduled appointment, they are requested to call at least 24 hours in advance of the appointment or as soon as is reasonably possible. The district's goal of meeting patient's need for care is based upon each department's capacity for appointments. The patient's cancellation notification allows departments to utilize appointments for other patients in need of medical attention.

DEFINITIONS:

1. A scheduled appointment is a set time dedicated to the patient to ensure that patients are not overbooked causing long wait times. This appointment guarantees that the medical provider has the appropriate amount of time to evaluate and determine treatment for each patient.
2. A no-show or missed appointment is any scheduled appointment in which the patient does not arrive for the appointment or arrives more than 10 minutes late and is therefore unable to be seen by the provider.
3. A late cancellation is any appointment cancelled less than 24 hours before the scheduled appointment time.

PROCEDURE:

1. Each patient is notified of the "No-Show, Missed Appointment and Late Cancellation" process when they schedule their first appointment.
2. Appointments are confirmed in person with an appointment card, by phone, email, or text 24 hours prior to the first appointment.
3. The patient is provided a copy of the "No-Show, Missed Appointment and Late Cancellation Form", upon check in at their first appointment. Patients are asked to sign a copy of the 'Missed Appointment Form'.
4. The provider is notified by designated staff of all missed appointments. Providers or their designee should review the medical record for critical concerns to determine whether a patient is waiting for test results, has not completed a course of treatment or requires follow-up care.
5. An attempt to contact a patient who has missed or cancelled an appointment(s) should be made to assist them in rescheduling or determining why they choose not to reschedule (unless provider documents that it is unnecessary to follow up with the patient).
6. Document all attempts made to contact the patient in the scheduler or medical record.
7. The provider will determine under what circumstances a registered letter should be sent following 3 unsuccessful attempts to reschedule the appointment. Document and retain the receipt of the letter in the medical record.
8. Record missed or cancelled appointments for new patients in the appointment scheduler (EHR or appointment book) or in the medical record for existing patients. Do not obliterate, delete or erase no-shows or cancelled appointments.

Title: OP Hospital No-Show, Missed Appointment, and Late Cancellation Policy	
Scope: Northern Inyo Healthcare District Hospital Outpatient Service Departments	Manual: Diagnostic Imaging, Laboratory, Cardiopulmonary, Dietary, Rehabilitation and OP Perinatal Services
Source: Charge Capture Manager	Effective Date:

9. For patients who chronically no-show or cancel appointments, send a (registered) letter stating that failure to keep appointments and follow the advice of their provider may put them at medical risk.
10. After 3 missed appointments, the patient may need to see their primary care physician or specialist to get a new referral for the service if it is determined that the service is still medically necessary. The primary care provider or their designee will make the determination of medical necessity.

REFERENCES:

1. Beta Healthcare Group, Physician Healthcare Practices, Sample 9/8/2019
2. UNC Health Care, No-Show, & Late Cancellation Policy: UNC Hospitals Neurology Clinic
3. Healthcare Business Insights, Checklist for Reducing Appointment No-Shows, Decision Resources, Inc. 2019
4. Toiyabe Indian Health Project, Inc., Cancellation, No Show and Late Arrival Policy May 2017

CROSS REFERENCE P&P

1. No Show/Cancellation Policy, OT, PT, SLP 12/2016

Committee Approval	**Date**
Financial Leadership Team Meeting	2/25/2020
Compliance	2/26/2020
Non-Clinical Consistency Oversight Committee	4/2/2020
Medical Executive Committee	4/7/2020
Board of Directors	

Developed: 11/2019
Reviewed:
Revised:
Supersedes:

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

NO SHOW/MISSED APPOINTMENT FORM

We, at (PRACTICE NAME), understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: (PRACTICE NUMBER)

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at (PRACTICE NAME) and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. (PRACTICE NAME) will assist you to reschedule this appointment if needed.

5. If you have two (2) "No-Show/Missed" appointments within a one-year period, you will receive a warning letter from our office.

6. If you have three (3) "No-Show/Missed" appointments within a one-year time, a no show fee may be assessed. Dismissal from the practice may also be considered.
   ***You will be notified by letter if the dismissal was approved.**

Notice of Nondiscrimination

Northern Inyo Healthcare District complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Northern Inyo Healthcare District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Northern Inyo Healthcare District:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ✓ Qualified sign language interpreters
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services, contact José García, Language Services Coordinator; 150 Pioneer Lane, Bishop, California 93514; phone (760) 873-2147, TTY 711; or email jose.garcia@nih.org.

If you believe that Northern Inyo Healthcare District has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Alison Murray, Civil Rights Coordinator
150 Pioneer Lane, Bishop, California 93514
Phone (760) 873-2145
TTY 711
Fax (760) 873-2108
Email alison.murray@nih.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Alison Murray is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 760-873-5811 (رقم هاتف الصم والبكم: 711).

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 760-873-5811 (TTY (հեռատիպ)՝ 711:

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 760-873-5811 (TTY: 711)។

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 760-873-5811（TTY：711）。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 760-873-5811 (TTY: 711) تماس بگیرید.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 760-873-5811 (TTY: 711) पर कॉल करें।

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 760-873-5811 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。760-873-5811（TTY:711）まで、お電話にてご連絡ください。

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 760-873-5811 (TTY: 711) 번으로 전화해 주십시오.

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 760-873-5811 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 760-873-5811 (телетайп: 711).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 760-873-5811 (TTY: 711).

Tagalong

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 760-873-5811 (TTY: 711).

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 760-873-5811 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 760-873-5811(TTY: 711).

I have read and understand (PRACTICE NAME'S) No Show/Missed Appointment process and understand my responsibility to plan appointments accordingly and notify (PRACTICE NAME) appropriately if I have difficulty keeping my scheduled appointments.

Date: _____ Time: _____AM/PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print Name: _____
(legal representative)

Signature: _____
(witness)

Print Name: _____
(witness)

Developed: 03/2020 Revised:

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

Staff use only - - - - - For Limited English Proficiency Patients only:

Interpreter name or ID# _____ □ Staff □ Phone □ Video
If you do not use an approved interpreter, please list the reason: _____

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: New Line of Service Implementation Policy and Procedure	
Scope: Northern Inyo Healthcare District	Manual: Revenue Cycle
Source:	Effective Date:

PURPOSE:

The purpose of this policy will ensure a strategic commitment to deliver excellent services to our patients by establishing a guideline to follow when considering a new line of service. This will facilitate adherence with professional practices, endorse compliance with regulatory statutes and accreditation requirements, promote uniformity of practice, and assure revenue viability during the discovery and implementation phase of potential new lines of service at Northern Inyo Healthcare District (NIHD).

POLICY:

When administration presents a new line of service option to the NIHD Board of Directors, standard business evaluations will have been completed and results of that work will be included in the presentation, and in Board packet that goes to the Board of Directors during their deliberations. Standard project workflows will be followed by completing a Project Request Form. This will place the new line of service proposal into the established project process for discovery. Upon approval by the Board of Directors, the project review process will be followed before implementation begins.

DEFINITIONS:

A new line of service at NIHD is defined as a grouping of medical care provider(s), their skills and areas of expertise, products and/or supplies, that when provided together will provide a new provision of care that NIHD is able to offer to the community. Some elements of these groupings may already exist at NIHD, but when grouped with the other elements, a new type of care will be offered.

DISCOVERY PHASE:

1. The following will be determined before the new line of service is proposed to the Board of Directors:
    a. Identify benefits and costs associated with opening a new service line:
        i. Evaluate most recent community needs assessment or perform a limited needs assessment for the new service
        ii. Complete a cost-accounting analysis or Return on Investment (ROI), to determine profitability of the service
    b. Facility determination
        i. Remodeling of an existing space
        ii. Access to new location
    c. Staffing
        i. Evaluation of staffing needs
    d. Materials Management
        i. Identify new supplies and capital expenses
    e. Documentation and system requirements
        i. Clinical Informatics
        ii. ITS Informatics
    f. Pharmacy Assessment
        i. New medication needs
        ii. Proper storage of medications

g. Compliance overview
    i. Licensing requirements
    ii. Other regulatory or guidance requirements
h. Identify Current Procedural Terminology (CPT) for services to be offered
i. Review billing requirements
j. Define the ITS support
    i. Computers, telephone(s) etc.
    ii. Wiring and cable access
k. Strategic Communications
l. Dietary needs
m. Present findings to the Executive Team and, as appropriate, the Executive Team will approve submission to the Board of Directors for approval

IMPLEMENTATION PHASE:

1. Upon Board of Directors approval, the following tasks will be performed prior to beginning the new service:
    a. Business Associates Agreement (BAA) and Contract review
        i. Compliance Officer or designee reviews, negotiates and executes BAA, done in conjunction with contract review to ensure no contract provision override the BAA
        ii. Director of the proposed new line of service and the appropriate Chief Officer review the contract
        iii. Compliance Officer review of contract
        iv. Chief Executive Officer executes contract(s), if applicable
    b. Project Management Team
        i. Identify team members
        ii. Assign specific tasks to each area
        iii. Develop assessment tool and a follow-up plan to assess the success, profitability, or additional needs of the service, and how this is to be measured
        iv. Set timelines for completion of tasks
    c. Credentialing
        i. Medical Staff Office completes Medical Staff On-Boarding
    d. Staffing
        i. Human Resources will develop staffing and recruitment plan as appropriate
    e. Billing
        i. Provider Enrollment
        ii. Make adjustments to any billing related practices as needed
    f. Charge Capture
        i. Identify charges by CPT code that will be billed out
        ii. Ensure charge codes are created in the Charge Master and Fee Schedules of the EHR and all ancillary systems
        iii. Create charge sheets
        iv. Develop workflows for charge entry and daily reconciliation
    g. Materials Management

i. Acquire new supplies and equipment
ii. Set up the office space

h. Clinical Informatics/Infection Control
   i. Build documentation templates for hospital based services
   ii. Provide education to medical providers (nurses and physicians)
   iii. Assess for possible Infection Control issues and mitigate any that are found

i. ITS Informatics
   i. Build system needs and documentation templates for clinical practices
   ii. Research integration with current EHR
      1. Integration testing
   iii. Application training and education
j. ITS and Clinical Engineering supply hardware and technical support
   i. Provide access to all appropriate systems
   ii. Arrange for/purchase of all devices necessary to the line of service (computers, telephones, medical devices and/or specialized equipment)
k. Pharmacy Review
   i. Build medication codes in appropriate systems
   ii. Acquire medications
   iii. Address medication storage
l. Dietary Review
   i. Determine if there will be any costs associated with Dietary needs during implementation
m. Development of forms, educational resources, policies and procedures specific to the new service
   i. Forms, internal documentation, chart documents, patient documents, must be reviewed and if appropriate, approved by the Forms Committee
n. Interpreter Services translate forms
o. Strategic Communications develop marketing plan
p. Assure that Contracts and/or all appropriate paperwork has been completed and returned to CEO

EVALUATION PHASE:

1. Using assessment tool developed through the development of the project to review and evaluate the new line of service
2. Submit review to Executive Team

REFERENCES:

1. Healthcare Business Insights, Revenue Cycle Academy; “Checklist of New Service Line Considerations”
2. Advisory Board, “Service Line Strategy Advisor”
3. The McKinsey Quarterly, “Service Line Strategies”, Health Care - July 2008

Title: New Line of Service Implementation Policy and Procedure	
Scope: Northern Inyo Healthcare District	Manual: Revenue Cycle
Source:	Effective Date:

4. Open Minds, 2011 Planning and Innovation Institution, "The Tools You Need to Successfully Launch a New Service Line & Diversify Your Revenue Streams", John Talbot, Ph.D., Executive Vice President
5. Agency for Healthcare Research and Quality, "How Do We Implement Best Practices in Our Organization" Series
6. Modern Healthcare Insights: "Innovative Look at Service Line Organizations", Series
7. Health Care Advisory Board: "Achieving Service Line Excellence; Best Practices for Creating a High-Performance Service Line Infrastructure:, Research Report, April 1, 2008

Committee Approval	**Date**
Financial Leadership	2/25/2020
Compliance	2/26/2020
Non-clinical Consistency Oversight Committee	4/2/2020
Medical Executive Committee	4/7/2020
Executive Team Meeting	
Board of Directors	

Developed: 11/2019wr
Reviewed:
Revised: **4/2/2020wr**
Supersedes:

Northern Inyo Healthcare District
One Team. One Goal. Your Health.
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

New Service Line Checklist

The following checklist will provide a guideline when planning and implementing a new line of service:

DISCOVERY PHASE:

1. Project Management Team and Chief Officer
    a. Community Needs Assessment ☐
    b. Cost-accounting analysis (ROI) ☐
2. Medical Staff Office
    a. Begin On-boarding process ☐
3. Facilities
    a. Determination of location for the service ☐
    b. Is remodeling required ☐
    c. Address access and safety issues ☐
4. Staffing
    a. Provider ☐
    b. FTE Requirements ☐
5. Materials Management
    a. Identify supply needs ☐
    b. Capital expenses ☐
6. Pharmacy review of medications ☐
7. Charge Capture Review
    a. Determine services to be performed ☐
8. Compliance Overview
    a. Initiate BAA if appropriate ☐
9. IT Support Defined ☐
    a. Process documentation storage location determined ☐
10. Clinical Engineering
    a. Research Medical device needs ☐
11. Determine billing requirements ☐
12. Prepare report of planning findings for Executive Team and Board ☐

IMPLEMENTATION PHASE

1. BAA and Contract
    a. BAA completion ☐
    b. Contract finalized ☐
2. Project Team Kick Off Meeting
    a. Identify team members ☐
    b. Development of an assessment tool ☐
    c. Assign tasks ☐
    d. Establish timeline for completion and implementation ☐

3. Credentialing
    a. Licensing Verification ☐
    b. Medical Staff On-Boarding completed ☐
4. Staffing
    a. HR to review and develop staffing plan and recruitment ☐
5. Billing
    a. Provider enrollment(s) submitted ☐
    b. System edits and or adjustments ☐
6. Charges
    a. Services requested of Charge Master Consultant ☐
    b. Pricing ☐
    c. Charge codes built and entered into HER and other systems as appropriate ☐
    d. Workflow for charge entry and reconciliation developed ☐
7. Materials Management
    a. Acquisition of supplies and equipment ☐
8. Maintenance
    a. Construction of or remodeling complete ☐
    b. Set up new location ☐
9. Clinical Informatics/Infection Control
    a. Build templates for documentation ☐
    b. Test system(s) performance ☐
    c. Education and training ☐
    d. Infection Control Assessment
        i. Mitigate if issues are identified ☐
10. IT Informatics Review
    a. Build templates for documentation ☐
    b. Integration testing with current EHR ☐
    c. Education and training ☐
11. Pharmacy Analysis
    a. Build medication code(s) in Pharmacy system ☐
    b. Build medication code(s) in EHR if appropriate ☐
    c. Acquire medications ☐
    d. Provide for storage of medication ☐
    e. Determine how area will access medication ☐
    f. Does medication preparation require special ☐
12. IT and Clinical Engineering Support
    a. Provide access to all appropriate system(s) ☐
    b. Purchase medical and service devices necessary to operations (computer, telephone, medical devices and specialized

equipment) ☐
c. Establish a project repository where project documents will be kept ☐

13. Forms, policies and procedures specific to the new services
    a. Forms developed ☐
    b. Forms approved by Forms Committee ☐
        i. Forms uploaded into system ☐
    c. Policies and Procedures developed ☐
    d. Policies and procedures approved through all appropriate committees ☐
    e. Board of Trustees approval ☐
        i. Policies and procedures uploaded into the system ☐
        ii. Policies and procedures assigned ☐
14. Interpreter Services
    a. Forms translated into appropriate language(s) ☐
15. Strategic Communications Marketing
    a. Signs/Flyers ☐
    b. Newspaper ☐
    c. Website update ☐
    d. Radio spot ☐
16. Dietary Needs
17. Go / No Go Project Team Meeting
    a. One week prior to service implementation meet for final review ☐

POST IMPLEMENTATION EVALUATION

1. Implementation analysis
    a. Validation that clinical, IT and fiscal workflows are successful ☐
    b. Make adjustments as needed ☐
2. Remove new service line signage and flyers after 30 days ☐
3. Archive project documentation for future reference
4. Perform analysis on initial ROI and report to Executive Team ☐
5. Review lessons learned and update documentation with acquired Information ☐

ICU Critical Indicators

2020

1. Unexpected Deaths
2. Ventilator Associated Complications
3. Unexpected Complications After Discharge or Transfer from ICU
4. Codes in the department
5. Staff Concerns

Approvals:

Medicine/ICU Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors: 1/15/20

Medical Services Critical Indicators

2020

1. Readmit to hospital w/in 30 days-same or related problem
2. Medical death
3. Hospice inpatient
4. Use of restraints
5. Unexpected transfers to the ICU
6. Codes in the department
7. Staff Concerns

Approvals:

Medicine/ICU Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors: 1/15/20

Perinatal Critical Indicators

2020

1. Maternal death or resuscitation
2. Fetal demise beyond 20 weeks gestation
3. Transfer to a higher level of care
4. APGAR score less than 7 at 1 or 5 minutes
5. Neonatal trauma
6. Maternal seizure
7. Vaginal deliveries coded with shoulder dystocia
8. 3rd and 4th degree lacerations
9. Postpartum hemorrhage requiring transfusion
10. Postpartum readmission
11. Disruption or infection of obstetrical wound
12. Delivery of infant less than 36 weeks gestation
~~12.~~13. Delivery of infant greater than 42 weeks gestation
~~13.~~14. Maternal admission to ICU
~~14.~~15. Maternal induction of labor less than 39 weeks without documented indication
~~15.~~16. Staff concerns.

Approvals:

Peri-Peds Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors: 1/15/20

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: MERP: Plan to Eliminate or Substantially Reduce Medication-Related Errors	
Scope: Pharmacy, Cardiopulmonary, Nursing & DI	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date:

Introduction

Northern Inyo Healthcare District (NIHD) operates a Critical Access 25-bed general acute care hospital located in Bishop, California. Northern Inyo Healthcare District serves a rural population of approximately 18,000 residents of Inyo County, 10,000 square miles in area, located between the eastern slopes of the Sierra Nevada and the Nevada/California border.

For purposes of this plan, and in accordance with California Health and Safety Code 1339.63, a "medication-related error" means any preventable medication related event that adversely affects a patient at Northern Inyo Hospital, and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Multi-disciplinary Process

The Pharmacy and Therapeutics Committee (P&T) is responsible for implementation of the Northern Inyo Healthcare District Medication Error Reduction Plan (MERP). The Pharmacy & Therapeutics Committee is a multi-disciplinary Medical Staff committee.

The Medical Staff Bylaws of 2/15/2017 establish the following:
The committee is composed of at least two active Medical Staff members, the Pharmacy Director, and the Director of Nursing (Chief Nursing Officer) or other nurse designee. Ex Officio members serving without vote include: Administrator, or the Administrator's designee and the Quality Improvement Coordinator.
The committee meets at least once each quarter. The committee is "responsible for development of all drug utilization policies and surveillance of all drug utilization practices within the Hospital, in a reasonable effort to assure optimum clinical results and minimal potential for hazard, subject to such approval by the District Board, the Administrator, and the Executive Committee [of the Medical Staff]."
The committee is accountable to the Executive Committee of the Medical Staff.

The Medication Administration Improvement Committee (MAIC), consisting of members of Nursing Administration, Pharmacy, Medical Staff, and Ancillary services

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was established in 2002 and revised in its composition in 2013. MAIC is a subcommittee of the P&T Committee. MAIC reviews all medication errors or near misses to determine cause and develop strategies for future prevention when needed. Policies and Procedures related to medication administration are reviewed in P&T Committee with input from MAIC team. MAIC findings are reported to P&T along with the indicators and any patterns found. MAIC meets monthly to complete concurrent and retrospective evaluations of medication errors and occurrences.

The Pharmacy and Therapeutics Committee with the help of the MAIC will evaluate, assess, and address each of the following:

Prescribing
Prescription order communications
Product labeling
Packaging and nomenclature
Compounding
Dispensing
Distribution
Administration
Education
Monitoring
Use

External Medication related error alerts will be made accessible to NIHD Staff:

1. ISMP Safety Alert newsletters will be distributed to Nurses and Pharmacists at NIHD via email.
2. Quarterly Action Agenda relative to ISMP alerts are reviewed at P&T committee. Actions are taken at the direction of the committee.

Annual Review of MERP:
The effectiveness of each of the systems within the MERP will be evaluated and reviewed at the P&T committee annually. The plan will be modified as warranted when weaknesses or deficiencies are identified. At NIHD the MERP will be approved annually by the P&T Committee.

Technology used at NIHD in the reduction or elimination of medication errors includes:
Our Electronic Health Record (EHR) provides for automated allergy checking, automated dose checking, automated interaction checking, barcode medication administration and computerized physician order entry. The EHR provides a medication administration record that highlights due and overdue medications. The EHR has medication reconciliation modules for admission, transfer and discharge.

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Source: Director of Pharmacy	Effective Date:

NIHD will be purchasing a new IV pump system in 2020. By unanimous decision, committee has chosen B. Braun. This ~~The decision of which pump to be purchased will be made in an~~ interdisciplinary committee consisted~~s~~ of Nursing, Clinical Informatics, Pharmacy, Purchasing, Biomedical E~~e~~ngineering, and Information T~~t~~echnology S~~s~~ervices. These pumps will have smart technology, including a drug library that contains safe upper and lower limits, and concentrations of the IV medications on our formulary. This drug library will be owned by pharmacy and reviewed annually in P&T.

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The specific planned areas of assessment and improvement for ~~2018-~~202019 are:

Prescribing:

1. Medication Order sets will be evaluated annually by ~~P&T committee~~the director of pharmacy or their designee.
2. Antibiotic Stewardship Program (ASP) Quality Improvement Program (QIP) 1.0 metrics will be collected and reported to P&T. Pharmacy will actively participate in this process.
3. The Joint C~~c~~ommission standards for safe opiate prescribing are being implemented via the Pain P~~p~~roject T~~t~~eam, an interdisciplinary committee consisting of Nursing, Physicians, Clinical Informatics, ~~Social services,~~ Medical S~~s~~taff Office~~services~~, ~~District education,~~ and Pharmacy.

Prescription Order Communication:
Verbal orders will be utilized only when absolutely essential due to technology or other significant disruptions or displacements.

Verbal order policy is in place with an emphasis on reducing verbal orders except during emergencies or when physician is in a sterile procedure. Optimization and prioritization of provider workflows for CPOE are an ongoing focus. This was done to decrease potential communication errors. NIHD is currently partnering with EHR vendor to make changes necessary for improved prescription order communication. ***INDUSTRY STANDARDS IN 2016 93% NOW ESTIMATED AT >98%.***

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~~**Product Labeling:**~~
~~Review barcode scanning reports for barcodes that are not scanned and update barcodes. Barcode reports will be reviewed monthly by pharmacy; necessary updates will be done as appropriate. Barcoding statistics from the legacy system are inherently different than the statistics in our current EHR. New system implementation date was 10-1-18. We will compile statistics from our new baseline of 10-1-18 and follow trends for improvement.~~

Product Labeling:
The present operating system does not support barcoding. Our informatics and IT

departments have been diligently working with the vendor to remedy this issue which will increase patient safety and comply with Joint Commission standards. The decision has been made to select a new EHR provider to facilitate this core standard.

We have added Codonics™ printers to the surgery department for the safe labeling of syringes in the operating room. The labels are color coded per the ASA guidelines.

Packaging and Nomenclature:
Pre-made medications will be acquired from a 503b compounding facility for medications that are unable to be compounded with extended expiration dates. Examples include premixed Oxytocin, Vancomycin 2 gram loading doses, and Narcotic PCA's.

Compounding:
Pharmacy continues to self-assess, minimally semi-annually, ~~We will assess~~ the competency of pharmacy personnel in compounding in accordance with the Board of Pharmacy Sterile Compounding Licensure requirements.
Pharmacy leadership will provide for ASHP sterile compounding training for each Pharmacy staff member upon hire and annually thereafter. ~~There are two new p~~New pharmacist staff members ~~who~~ will undergo first time "wet lab" training and education for compliance with the anticipated regulatory onset of USP <797> and <800> on 12-1-19. It is noteworthy that this training is being conducted knowing that the physical plant of the pharmacy is pending relocation and may not complete this process on 12/1/19. Regardless staff will be prepared and credentialed by this date.

Dispensing:
Automated dispensing cabinets (ADC) have been added to each surgical suite, the operating corridor, and radiology department near CT and MRI. The Pharmacy department stocks these ADC twice a day. This has removed the requirement for medications to have to be requisitioned from pharmacy (potential source of error) and time sensitive operation.

Distribution:
A barcode scanning process has been implemented for the medication dispensing cabinet restocking process. The process is used to verify and validate the correct medication and earliest expiration date during restocking. This is an additional layer of safety beyond the pharmacist checking the ADC fills prior to distribution.
Process for (pharmacist-RN) confirmation of high-risk intravenous infusions prior to use in the emergency department has been established. This is an additional layer of safety prior to administration.
Pharmacy staff, to ensure full and complete reconciliation of all controlled substances, perform daily controlled substance adjudication.

NORTHERN INYO HEALTHCARE DISTRICT
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Source: Director of Pharmacy	Effective Date:

Administration:
Pasero Opioid Sedation Scale (POSS) and Richmond Agitation Sedation Scales (RASS) have been added to routine narcotic/sedative administration monitoring practices. Hold parameters will add a layer of safety to patient medication management.
Drug library will be implemented with established dose regimens providing guardrails for safe and effective medication administration. (SMART Pumps)

Tracers Activity:
As part of medication safety Tracer activity, a medication pass and safe injection practice observation will be done across the continuum of care quarterly.
The results will be reported to nursing administration and P&T committee. The observations will be used to educate clinical staff as to best practices. Training and changes in practice will be initiated as needed from the observations.

Education:
Education is provided during orientation and annually on safe injection practice for all staff who prepare and administer injectable medications.

With the acquisition of the BBraun Infusion Pumps (Smart Pumps) later in 2020 all nursing staff utilizing IV infusion pumps will be educated on the new drug library and utilization of smart functionality. The drug library will be maintained and reviewed annually in P&T. Updates will be done as needed throughout the year. This technology incorporates both "soft" and "hard" stops to improve patient safety per ISMP.

The pharmacy will continue to provide an hour of education during nursing orientation to include ADC training, medication security, High Risk-High Alert medications, Look Alike-Sound Alike Medications, multi-dose vials, infection control, drug information, and basic pharmacy information.

The pharmacist will identify and educate patients who will benefit from additional information regarding the proper use of, and rationale for their medications prior to discharge.

Monitoring:

Adverse medication events are documented via the unusual occurrence reporting system (UOR) and then reviewed at the Medication Administration Improvement Committee (MAIC).

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Source: Director of Pharmacy	Effective Date:

Baseline and routine INR's will be reviewed by pharmacy for all inpatients taking warfarin.

Use:

1. Beta Blocker use prior to anesthesia is monitored for patient compliance, notification of physician when non-compliant to have opportunity to give med prior to surgery. (See Pillars of Excellence Pre-op/PACU.) Patient safety-outcome-evidence based best practice is incorporated by this process.
2. Pneumonia was added as a criteria qualifying for a surveillance MRSA nasal swab. This will reduce the amount (days of therapy) of Vancomycin used empirically for Pneumonia.

REFERENCES: ISMP "CDPH Medication Error Reduction Plan" December 2016

CROSS REFERENCES : High Alert Medications Policy NIHD
Medication Reconciliation Policy NIHD
Omnicel (ADU) Dispensing Cabinets Policy NIHD
Antibiotic Stewardship Program Policy NIHD

Approval	**Date**
CCOC	1/27/2020
Pharmacy & Therapeutics	
Medical Executive Committee	
Board of Directors	
Last Board of Director review	

Developed: 11/2019fl
Reviewed:
Revised: 1/2020fl
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of emergency care conditions.

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:
1. Database:
    a. Subjective:
        i. Obtain pertinent history related to emergency symptoms.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective:
        i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays. (See *Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife*).
2. Assessment:
    a. Formulate diagnosis consistent with the data base collected.
    b. Document diagnosis in the patient chart.
3. Treatment Plan – Medical Regimen:
    a. Patients requiring emergency care will be stabilized to the best of the capabilities of the setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist or appropriate practitioner from the emergency department for care or to an accepting outside physician if transfer to another facility is warranted.
        i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the NP or CNM the patient can tolerate transfer by wheel chair, an RN must accompany the patient to the emergency department.

ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.

iii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.

~~a. Patients requiring emergency care will be stabilized to the best of the capabilities of the Northern Inyo Healthcare District (NIHD) setting and transferred to or referred to an appropriate provider. These patients shall become the responsibility of the accepting physician and/or NIHD Base Hospital during ambulance transport.~~

b. The NP or CNM may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
   i. Establishing and maintaining an airway
   ii. Cardiopulmonary resuscitation
   iii. Control of hemorrhage by external pressure or tourniquet
   iv. Establishing an intravenous line
   v. ~~Injection~~ Administration of epinephrine for ~~asthma,~~symptoms of anaphylaxis~~etic shock or laryngeal edema~~
   vi. Administration of oxygen for acute dyspnea
   vii. Splint skeletal injuries
   viii. Irrigate wounds
   ix. Apply heat or cold for exposure
   x. Administration of Narcan for suspected narcotic overdose
   xi. Administration of intravenous or oral glucose for suspected ~~insulin reaction~~hypoglycemia
   xii. Follow ~~Advanced Cardiac Life Support Guidelines~~resuscitation guidelines as appropriate
c. Physician Consultation: As described in the *General Policy Standardized Procedure.*
d. Referral to Physician ~~or Specialty Clinic~~: Conditions for which diagnosis and/or treatment are beyond the scope of the NP's or CNM's knowledge and/or skills, or for those conditions that require consultation.
   ~~i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the NP or CNM the patient can tolerate transfer by wheel chair, an RN must accompany the patient to the emergency department.~~
   ~~ii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.~~
e. Furnishing Medications – Medical Regimen:
   i. Follow *Furnishing Medications/Devices Standardized Procedure*, utilizing formulary.

4. Documentation:

a. All emergency care provided will be recorded in the patient chart.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

CROSS REFERENCE P&P:

1. EMTALA Policy

ATTACHMENTS:

1. List of Authorized Nurse Practitioners or Certified Nurse Midwives

Approval	**Date**
Interdisciplinary Practice Committee	~~10/31/19~~02/10/20
Medicine/Intensive Care Committee	12/05/19
Medical Executive Committee	03/03/20
Board of Directors	
Last Board of Directors Review	02/20/19

Developed:
Reviewed:
Revised: 5/2018 dp, 12/2018 dp, 2/2020
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

APPROVALS

_____	_____
Chairman, Interdisciplinary Practice Committee	Date
_____	_____
Administrator	Date
_____	_____
Chief of Staff	Date
_____	_____
President, Board of Directors	Date

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

1. _____ _____
   NAME DATE
2. _____ _____
   NAME DATE
3. _____ _____
   NAME DATE
4. _____ _____
   NAME DATE
5. _____ _____
   NAME DATE
6. _____ _____
   NAME DATE
7. _____ _____
   NAME DATE
8. _____ _____
   NAME DATE
9. _____ _____
   NAME DATE
10. _____ _____
    NAME DATE

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Protocol - Emergency Care Policy for the Physician Assistant	
Scope: Physician Assistants	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 3/21/18

PURPOSE:
This standardized protocol developed for use by the Physician Assistant (PA) is designed to establish guidelines for the management of emergency care conditions.

POLICY:

1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant.*
2. Circumstances:
    a. Patient population: pediatric and adult patients.
    b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in Delegation of Services Agreement.

PROTOCOL:

1. Definition: this protocol covers the management of Emergency Care conditions which may present to NIHD and its affiliated locations.
2. Database
    a. Subjective
        i. Obtain pertinent history related to emergency symptoms.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective
        i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and imaging studies.
3. Assessment
    a. Formulate diagnosis consistent with the data base collected.
    b. Document diagnosis in the patient chart.
4. Treatment Plan – medical regimen
    a. Patients requiring emergency care will be stabilized to the best of the capabilities of the setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist or appropriate practitioner from the emergency department for ~~inpatient~~ care or to an accepting outside physician if transfer to another facility is warranted.
        i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the PA, the patient can

tolerate transfer by wheelchair, an RN must accompany the patient to the emergency department.

ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.

iii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.

~~i.~~iv.

b. The Physician assistant(s) may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
   i. Establishing and maintaining an airway
   ii. Cardiopulmonary resuscitation
   iii. Control of hemorrhage by external pressure or tourniquet
   iv. Establishing an intravenous line
   v. ~~Injection~~ Administration of epinephrine for ~~asthma,~~ symptoms of ~~anaphylactic~~ anaphylaxis~~shock or laryngeal edema~~
   vi. Administration of oxygen for acute dyspnea
   vii. Splint or reduce skeletal injuries
   viii. Incision and drainage of abscesses
   ix. Irrigate and repair wounds
   x. Apply heat or cold for exposure
   xi. Administration of Narcan for suspected narcotic overdose
   xii. Administration of intravenous or oral glucose for suspected hypoglycemia
   xiii. Follow ~~Advanced Cardiac Life Support Guidelines~~resuscitation guidelines as appropriate
c. Physician Consultation: As described in the *General Policy Standardized Protocol.*
d. Consult specialty physician or transfer care of patient.
e. Refer to Physician ~~or Specialty Clinic~~: Diagnosis and/or treatment are beyond the scope of the PA's knowledge and/or skills, or for those conditions that require consultation.

~~. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the PA, the patient can tolerate transfer by wheelchair, an RN must accompany the patient to the emergency department.~~

~~. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.~~

~~h.~~f. Medications – see Delegation of Services Agreement and *Medication/Device Policy for Emergency Department Physician Assistant*

5. Documentation
    a. All emergency care provided will be recorded in the patient chart.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

CROSS REFERENCE P&P:

1. EMTALA Policy

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

Approval	**Date**
Interdisciplinary Practice Committee	~~10/31/19~~2/10/20
Medicine/Intensive Care Committee	12/05/19
Medical Executive Committee	3/3/20
Board of Directors	
Last Board of Directors Review	02/20/19

Developed: 2/2018 sb
Reviewed:
Revised: 2/2018 dp, 12/2018 dp, 2/2020
Supersedes: *Emergency Care Policy for the Rural Health Clinic Physician Assistant; Emergency Care Policy for the Emergency Department Physician Assistant – Standardized Protocol*
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Medical Screening Exam for the Obstetrical Patient	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date: 10/17/19

PURPOSE

To outline the methodology for the medical screening examination of the obstetric patient by the Registered Nurse (RN).

POLICY

1. It is the policy of Northern Inyo Healthcare District (NIHD) that all pregnant women 20 weeks or greater presenting to the obstetrical department for care will receive a Medical Screening Examination by a Registered Nurse with demonstrated competency in this standardized procedure, when requested and without discrimination and regardless of their ability to pay.
2. Registered Nurses shall demonstrate competency in the Medical Screening Examination on an annual basis following this Standardized Procedure.

PROCEDURE

1. Experience and educational requirements of the RN:
    a. Current California Registered Nurse (RN) license
    b. Current NRP and BLS certifications
    c. Successful completion of annual antepartum and intrapartum continuing education per department requirements
    d. Completion of electronic fetal monitoring program (Intermediate or Advanced Fetal Monitoring).
2. Method of initial and continued evaluation of competence:
    a. Initial Evaluation
        i. Successfully complete at least two (2) different obstetric patient medical screening examinations under the observation of a Licensed Independent Practitioner (LIP) or nurse preceptor.
        ii. A qualified “nurse preceptor” is a RN who may validate the competency of another RN to perform this procedure. A nurse preceptor must have completed at least five (5) obstetric patient medical screening examinations.
        iii. Determined competency must be documented on the Medical Screening Examination of Obstetric Patient Competency Validation Tool.
    b. Ongoing Evaluation
        i. Annual competency validation to be performed by successfully completing one obstetric patient Medical Screening Exam.
3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RN’s competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
4. Settings where Standardized Procedure may be preformed
    a. The Medical Screening Exam may take place in the Perinatal Department or the Emergency Department if necessary.
5. Standardized Procedure
    a. Circumstances under which Standardized Procedure may be performed:
        i. A pregnant women 20 weeks or greater presenting to Northern Inyo Hospital for care.
    b. Following examination and assessment of the patient, the RN will collaborate with the Licensed Independent Practitioner (LIP) to develop course of care.
    c. The on-call LIP must be notified immediately if:

i. Delivery is imminent. Preparations should be made for immediate delivery.
ii. Complications or abnormal assessments arise during the patient assessment. Such problems include:
1. Fever (~~100.5°F or above~~greater than 100.4°F), and/or signs of infection
2. Excessive vaginal bleeding (more than spotting)
3. Elevated blood pressure
4. Hyperreflexia
5. Non-vertex presentation
6. Tetanic contraction pattern
7. Non-reactive NST, Category 3 or worsening Category 2 strip
8. Premature gestation presenting in labor
9. Ruptured membranes

d. Contraindications to performing this procedure: Patient refusal
e. Procedure
i. Validate appropriate patient selection criteria:
1. Patient must be an obstetric patient presenting for care
2. Patient must give consent.
3. Patient must have absence of complications as listed under Procedure, section 5.c.ii.
ii. Explain procedure to patient
iii. If delivery is imminent, call the LIP and prepare for immediate delivery.
iv. If delivery is not imminent, continue assessment which will include but is not limited to:
1. Gravida, parity, EDC
2. Chief compliant/reason for visit
3. Review of prenatal record if available, including obstetric history and risk factors
4. Fetal movement
5. Uterine contraction patterns
a. Assess for:
b. Frequency
c. Duration
d. Intensity
e. Resting tone
6. If normal, include this information with report to provider when total assessment is completed.
7. Potential complications may include but are not limited to:
a. Preterm gestation
b. Tetanic contraction pattern.
8. If potential complications are present – call the LIP
v. Determine the status of the membranes:
1. Ask and assess the patient for history or presence of leakage of fluid
a. If patient reports leakage of fluid or possible rupture of membranes:
i. Check for pooling and/or gross rupture of membranes
ii. Collect fern sample for analysis
iii. If fern sample is indeterminate, laboratory sample may be sent with order
iv. Assess the color, odor, or amount of fluid present

2. Include this information with report to provider when total assessment is completed.

vi. Determine the status of the cervix by performing a digital cervical exam, unless contraindicated. If contraindications present, digital cervical exam may only be performed with an order.
   1. Contraindications include:
      a. Less than 36.0 weeks gestation
      b. Active vaginal bleeding
      c. Known or suspected placenta previa
      d. Leakage of fluid
   2. Asses the cervix for:
      a. Dilation
      b. Effacement
      c. Station
   3. Include this information with report to provider when total assessment is completed

vii. Determine presenting part during cervical examination, unless contraindicated (see 5.b.vi.1 above)
   1. If fetus is cephalic, include this information with report to provider when total assessment is completed.
   2. If presenting part is other than cephalic, call the LIP

viii. Assess for signs and symptoms of preeclampsia, including:
   1. Blood pressure (Normal: less than 140/90)
   2. Proteinuria (Normal: using urine dip stick, less than +3)
   3. Hyperreflexia (Normal: DTRs less than +3)
   4. Epigastric pain (Normal: absence of epigastric pain)
   5. Visual disturbances (Normal: absence of visual disturbance)
   6. If normal, include this information with report to provider when total assessment is completed
   7. If abnormal– call the LIP

ix. Assess for maternal infection
   1. If temperature is ~~100.5°F or above~~greater than 100.4°F, suspect infection – call the LIP
   2. If temperature is equal to or less than 100.~~5~~4°F, include this information with report to provider when total assessment is completed

x. Assess bleeding:
   1. Call the LIP if bleeding is more than spotting
   2. If bleeding (more than spotting) is absent, include this information with report to provider when total assessment is completed

xi. Assessment of fetal wellbeing:
   1. Identify fetal heart rate pattern with application of an electronic fetal monitoring system or, if gestation is less than 24 weeks, using a Doppler.
   2. Utilizing NICHD criteria and nomenclature, assess NST reactivity or strip Category.
   3. If NST is reactive or Category 1, include this information with report to provider when total assessment is completed.

4. If NST is non-reactive, or if strip is Category 3 or worsening Category 2, call the LIP

f. At the completion of the medical screening examination, the RN will report to on-call LIP, by phone or in person, the findings of the examination and any other pertinent information before any further procedures are performed. Regardless of the assessment, any patient meeting the following criteria will be examined, in person, by a LIP prior to discharge home:
   i. Maternal temperature ~~100.5°F or above~~greater than 100.4°F, of uncertain etiology
   ii. Altered level of consciousness
   iii. Active vaginal bleeding
   iv. Rupture of membranes
   v. Category 3 or worsening Category 2 strip
   vi. Major maternal trauma.

g. In regards to a patient who is determined to not be in labor but needs additional evaluation to rule out an emergency condition:
   i. This patient will be seen in the Emergency Department and be provided with a medical screening examination to rule out other medical conditions prior to being discharged home. Prior to transfer back to the Emergency Department, the L&D RN will report to the on-call LIP the findings of the labor examination and any other pertinent information. This RN will also call report to the Emergency Department RN and/or the Emergency Department Attending provider to inform them of the patient's impending return to the Emergency Department.

h. Documentation:
   i. Patient assessment, including fetal assessment, will be documented in the EHR according to department policy.

6. Review of Standardized Procedure
   a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.
   b. Quality improvement monitoring of this standardized procedure is ongoing.
      i. Chart audits will be performed for all births occurring outside of a hospital facility following a Medical Screening Exam by a RN.

Approval	**Date**
Interdisciplinary Committee	~~8/27/19~~02/10/20
PeriPeds Committee	09/26/19
Medical Executive Committee	~~10/1/19~~03/03/20
Board of Directors	10/16/19
Last Board of Directors Review	10/16/19

Developed:
Reviewed:
Revised: 12/2018af

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedures for Medical Functions in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: DON - ED & Inpatient Services	Effective Date: 6/10/19

PURPOSE:
The purpose of the policy is to define designated medical functions that may be performed by the RN as a standardized procedure in the ED.

POLICY:
It is the policy of Northern Inyo Healthcare District (NIHD) that only standardized procedure functions based on defined circumstances as outlined in this document may be performed by a Registered Nurse (RN) in the Emergency Department (ED) without previous written authorization of the Emergency Department Physician ~~or Licensed Independent Practitioner (LIP).~~.

PROCEDURE:

1. Competency Requirements
    a. To be eligible to perform this standardized procedure in the ED, the RN must:
        i. Hold a current CA RN License
        ii. Complete an initial training course specific to the elements of the standardized procedure outlined in this policy.
        iii. Competency is demonstrated annually and documented in the employee's competency assessment files.
        iv. A list of RN's competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
        v. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.
2. Abdominal Pain
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 18 years of age and older presenting with complaint of Abdominal Pain with a documented Emergency Severity Index (ESI) level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Abdominal Pain and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
            1. Saline Lock
            2. NPO
            3. CBC with automated differential
            4. Comprehensive Metabolic Panel

5. Urine Dip and Hold Urine
6. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
7. Female 10 years of age to 60 years of age:
    a. Pregnancy Test Urine Qualitative
8. For Upper Abdominal Pain:
    a. Lipase
    b. EKG if age >35
9. If nausea present:
    a. Ondansetron (Zofran) 4 mg IV X1
10. If vomiting present:

    If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml

d. Complications:
    i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

3. Chest Pain 35 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 35 years of age and older presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
            1. STAT EKG
            2. Continuous Pulse Oximetry
            3. Continuous Cardiac Monitoring
            4. Saline Lock
            5. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
            6. CBC with automated differential
            7. Comprehensive Metabolic Panel
            8. Troponin I

9. If patient takes Coumadin:
    a. Prothrombin Time (PT) and INR
    b. Partial Thromboplastin Time
10. Oxygen via nasal cannula to keep oxygen saturation >95%
11. Aspirin 325mg PO Stat if not taken prior to arrival, or equivalent to equal 325mg if partial dose taken prior to arrival, and no contraindications to aspirin

d. Complications:
    i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

4. Chest Pain 16 years of age to 34 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 16 years of age to 34 years of age presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
            1. STAT EKG
            2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
    d. Complications:
        i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
5. Dysuria
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED with complaint of Dysuria with a documented ESI level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:

i. Any patient classified as an ESI Level 1.
ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
iii. Any significant change in patient condition

c. Standardized procedure:
   i. Upon presentation to the ED with complaint of Dysuria and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
      1. Urine Dip and Hold Urine
      2. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
      3. Female 10 years of age to 60 years of age:
         a. Pregnancy Test Urine Qualitative

d. Complications:
   i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

6. Fever 16 years of age and older
   a. Circumstances under which the procedure maybe performed:
      i. Any patient in the ED 16 years of age and older presenting with complaint of fever with a documented ESI level 2-5.
   b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
         1. Acetaminophen 650mg PO X1 for temperature >100.~~5~~ 4 Fahrenheit if unable to swallow may order PR.
         2. If Acetaminophen has been administered in the last 6 hours, and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 600mg PO X1.
   d. Complications:
      i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
   e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

7. Fever 3 months of age to 15 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 3 months to 15years of age presenting with complaint of fever with a documented ESI level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
            1. Acetaminophen Suspension 15mg/kg PO X1 (maximum dose 1000mg) for temperature >100.~~5~~4 Fahrenheit if unable to swallow notify ED Physician ~~or LIP~~. If patient is greater than 6 months of age and Acetaminophen has already been administered in last 6hours and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 10mg/kg PO X1 (maximum dose 600mg) for temperature greater than 100.~~5~~4 Fahrenheit.
    d. Complications:
        i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
8. Extremity Deformity or pain from trauma
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 5 years of age and older presenting with extremity deformity or pain from trauma with a documented ESI level 2-5, and assessed to have normal circulation, movement, and sensation in the distal extremity.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with extremity deformity or pain from trauma assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the

EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.

1. If Ibuprofen has not been administered in the last 6 hours order will be placed for Ibuprofen 10mg/kg max dose of 600mg PO X1, if no NSAIDS have been taken in the last 6 hours.
2. Contact ED Physician ~~or LIP~~ for pain medication order if needed
3. Obtain Radiology: X-ray of the affected extremity
4. Ice Therapy
5. Elevate affected extremity

d. Complications:
   i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

9. Vomiting 18 years of age and older
   a. Circumstances under which the procedure maybe performed:
      i. Any patient in the ED 18 years of age and older presenting with complaint of vomiting with a documented ESI level 2-5.
   b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
         1. Place Saline Lock
         2. If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml
         3. Ondansetron (Zofran) 4mg IV X1
   d. Complications:
      i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
   e. Documentation:
      i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

10. Vomiting 6 months of age to 17 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 6 months to 17 years of age presenting with complaint of vomiting with a documented ESI level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
            1. Ondansetron (Zofran) 0.5mg/kg Oral Disintegrating Tab (ODT), max dose 4mg.
    d. Complications:
        i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:

        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

11. Shortness of Breath WITH history of Asthma (patients of all ages)
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED with complaint of Shortness of Breath with history of Asthma and with a documented ESI level 2-5.
    b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Shortness of Breath with history of Asthma and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
            1. Continuous pulse oximetry
            2. Oxygen administration titrate to keep saturation >90%
            3. Duoneb x1
    d. Complications:

i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

12. Shortness of Breath 18 years of age and older ~~without~~ WITHOUT history of Asthma

a. Circumstances under which the procedure maybe performed:

i. Any patient presenting to the ED 18 years of age and older with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.

b. Circumstances under which the Physician ~~or LIP~~ must be contacted:

i. Any patient classified as an ESI Level 1.

ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.

iii. Any significant change in patient condition

c. Standardized procedure:

i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.

1. Saline Lock
2. Continuous pulse oximetry
3. Continuous cardiac monitoring
4. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
5. EKG if patient >35 years of age
6. Oxygen administration titrate to keep saturation >90%
7. If wheezes are present:
    a. Duoneb x1

d. Complications:

i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

13. Shortness of Breath 17 years of age and younger ~~without~~ WITHOUT history of Asthma

a. Circumstances under which the procedure maybe performed:

i. Any patient presenting to the ED 17 years of age and younger with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.

b. Circumstances under which the Physician ~~or LIP~~ must be contacted:
   i. Any patient classified as an ESI Level 1.
   ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
   iii. Any significant change in patient condition

c. Standardized procedure:
   i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician ~~or LIP~~ cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician ~~or LIP~~.
      1. Continuous pulse oximetry
      ~~2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable~~
      ~~3.~~2. Oxygen administration titrate to keep saturation >90%
      ~~4.~~3. If wheezes are present in patients 2 years of age or older:
         a. Albuterol 2.5mg via hand held nebulizer x1

d. Complications:
   i. Immediate Physician ~~or LIP~~ notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

REFERENCES:

1. **California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.**
2. **Emergency Severity Index (ESI) Implementation Handbook, 2012 Edition. Retrieved from www.ahrg.gov/researdh/esi/esi7.htm.**

Approval	Date
Emergency Services Committee	1/8/20
Pharmacy and Therapeutics Committee	2/21/19
Radiology Committee	2/19/19
Interdisciplinary Committee	~~10/31/19~~2/10/20
MEC	~~2/4/20~~3/3/20
Board of Directors	
Last Board of Directors Review	4/17/19

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedures for Medical Functions in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: DON - ED & Inpatient Services	Effective Date: 6/10/19

Developed: 1/9/2019
Reviewed:
Revised: 2/2020
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

PURPOSE:
The purpose of establishing an ALARA (as low as reasonably achievable) Program is to incorporate practices, procedures and quality assurance checks to keep occupational and medical exposure to radiation as low as reasonably achievable.

Definitions:

ALARA – "as low as reasonably achievable," acronym for the philosophy of keeping medical and occupational radiation exposure as low as reasonable achievable.

RSO – Radiation Safety Officer

RSC – Radiation Safety Committee

POLICY:
The term ALARA is an acronym for maintaining radiation exposures, and effluent releases of radioactive material in uncontrolled areas "as low as reasonably achievable" taking into account the available technology, economic costs in relation to benefits to the public health and safety, and other societal and socioeconomic considerations in their relationship with the utilization of radioactive materials and radiation – producing equipment in the public interest.

The ALARA philosophy extends to exposure to individuals in the performance of their duties (Occupational exposure) and to patients undergoing medical evaluations and treatments.

To achieve this goal, the management should address dose reduction for both workers and patients.

Although the program presented here is developed specifically for occupational exposure considerations, management should incorporate into their program those procedures, practices, and quality assurance checks that can eliminate unnecessary or extraneous radiation exposures to patients without compromising the quality of medical service. Such practices and checks include, but are not limited to:

a) Use of appropriate and well-calibrated instrumentation and equipment.
b) Use of appropriate digital imaging techniques
c) Use of organ shields in diagnostic radiology.
d) Staying with the well-established dosage limits unless deviation is absolutely essential in the judgment of the responsible physician.

1. Management Commitment

a) We, the management of Northern Inyo Hospital, are committed to an efficient medical use of radioactive materials and radiation producing equipment by limiting their use to clinically indicated procedures, utilizing efficient exposure techniques, and optimally operated radiation equipment; limiting dosages to those recommended by the manufacturer unless otherwise necessary, using calibrated diagnostic and related instrumentation; and using appropriately trained personnel.

b) We commit to the program described below for keeping occupational individual and collective doses ALARA. Toward this commitment, we hereby describe an administrative organization for radiation safety and will develop all necessary written policy, procedures, and instruction to foster the ALARA philosophy within our institution. The organization will include a Radiation Safety Committee (RSC) and a Radiation Safety Officer (RSO).

c) We will perform a formal annual review of the radiation safety program, including ALARA considerations. The review will cover operating procedures and past dose records, inspections, and recommendations of the radiation safety staff or consultants.

d) We will modify operating and maintenance procedures, equipment, and facilities if these modifications will reduce exposures and the cost is justified.

2. Radiation Safety Committee

a. Review of Proposed Users and Uses
   (1) The RSC will thoroughly review the qualifications of each applicant with respect to the types and quantities of radioactive materials and radiation-producing equipment and methods of use for which application has been made, to ensure that the applicant will be able to take appropriate measures to maintain exposure ALARA.
   (2) When considering a new use of radioactive material or radiation producing equipment, the RSC will review the efforts of the applicant to maintain exposure ALARA.
   (3) The RSC will ensure that the users justify their procedures and that individual and collective doses will be ALARA.

b. Delegation of Authority

(The judicious delegation of RSC authority is essential to the enforcement of an ALARA program.)

   (1) The RSC will delegate authority to the RSO for enforcement of the ALARA program.
   (2) The RSC will support the RSO when it is necessary for the RSO to assert authority. If the RSC has overruled the RSO, it will record the basis for its action in the minutes of the semiannual meeting.

c. Review of ALARA Program

   (1) The RSC will encourage all users to review current procedures and develop new procedures as appropriate to implement the ALARA concept.
   (2) The RSC will perform an annual review of occupational radiation exposure. A special meeting may be called for particular attention to instances in which the

investigational levels in Table 1 are exceeded. The principal purpose of this review is to assess trends in occupational exposure as an index of the ALARA program quality and to decide if action is warranted when investigational levels are exceeded (see Section 4 below for a discussion of investigational levels). Maximum legal limits of occupational exposure are listed in Table 2, for reference.

(3) The RSC will evaluate the institution's overall efforts for maintaining doses ALARA on an annual basis. This review will include the efforts of the RSO, authorized users, and workers as well as those of management.

Table 1
Investigational Levels*

	Investigational Levels (mrems/calendar quarter)	
	Level I**	Level II**
1. Whole body; head and trunk; active blood-forming organs; or gonads, lens of eye	312	624
2. Lens of Eye	936	1872
3. Extremities	3125	6250
4. Skin of whole body	750	2250
5. Thyroid uptake	0.1 uCi	0.3 uCi

*Note that investigational levels in this program are not new dose limits but serve as checkpoints above which the results are considered sufficiently important to justify investigations. See Section 4 for further discussion.
**Investigational levels are as listed on Radiation Detection Company Dosimetry Report.

Table 2
Maximum Annual Levels*

	Maximum Annual Occupational Dose limits in mrem
1. Whole body	5,000
2. Extremities, Skin	50,000
3. Lens of the eyes	15,000
4. Fetus	500

*Legal limits for occupational radiation exposure, NCRP Report No. 116, Table 19.1

3. Radiation Safety Officer

a. Annual and Quarterly Review

(1) *Annual review of the radiation safety program.* The RSO will perform an annual review of the radiation safety program for adherence to ALARA concepts. Reviews of specific methods of use may be conducted on a more frequent basis.

(2) *Quarterly review of occupational exposures.* The RSO will review at least quarterly the radiation doses of authorized users and workers to determine that their doses are ALARA in accordance with the provisions of Section 5 of this program and will prepare a summary report for the RSC.
(3) *Quarterly review of records of radiation surveys.* The RSO will review radiation surveys in unrestricted and restricted areas to determine that dose rates and amounts of contamination were at ALARA levels during the previous quarter and will prepare a summary report for the RSC.

b. Education Responsibilities for ALARA Program

The RSO (in cooperation with authorized user) will ensure that radiation workers and, as applicable, ancillary personnel are trained and educated in good health physics practices and procedures.

(1) The RSO (or designee) will schedule briefings and educational sessions to inform workers of the ALARA program efforts.
(2) The RSO (or designee) will ensure that authorized users, workers, and ancillary personnel who may be exposed to radiation will be instructed in the ALARA philosophy and informed that management, the RSC, and the RSO are committed to implementing the ALARA concept.

c. Cooperative Efforts for Development of ALARA Procedures

(1) Radiation workers will be given opportunities to participate in formulating the procedures that they will be required to follow.
(2) Radiation workers will be instructed in recourses that may be taken if they feel that ALARA is not being promoted in the workplace.

d. Reviewing Instances of Deviation from Good ALARA Practices

The RSO will investigate all know instances of deviation from good ALARA practices and, if possible, will determine the causes. When the cause is known, the RSO will implement changes in the program to maintain doses ALARA.

4. Authorized Users

a. New Methods of Use Involving Potential Radiation Doses

(1) The authorized user will consult with the RSO and/or RSC during the planning stage before using radioactive materials and radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trials runs may be helpful.
(2) The authorized user will review each planned use of radioactive materials or radiation-producing equipment to ensure that doses will be kept ALARA. Simulated trial runs may be helpful.

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

5. Establishment of Investigational Levels in Order to Monitor Individual Occupational Radiation Doses (External and Internal)

This institution hereby establishes investigational levels for occupational radiation doses which, when exceeded, will initiate review or investigation by the RSC and/or the RSO. The investigational levels that we have adopted are listed in Table 1. These levels apply to the exposure of individual workers. The following actions will be taken at the investigational levels stated in Table 1.

a. Personnel Dose Less than Investigational Level I

Except when deemed appropriate by the RSO, no further action will be taken in those cases where an individual's dose is less than Table I values for the investigational Level I.

b. Personnel Dose Equal To or Greater Than Investigational Level I But Less Than Investigational Level II

The RSO will review the dose of each individual whose quarterly dose exceeds the investigational Level I and will report the results of the reviews at the first RSC meeting following the quarter when the dose was recorded. If the dose does not equal or exceed Investigational Level II, no specific action related to the exposure is required unless deemed appropriate by the Committee. The committee will, however, review each such dose in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the committee minutes.

c. Personnel Dose Equal to and Greater Than Investigational Level II

The RSO will investigate in a timely manner the causes of all personnel doses equaling or exceeding Investigational Level II and, if warranted, will take action. A notification letter will be sent to all personnel with doses equaling or exceeding Investigational Level II. A report of the investigation and any actions taken will be presented to the RSC at its first meeting following completion of the investigation. The details of these reports will be included in the RSC minutes.

d. Reestablishment of Investigational Levels to Level Above Those Listed in Table 1

In cases where a worker's or a group of workers' doses need to exceed an investigational level, a new, higher investigational level may be established for that individual or group on the basis that it is consistent with good ALARA practices. Justification for new investigational levels will be documented.

The RSC will review the justification for and must approve or disapprove all revisions of investigational levels.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ALARA Program*	
Scope: Hospital Wide	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

REFERENCES:

1. CA Title 17
2. CA-RHB "Guide for the preparation of an application for a radioactive materials license authorizing medical use"
3. 10 CFR 35, 10 CFR 20
4. NCRP Report No. 116, Table 19.1
5. Radiation Detection Company Dosimetry Report

CROSS REFERENCE P&P:

1. Dosimetry Program - Occupational Radiation Exposure Monitoring Program

Approval	**Date**
Radiation Safety Committee	5/16/17
Radiology Services Committee	5/16/17
Medical Executive Committee	6/5/17
Board of Directors	6/21/17
Last Board of Director review	1/18/17

Developed:
Reviewed: 6/20/2018
Revised:
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Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Area Monitoring and controls	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: to provide guidelines to ensure area radiation and radiation-emitting machines are monitored to keep radiation exposure to workers and patients ALARA (as low as reasonably achievable).

POLICY:

1. Radiation Area Monitoring: Exposure badges (not control badges) shall be placed in the technologist hallway/control areas. Area monitor exposure reports shall be maintained with occupational exposure reports in the Director of Diagnostic Imaging's office and shall be reviewed by the RSO.

2. Instrument Calibration and Maintenance: Instruments shall have periodic maintenance, annually and as needed. Quality control shall be performed following the manufacturer recommendations.

References:

1. CDPH-RHB *Radiation Safety and Protection Program Requirement Guidance.* 2008

Approval	**Date**
Radiology Services Committee	**5/17/2016**
Medical Executive Committee	**6/7/2016**
Administration	
Board of Directors	**6/15/16**

Developed:
Reviewed: 2/15/17
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Supersedes:

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Radiation Protection for the Patient	
Scope:	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

POLICY: ALARA (as low as reasonably achievable) principles shall be maintained to provide high quality imaging exams with the lowest radiation exposure to the patient.

PROCEDURE:

1. The x-ray beam shall be collimated to the area of interest. Excessive field size contributes directly to exposure of patients and scatter radiation degrades image quality.
2. Gonadal shielding must be used for all patients of childbearing age, unless the use of such shielding interferes with the diagnostic image.
3. Correct positioning and proper exposure techniques should be used to avoid "repeat" exposures.
4. Careful instruction shall be provided to the patient and positioning devices shall be used to avoid motion.
5. Fluoroscopic "beam on" time should be as little as possible to provide a high quality exam.

Reduction in patient exposure also reduces the personnel exposure from scatter radiation.

Approval	**Date**
Radiology Services Committee	**5/17/2016**
Medical Executive Committee	**6/7/2016**
Administration	
Board of Directors	**6/15/16**

Developed:
Reviewed: 5/5/2016
Revised:
Supercedes: *Radiation protection for the patient, 2008*

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*	
Scope: Diagnostic Imaging	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 12/31/16

PURPOSE: To define radiation events and radiation exposures in Computed Tomography (CT), Nuclear Medicine (NM), and fluoroscopy that are recordable or reportable to regulatory and accreditation bodies; To outline the process for investigation and reporting of these events

DEFINITIONS:

Action Plan - The product of the root cause analysis, which identifies the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future.

Byproduct material – any radioactive material (except enriched uranium or plutonium) produced by a nuclear reactor; material that has been made radioactive through the use of a particle accelerator or any discrete source of radium-226 used for commercial, medical, or research activity.

CT scan - axial or helical acquisition acquired on computed tomography equipment

CT study – Scan(s) of a region of interest intentionally acquired for a single diagnosis, does not include repeat imaging due to operator or machine error; (CT Study and Examination are used interchangeably in CDPH RHB regulations)

Effective Dose – reflects the risk of a non-uniform exposure in terms of an equivalent whole body dose; quantity defined in ICRP Publication 60 as a weighted sum of equivalent doses to all relevant tissues and organ with the purpose "to indicate the combination of different doses to several different tissues in a way that is likely to correlate well with the total of the stochastic effects". This is, therefore, applicable even if the absorbed dose distribution over the human body is not homogeneous. The unit is the joule per kilogram ($J\ kg^{-1}$) and is given the special name sievert (Sv). Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

Examination – One or more scans of a region of interest intentionally acquired for a single diagnosis, performed during a single visit/appointment, does not include repeat imaging due to operator or machine error (CT Study and Examination are used interchangeably in CDPH RHB regulations)

Organ dose - quantity defined in ICRP Publication 60 in relation to the probability of stochastic effects (mainly cancer induction) as the absorbed dose averaged over an organ, i.e., the quotient of the total energy imparted to the organ and the total mass of the organ. The unit is the joule per kilogram and is given the special name gray (Gy). Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

Patient movement or interference – voluntary or involuntary movement by the patient; patient, patient family, or other caregiver interference interrupting or disrupting study; abnormal patient anatomy or injury requiring additional scan when routine procedures were followed but did not provide adequate imaging of area of interest

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*	
Scope: Diagnostic Imaging	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 12/31/16

Radiology Report – formal documented interpretation of diagnostic test

Rad - One of the two units used to measure the amount of radiation absorbed by an object or person, known as the "absorbed dose" which reflects the amount of energy that radioactive sources deposit in materials through which they pass. The radiation-absorbed dose (rad) is the amount of energy (from any type of ionizing radiation) deposited in any medium (e.g., water, tissue, air). An absorbed dose of 1 rad means that 1 gram of material absorbed 100 ergs of energy (a small but measurable amount) as a result of exposure to radiation. The related international system unit is the gray (Gy), where 1 Gy is equivalent to 100 rad.

REM - One of the two standard units used to measure the dose equivalent (or effective dose), which combines the amount of energy (from any type of ionizing radiation that is deposited in human tissue), along with the medical effects of the given type of radiation. For beta and gamma radiation, the dose equivalent is the same as the absorbed dose. By contrast, the dose equivalent is larger than the absorbed dose for alpha and neutron radiation, because these types of radiation are more damaging to the human body. Thus, the dose equivalent (in rems) is equal to the absorbed dose (in rads) multiplied by the quality factor of the type of radiation [see Title 10, Section 20.1004, of the *Code of Federal Regulations* (10 CFR 20.1004), "Units of Radiation Dose"]. The related international system unit is the sievert (Sv), where 100 rem is equivalent to 1 Sv.

Recordable event – an event involving radiation or radioactive material where radiation or a radiopharmaceutical is administered without a written directive where a written directive is required; a radiopharmaceutical or radiation where a written directive is required without daily recording of each administered radiopharmaceutical dosage or radiation dose in the appropriate record; event is recorded, investigated, reviewed by Radiation Safety Committee and documentation maintained by facility

Reportable event – an event involving radiation or radioactive material where the dose or exposure meets the standards or is associated with significant deviation from the usual processes as outlined by regulatory and/or accreditation bodies; event is recorded, investigated, reviewed by Radiation Safety Committee; documentation maintained by facility and reported to regulatory and/or accreditation bodies

Root Cause Analysis - A root cause analysis is defined as a process for identifying the basic and casual factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause is the most fundamental reason a problem (a situation where performance does not meet expectation) has occurred.

Sievert (Sv) = 100 rem

Single field – as it relates to fluoroscopy, single field refers to a location on the skin through which the stationary fluoroscopic beam is directed.

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Shallow dose to skin - The external exposure dose equivalent to the skin or an extremity at a tissue depth of 0.007 centimeters (7 mg/cm^2) averaged over an area of 1 square centimeter. Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

POLICY:

1. Except for an event that results from patient movement or interference, NIH shall report to the California Department of Public Health Radiologic Health Branch (CDPH RHB) an event in which the administration of radiation results in any of the following:

A. Repeating of a CT examination, unless otherwise ordered by a physician or a radiologist, if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.

b. 0.5 Sv (50 rem) to an organ or tissue.

c. 0.5 Sv (50 rem) shallow dose to the skin.

B. A CT examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.

b. 0.5 Sv (50 rem) to an organ or tissue.

c. 0.5 Sv (50 rem) shallow dose to the skin.

C. A CT for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.

b. 0.5 Sv (50 rem) to an organ or tissue.

c. 0.5 Sv (50 rem) shallow dose to the skin.

D. CT or fluoroscopic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

E. A CT dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

NIH shall, no later than **five business days** after the discovery of an event described in section 1, paragraph E, and no later than **10 business days** after discovery of an event described in section 1, paragraphs A to D, provide notification of the event to the CDPH RHB and the referring physician of the person subject to the

event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

2. NIH shall record any of the following events, except for an event that results from patient intervention, in which the administration of byproduct material or radiation from byproduct material *does not* result in a dose that exceeds 0.05 Sv (5 rem) effective dose equivalent, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) shallow dose equivalent to the skin:

A. An administration of a wrong radioactive drug containing byproduct material;

B. An administration of a radioactive drug containing byproduct material by the wrong route of administration;

C. An administration of a dose or dosage to the wrong individual

D. An administration of a dose or dosage delivered by the wrong mode of treatment; or

E. A leaking sealed source.

Recordable events involving byproduct material shall be documented as outlined in the procedure section of this policy. Recordable events shall be discussed and analyzed in the NIH Radiation Safety Committee. Discussion shall be documented in the minutes, as should actions taken, if any.

3. NIH shall report any event, except for an event that results from patient intervention, in which the administration of byproduct material or radiation from byproduct material results in a dose that exceeds 0.05 Sv (5 rem) effective dose equivalent, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) shallow dose equivalent to the skin from any of the following:

A. An administration of a wrong radioactive drug containing byproduct material;

B. An administration of a radioactive drug containing byproduct material by the wrong route of administration;

C. An administration of a dose or dosage to the wrong individual

D. An administration of a dose or dosage delivered by the wrong mode of treatment; or

E. A leaking sealed source.

NIH shall report any event resulting from intervention of a patient in which the administration of byproduct material or radiation from byproduct material results or will result in unintended permanent functional damage to an organ or a physiological system, as determined by a qualified physician.

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Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 12/31/16

NIH shall notify by telephone the CDPH RHB **no later than the next calendar day** after discovery of the medical event described in section 3. NIH shall provide notification of the event described in section 3 to the referring physician and also notify the individual who is the subject of the medical event no later than **24 hours** after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful.

NIH shall submit a written report to the CDPH RHB (RAM section) within **15 days** of discovery of the medical event described in section 3. The written report may not contain the individual's name or any other information that could lead to the identification of the individual. NIH shall annotate the individual's name and identification number to the report and provide the annotated report to the referring physician within **15 days** of the discovery of the event.

4. Except for an event that results from patient movement or interference, NIH shall report to the California Department of Public Health Radiologic Health Branch (CDPH RHB) an event in which the administration of radiation results in any of the following:

A. A fluoroscopic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

NIH shall, no later than **10 business days** after discovery of an event described in section 4 provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

5. NIH shall report to the Joint Commission any cumulative fluoroscopic exposure of 1500 rads or more to a single field of skin. The Joint Commission defines "cumulative" for the purposes of this event as "dose over a period of six months to a year."

PROCEDURE:

1. Any potential reportable/recordable event is to be reported immediately to the Chief Performance Excellence Officer or Administrator. Upon notification, this individual, or designee, will direct an initial investigation to determine if the occurrence is indeed a reportable/recordable event as defined by this policy.

2. A Medical Radiation Physicist shall be consulted for dose and exposure calculations and methodology.

3. Upon determination that a reportable/recordable event has occurred, the Chief Performance Excellence Officer or Administrator will notify the Chief of Staff or his/her representative.

4. A team is to be formed to respond to a reportable/recordable event. The team should include, but not necessarily be limited to, the following:

a. Appropriate representatives of Administration, Medical Staff, Safety, Performance Improvement, and departments directly involved in event.

b. Those individuals directly involved in the event.

5. The team will undertake those actions necessary to remediate any immediate threat or likelihood of the sentinel event/unusual occurrence recurring.

6. The team will follow the actions outlined in the PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure.

7. Joint Commission shall be notified as deemed appropriate by the team and Administration.

8. Once a **recordable event** has been identified, the following steps shall be taken:

   a. The technologist involved in the recordable event shall complete a hospital incident report.

   b. The employee, supervisor and department director shall sign the incident report.

   c. Notify the Radiation Safety Officer immediately.

   d. Notify the ordering physician immediately.

   e. Make a copy of the following items to be placed in the "Recordable Events" file in the Nuclear Medicine Department:

      i. Signed physician order

      ii. Patient's facesheet

      iii. A description of the occurrence in full detail, including names of all involved

      iv. A description of what was done as follow-up to the incident

      v. Review action plan, if developed

   f. The Radiation Safety Committee shall analyze the situation at the quarterly meeting and document actions taken, if any.

9. Once a **reportable event** involving CT or fluoroscopy has been identified, the following steps shall be taken:

   a. NIH shall, no later than five business days after the discovery of an event described in section 1, paragraph 5, and no later than **10 business days** after discovery of an event described in section 1, paragraphs 1 to 4, provide notification of the event to the CDPH RHB and the

referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

b. The information provided to the CDPH RHB should include the following:

   i. Radiation generating equipment specifics (i.e. manufacturer, model number, and software version)

   ii. Radiation generating equipment settings

   iii. Operator's name

   iv. Patient's physician name and contact information

   v. Copy of physician's order for CT or fluoroscopic exam

   vi. Explanation as to reason for reporting event

   vii. Prepared internal investigation reports (include cause and corrective action to prevent reoccurrence), as appropriate

   viii. Patient dose calculations (include methodology)

   ix. Copies of letters sent to the patient and physician

c. Notify CDPH RHB of CT and fluoroscopic events via letter to the following address:

   i. Chief X-Ray ICE
   Event Notification
   Radiologic Health Branch
   California Department of Public Health
   P.O. Box 997414, MS 7610
   Sacramento, CA 95899-7414

   ii. Overnight address:
   Chief X-Ray ICE
   Event Notification
   Radiologic Health Branch
   California Department of Public Health
   1500 Capitol Avenue, MS 7610
   Sacramento, CA 95814

d. The Radiation Safety Committee shall analyze the situation and action plan at the quarterly meeting and document actions taken, if any.

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*	
Scope: Diagnostic Imaging	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 12/31/16

10. Once a **reportable event** involving byproduct material has been identified, the following steps shall be taken:

    a. The technologist involved in the reportable event shall complete a hospital incident report.

    b. The employee, supervisor and department director shall sign the incident report.

    c. Notify the Radiation Safety Officer and NIH administration immediately.

    d. Notify the CDPH RHB no later than the next calendar day following discovery.

    e. Notify the ordering physician.

    f. Submit, within **15 days,** a written report to CDPH RHB including:

        i. Facility's (licensee's) name

        ii. The name of the prescribing physician

        iii. A brief description of the event

        iv. Why the event occurred

        v. The effect, if any, on the individual(s) who received the administration

        vi. What actions, if any, have been taken or are planned to prevent recurrence

        vii. Certification that the licensee notified the individual (or the individual's responsible relative or guardian), and if not, why not.

        viii. The report may not contain the individual's name or any other information that could lead to identification of the individual.

    g. NIH shall provide notification of the event to the referring physician and also notify the individual who is the subject of the medical event no later than **24 hours** after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful. The licensee is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within 24 hours, the licensee shall notify the individual as soon as possible thereafter. The licensee may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the medical event, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual (who is the subject of the medical event) may be made to that individual's responsible relative or guardian. If a verbal notification is made, the licensee shall inform the individual, or appropriate responsible

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*	
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Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 12/31/16

relative or guardian, that a written description of the even can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.

h. NIH shall:

i. Annotate a copy of the report provided to the CDPH RHB with the:

1. Name of the individual who is the subject of the event; and

2. Social security number or other identification number, if one has been assigned, of the individual who is the subject of the event; and

3. Provide a copy of the annotated report to the referring physician no later than **15 days after** the discovery of the event.

i. Notify CDPH RHB of RAM/byproduct material events via letter to the following address:

Department of Public Health
Radiologic Health Branch
California Department of Public Health
500 S Kraemer Blvd.
Radioactive Materials, Suite 235
Brea, CA 92821

j. The Radiation Safety Committee shall analyze the situation and action plan at the quarterly meeting and document actions taken, if any.

11. Records of reportable and recordable events shall be maintained at the facility in the custody of the Radiation Safety Committee for the life of the patient plus 10 years.

REFERENCES:

1. CA SB 1237, Health and Safety Code Section 115113
2. NRC Regulations, 10 CFR 35.3045
3. The Joint Commission Sentinel Event Alert, Issue 47, August 24, 2011
4. CA-RHB Radiologic Technology Certification Committee Meeting Minutes, October 23, 2013
5. Russell, L. & Pizzutiello, B. Radiation Safety Webinar on California State Law and Joint Commission Sentinel Event Alert #47. CDPH-Radiologic Health Branch.
6. CDPH RHB, Information Notice Regarding Senate Bill (SB) 1237, California Health and Safety (H & S) Code Section 115113. 14 Jan 2011.

CROSS REFERENCE P&P:

1. PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*	
Scope: Diagnostic Imaging	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 12/31/16

Approval	**Date**
Radiology Services Committee	**11/15/16**
Radiation Safety Committee	**6/23/16**
Medical Executive Committee	**12/6/16**
Board of Directors	**12/14/16**

Developed: 05/05/2016
Reviewed: 6/20/2018
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Supercedes:

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI CT Radiation Safety Policy*	
Scope: Departmental	Manual: Administrative, CT
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 3/21/16

PURPOSE: To establish and maintain safe practice at all times in our CT department

POLICY: Computed tomography will be performed by appropriately licensed and trained technologists in accordance with the ALARA program, and Image Gently ® /Image Wisely ® training.

1. All technologists operating the CT scanner will meet the requirements as determined by CMS, ACR, and The Joint Commission.
2. All technologists operating the CT scanner shall have a thorough understanding of the CT radiation dose, including dose index and "optimal" dose index ranges.
3. Staff involved with CT imaging procedures will be issued radiation monitoring occupational exposure badges. The badge readings will be reviewed by the Radiation Safety Officer. Any readings that are deemed excessive will be addressed by the Radiation Safety Officer directly to the staff member.
4. Public access to the CT suite is restricted. Appropriate signs are posted when radiation is in use.
5. Pediatric specific protocols that have been established based on patient age and/or weight will be utilized whenever possible and kept on file on the unit console.
6. All staff will comply with published ALARA recommendations.
7. All staff will make every effort to conform to Image Gently ® /Image Wisely ® standards.
8. A remotely operated flow-rate injector will be utilized for all intravenous contrast injections.
9. All standards set forth by the Occupational Safety and Health Administration and the Joint Commission will be followed.
10. All patients will be appropriately shielded for all CT imaging studies.
11. Dose reduction (optimization) techniques will be utilized whenever possible. The radiation dose will be set at the lowest values possible while still maintaining appropriate diagnostic imaging quality and;
12. Modifications which will increase patient dose will not be made to physicist-approved default protocols without review by the facility's physicist.
13. Documentation will be made of any changes to the default protocols to include details of the protocol change (technical parameters and the rationale for the change. Any adverse effect on patient dose shall trigger a review by the facility's physicist.
14. Deviations from approved procedures require approval of the ordering physician or radiologist. Protocol deviations may be given by verbal order, but require a physician signature within 48 hours.

REFERENCES:

1. American College of Radiology
2. Intersocietal Accreditation Commission – Computer Tomography Laboratories

Approval	**Date**
Radiology Services Committee	2/16/2016
Medical Executive Committee	3/1/2016
Board of Directors	3/16/16
Last Board of Directors Review	6/20/18

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI CT Radiation Safety Policy*	
Scope: Departmental	Manual: Administrative, CT
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 3/21/16

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Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI Lead Apron/ Protective Equipment Policy*	
Scope: Departmental	Manual: Administrative, PACU
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 3/21/16

PURPOSE: A lead apron is a protective garment which is designed to shield the body from harmful radiation, usually in the context of medical imaging. This policy provides guidance for appropriate use of lead aprons and apparel.

POLICY:
Lead aprons are used in medical facilities to protect workers and patients from unnecessary x-ray radiation exposure from diagnostic radiology procedures. A lead apron is a protective garment which is designed to shield the body from harmful radiation, usually in the context of medical imaging. Both patients and medical personnel utilize lead aprons, which are customized for a wide range of usages. As is the case with many protective garments, it is important to remember that a lead apron is only effective when it is worn properly, matched with the appropriate radiation energy and is used in a safe and regularly inspected environment. For example, per California Title 17 (*30307 Fluoroscopic Installations*) "Protective aprons of at least 0.25 mm lead equivalent shall be worn in the fluoroscopy room by each person, except the patient, whose body is likely to be exposed to 5 mR/hr or more."

Personnel who are required to wear lead aprons or other similar radiation protection devices should visually inspect these devices prior to each use for obvious signs of damage such as tears or sagging of lead.

Examples of when a lead apron is effective and appropriate:
• A lead apron is inadequate for shielding 111In but is appropriate for an 80 kVp xray beam (about 95 percent of the x-rays will be shielded). The lead apron can cause stress and pain in the back muscles; to protect back strain often a skirt style apron covering the lower abdomen is adequate.

• For fluoroscopic procedures a lead apron of at least 0.25 mm lead equivalence (0.5 mm is recommended) will reduce scattered x-rays by 95%. Additionally a thyroid collar and lead impregnated eyewear are recommended. A lead apron is not necessary if only imaging patients (e.g., chest radiograph).

• All occupation workers exposed to greater than 5 mrem/hr from fluoroscopic units must wear lead. Dose rates of greater than 5 mrem/hr can be measured within 6 feet of the table and includes where the fluoroscopist stands.

Examples of when a lead apron is NOT appropriate:
• A lead apron does not provide much shielding during nuclear medicine exams. Lead apparel in the nuclear medicine area may increase scatter radiation, thereby, increasing radiation exposure to the patient and staff.

REFERENCES:
1. California Title 17 (*30307 Fluoroscopic Installations*)

CROSS REFERENCE P&P:
1. DI Lead Apron Inventory and Inspection

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI Lead Apron/ Protective Equipment Policy*	
Scope: Departmental	Manual: Administrative, PACU
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 3/21/16

Approval	**Date**
Radiology Services Committee	2/16/2016
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Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - C-Arm (fluoroscope) Radiation Safety	
Scope: Departmental	Manual: Radiology
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: Ensure mobile fluoroscopy equipment is operated in compliance with Title 17, 30307 and CA-DHS Radiation Safety Advisory 05-02.

POLICY:

1. The spacer cone shall remain mounted to the C-arm to prevent operation of the equipment with a source-skin distance of less than 30 cm (12 inches).
2. The spacer cone may be removed following instruction of a supervising physician (CA licensed "X-ray operator and supervisor), only if the cone is deemed a safety risk to the patient or sterile field.
3. Physicians and fluoroscopy personnel are granted an exemption to remove the spacer cones and operate at source-skin distances of not less than 20 centimeters for medical procedures in which the cone is contraindicated or compromises the procedure.
4. Manufacturer's published precautions for use of spacer cone shall be maintained.
5. The spacer cone shall be replaced upon completion of the exam for which removal was authorized.

REFERENCES:

1. California Code of Regulations, Title 17, Section 30307
2. CA-DHS Radiation Safety Advisory 05-02 (attached)

Committee Approval	**Date**
Radiology Services Committee	**8/19/2014**
Medical Executive Committee	**9/2/2014**
Administration	**8/19/2014**
Board of Directors	**9/17/2014**

Developed: 7/20/2014
Reviewed: 6/20/2018
Revised:
Supercedes: C-arm Fluoroscopy Radiation safety 10/31/2007
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Diagnostic Imaging - Disposal of radioactive sharps**	
Scope: Multidepartmental	Department: **Diagnostic Imaging, Infection Control Blue Manual**
Source: Radiology Director	Effective Date:

Purpose:

To prevent needle sticks and ensure safe disposal of radioactive sharps.

Policy:

1. Needles used with radioactive materials shall be recapped with a needle-capping device or one-handed recapping technique.

2. Needle/syringe shall be transported in a lead lined metal box.

3. Once the syringe and needle are returned to the Nuclear Medicine Hot Lab, they will be discarded in a sharps container.

4. The sharps container shall be stored in a lead shielded container or cabinet for decay at least 10 half-lives. The surface radiation survey of the container shall be indistinguishable from background prior to disposal.

5. Following radioactive decay in storage, all radiation labels shall be obliterated and sharps container shall be disposed of according to hospital policy.

Reference:
10 CFR 20.2
10 CFR 35.92

Committee Approval	**Date**
Radiology Services Committee	**8/19/2014**
Medical Executive Committee	**9/2/2014**
Administration	**8/19/2014**
Board of Directors	**9/17/2014**

Developed: 9/98;
Reviewed:
Revised: 10/2000; 6/2003; 10/2006 mw, 11/2010pd, 8/2011pd, BS 9/12, 11/13 PD, 7/2014 PD
Supercedes:
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel	
Scope: Hospital Wide	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:01-01-2017

PURPOSE: provide guidelines and documentation of training of non-nuclear medicine personnel for the safe handling and delivery (to nuclear medicine department) of radioactive packages

POLICY:
All non-nuclear medicine personnel, i.e., security officer on duty or purchasing/materials management personnel, who may receive and/or deliver (to nuclear medicine) packages containing radioactive materials will be trained regarding proper handling and delivery of these packages.

PROCEDURE:
Appropriate personnel are instructed to follow the guidelines listed below upon receiving radioactive packages. A signed copy of this procedure will be kept in the Radiology Manager's office to document training.

- Visually inspect the package, prior to handling. Notify Nuclear Medicine personnel immediately if package appears to be damaged or leaking. Do not handle a damaged or leaking package.
- Wear gloves when handling any radioactive package.
- Use cart or "dolly" to deliver radioactive packages. This maximizes distance between personnel and the package, minimizing radiation exposure rates.
- Promptly deliver all radioactive packages received to the Nuclear Medicine Department. If a nuclear medicine technologist is present, deliver package to them. If no nuclear medicine technologist is present, leave package at the hot lab door.
- Remove gloves immediately after delivery of package, dispose of the gloves in the Nuclear Medicine Imaging room trash.

If there are any questions regarding handling of radioactive packages, contact the Nuclear Medicine Department, ext. 2636; or the Director of Diagnostic Imaging, ext. 2634.

This document may be printed and used for documentation of annual training.

Trainee signature:_____

Nuclear Medicine Technologist – Trainer: _____

REFERENCES:

1. 10 CFR 20
2. 10 CFR 35
3. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel	
Scope: Hospital Wide	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:01-01-2017

Committee Approval	**Date**
CCOC	**12-18-17**
Radiology Services Committee	**02/19/19**
Medical Executive Committee	**03/05/19**
Board of Directors	**03/20/19**

Revised: 11-21-17
Supercedes: Handling of Radioactive Packages, Non-nuclear medicine personnel, 2014
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation*	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: The purpose of this guideline is to ensure that new Nuclear Medicine department employees are oriented to the practices, policies and equipment in the department. This guideline also documents annual review and re-orientation for all Nuclear Medicine department employees.

POLICY: Nuclear Medicine employees shall be oriented to the practices and policies in the nuclear medicine department.

PROCEDURE:

1. Each area on the list below shall be reviewed, in accordance with state and federal guidelines.
2. Employee shall review information and equipment listed below with the Radiation Safety Officer or Director of Diagnostic Imaging.
3. Employee shall sign this document and place in technologist's binder. Provide a copy to the Human
4. Resources department for employee personnel files.

	Area of orientation or review	Tech initials	RSO/DDI initials
	Proper operation and safety - GE Infinia Hawkeye and Xeleris workstation		
	Proper operation and safety - Atomlab 500 and 100 plus dose calibrators		
	Proper operation and safety – Ludlum Model 44-10 Gamma Scintillator Meter		
	Proper operation and safety – Ludlum 14-C GM survey meter		
	Proper operation and safety – Captus 3000 Uptake Probe and Well Counter		
	Proper operation and safety – Mo99/Tc99m Generator		
	Review Radiation Safety Program (ALARA Program)		
	Review location of monthly Occupational Exposure Reports		
	Review preparation and handling of radiopharmaceuticals		
	Proper operation and safety of "Germfree" Radiopharmacy laminar flow hood		
	Review quality control procedures for radiopharmaceuticals		
	Review procedures for monitoring and storing radioactive waste		
	Review procedures for shipping/receiving radioactive materials		
	Review procedures for in-house transportation of radioactive materials		
	Review procedures for injection of radioactive materials		
	Review procedure for daily surveys for radioactive contamination		
	Review procedure for weekly area survey and wipe tests for radioactive contamination		
	Review procedure for Hot Lab security		
	Review procedures for Nuclear Medicine patient examinations		
	Signature:	Date	
	RSO/DDI signature:	Date	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Nuclear Medicine New Employee/Annual Orientation*	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use. CA-DPH. 2010. Item 13 – Personnel Training Program

Approval	**Date**
Radiology Services Committee	12/16/2015
Medical Executive Committee	1/5/2016
Board of Directors	01/19/2016
Last Board of Director review	

Developed:
Reviewed: 11/01/2015
Revised: 9/26/14 DDI, 4/15/2015,
Supercedes: "Department Specific New/Annual Employee Orientation" 2009
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Ordering Radioactive Materials*	
Scope: Multi-departmental	Manual: Nuclear Medicine, Purchasing
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: ensure that materials and quantities of radioactive materials (RAM) ordered are authorized by the license and that possession limits for RAM are not exceeded.

POLICY: The nuclear medicine technologist maintains written records that identify the authorized user or department, isotope, chemical form, activity, and supplier.

PROCEDURE:

1. For routinely and occasionally used materials, the Radiation Safety Officer or designee (nuclear medicine technologist) shall keep written records that identify the authorized user or department, isotope, chemical form, activity, and supplier.
2. The written records of order will be checked to confirm that the RAM received were ordered through proper channels.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
2.

CROSS REFERENCE P&P:

1.
2.
3.

Committee Approval	Date
Radiology Services Committee	**2/17/2015**
Medical Executive Committee	**4/7/2015**
Administration	**2/17/2015**
Board of Directors	**4/15/2015**

Developed:
Reviewed:
Revised:
Supercedes:
Responsibility for review and maintenance:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Ordering Radioactive Materials*	
Scope: Multi-departmental	Manual: Nuclear Medicine, Purchasing
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Material Hot Lab Security	
Scope: Hospital Wide	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:01-01-2018

PURPOSE:
To define authorized entrance to the radioactive materials (RAM) hot lab.

POLICY:
1. The hot lab door shall remain locked at all times, unless authorized personnel are inside or supervising entrance to the hot lab.
2. Only authorized nuclear medicine personnel, Radiation Safety Officer and Medical Physicists may enter the hot lab unsupervised.
3. For after hours deliveries, contact the Nuclear Medicine Technologist, the Imaging Manager, or Director of Diagnostic Services for access to the hot lab for deliveries of RAM packages after –hours in accordance with the "Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure"

REFERENCES:
1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
2. 10 CFR 35

Cross Reference Policy
1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

Committee Approval	**Date**
CCOC	**12-18-17**
Radiology Services Committee	**11/21/17**
Medical Executive Committee	**12/05/17**
Board of Directors	**12-13-17**

Supercedes: Hot Lab Security, 2014
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Material Spills Procedure	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 7/20/2014

PURPOSE: To define the duties of the nuclear medicine technologist in the event of major and minor spills in the hospital

PROCEDURE:

Major Spills

1. Clear the area. Notify all persons not involved to vacate the room.
2. Prevent the spread. Cover the spill with absorbent pads, but do not attempt to clean up. Confine the movement of all personnel potentially contaminated to prevent the spread
3. Shield the source. If possible, the spill should be shielded, but only if it can be done without further contamination or without significantly increasing personnel radiation exposure.
4. Close the room. Vacate and lock the room. Place appropriate radioactive materials sign on locked door.
5. Call for help. Notify the Radiation Safety Officer immediately.
    a. Telephone number- EXT. 2636
    b. Home number- 760-920-8630
6. Decontamination of personnel. Contaminated clothing should be removed and stored for further evaluation by the Radiation Safety Officer. If the spill is on the skin, flush with warm water thoroughly, wash with mild soap or Radiacwash.
7. Complete Radioactive Materials (RAM) Spills report. File in Nuclear Medicine office.
8. Complete Quality Review Report (QRR), send to QAPI.

Minor Spills

1. Notify persons in the area that a small spill has occurred.
2. Prevent the spread. Cover the spill with absorbent paper.
3. Carefully and quickly, clean the spill. Use absorbent pads and place in plastic bags. Dispose of bags in shielded radioactive waste container. Include all other contaminated materials such as disposable gloves, foot covers.
4. Survey the area with a GM survey meter. Check all areas at the surface of spill and also surrounding areas for possible contamination. The level of exposure must be indistinguishable from background exposure level, or the spill area must be shielded.
5. Wipe test the area of spill to check for removable contamination. Repeat cleaning of the area until the wipe test is less than 2000dpm/cm2. If unable to clean sufficiently, cover with plastic backed absorbent paper. Place the absorbent side on the area of the spill, plastic up.
6. Report. Notify the Radiation Safety Officer of the incident.
7. Complete RAM Spills report. File in Nuclear Medicine office.
8. Complete Quality Review Report (QRR), send to QAPI.

REFERENCES:

1. 10 CFR 20
2. 10 CFR 35

Title: Diagnostic Imaging - Radioactive Material Spills Procedure	
Scope: Departmental	Manual: Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 7/20/2014

3. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf, Appendix K.

Committee Approval	**Date**
Radiology Services Committee	**8/19/2014**
Medical Executive Committee	**9/2/2014**
Administration	**8/19/2014**
Board of Directors	**9/17/2014**

Developed:
Reviewed:
Revised:7/23/2014
Supercedes: Nuclear Medicine Spills Policy, 2004
Responsibility for review and maintenance: DDI, RSO

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure	
Scope: Departmental	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 01-01-2018

PURPOSE: provides procedure for the safe receipt and handling of radioactive materials when nuclear medicine and trained purchasing/materials management personnel are not present to receive packages

POLICY:

1. If a courier arrives at the hospital after operating hours with radioactive packages, the courier will be directed to the Emergency entrance.

2. The Emergency Department clerk or any other emergency department personnel will call the Nursing Supervisor to sign for the package.

3. The Nursing Supervisor will contact:

    1. The Nuclear Medicine Technologist
    2. Manager of Diagnostic Imaging, or
    3. The Director of Diagnostic Services

4. The Nursing Supervisor will escort the courier to the Nuclear Medicine department to secure the radioactive packages in the Hot Lab (R132 in Nuclear Medicine).

5. The Nursing Supervisor will not handle the radioactive package at any time.

6. Should any problems or questions arise regarding this policy and procedure the Nuclear Medicine Technologist and/or the Radiation Safety Officer (RSO) will be called by the Nursing Supervisor. The numbers for the NMT and the RSO are posted on the hot lab door.

PROCEDURE:

1. Call the Nursing Supervisor to the Emergency entrance upon arrival of a courier making delivery of radioactive isotopes.
2. The Nursing Supervisor will sign for the package and escort the courier to the Nuclear Medicine Hot Lab and unlock the door with the punch key provided.
3. The courier will place the package in the Hot Lab on the floor to the left of the door and the Nursing Supervisor will make sure that the Hot Lab door is securely locked when he or she leaves.

REFERENCES:

1. Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
2. 10 CFR 35

Cross Reference Policy

1. Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Materials Delivery After-hours Policy/Procedure	
Scope: Departmental	Manual: Administrative, Nuclear Medicine
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 01-01-2018

Committee Approval	**Date**
CCOC	**12-18-17**
Radiology Services Committee	**11/21/17**
Medical Executive Committee	**12/05/17**
Board of Directors	**12-13-17**

Supercedes: Nuclear Medicine after hours delivery - 2014
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Diagnostic Imaging - Radioactive Waste Storage and Disposal	
Departments/Scope: Nuclear Medicine	
Source: Diagnostic Imaging Director	Effective Date: 01-01-2018

PURPOSE:
To ensure that radioactive waste is properly stored and handled until such time that it can be discarded following the general hospital waste procedures.

POLICY:

Radioactive waste shall be stored in the hot lab, or designated radioactive materials storage room, shielded, for a minimum of 10 half-lives and until it is indistinguishable from background radiation exposure levels, whichever is longer.

Human excreta is not considered radioactive waste. Human waste from patients undergoing diagnostic nuclear medicine procedures shall be handled according to hospital body fluid policy.

Radioactive materials are not disposed of into the sewage system, except wash water, which does NOT exceed allowable limits as stated in 10 CFR 20.

PROCEDURE:

1) Document all radioactive waste stored for decay on the "Waste Storage Log." If multiple isotopes are involved, always document the isotope with the longest half-life.

2) Store radioactive waste for 10 half-lives and until the radiation exposure levels, at the surface, are indistinguishable from background, whichever is longer.

3) Deface or destroy all radioactive labels.

4) Discard waste that is indistinguishable from background, and has been stored greater than 10 half-lives, following regular hospital waste guidelines.

5) Log discarded trash out on the "Waste Storage Log."

Reference
10 CFR 20.2

Committee Approval	Date
Committee Approval	**Date**
CCOC	**12-18-17**
Radiology Services Committee	**11/21/17**
Medical Executive Committee	**12/05/17**
Board of Directors	**12-13-17**

Supercedes: Radioactive waste storage and disposal, 11/2014
Responsibility for review and maintenance: DDI

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Dosimetry Program - Occupational Radiation Exposure Monitoring Program*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

PURPOSE:
To establish guidelines for monitoring occupational radiation exposure and ensure that radiation worker's exposure and monitoring complies with ALARA principles.

POLICY:
In order to detect and evaluate occupational exposure to external radiation, individual monitoring devices will be issued to individuals who are likely to receive, in one year from sources external to the body, a dose in excess of 10 percent of the legal limit as defined in the ALARA Program.

Radiation Monitoring Badges:

1. Employees in areas with potential for radiation exposure shall contact their direct supervisor or the Radiation Safety Officer (RSO) to have a radiation ("film") badge ordered.
2. The RSO will order the badge and deliver to the employee or their supervisor when it arrives.
3. NIH provide "TLD" (thermoluminescent dosimeters) badges and rings to monitor radiation exposure.
4. **A badge shall be worn at all times while performing any radiographic procedure, including mammograms and fluoroscopy in the operating rooms.**
5. The badge shall be worn at collar (thyroid) level outside of lead.
6. If two (2) dosimetry badges are issued (either because of high dosimetry levels or fetal monitoring), the second badge shall be worn at waist level under lead.
7. If a finger badge is issued, this shall be worn on the hand most likely to receive the most exposure.
8. At no time will any employee deliberately tamper with a dosimetry badge, as this is ground for disciplinary action.
9. The Radiation Safety Officer shall review the records monthly, and all employees shall have access to their records at any time.
10. A record that does not contain sensitive information shall be posted at the employee information board in the Imaging Department break room and the bulletin board located in the office of the Director of Diagnostic Imaging.
11. All original records shall be kept for the duration of licensure of the hospital as required by the state and/or the NRC.
12. Review of staff dosimetry monitoring shall be conducted at least every quarter by the Radiation Safety Officer, Diagnostic Medical Physicist or Health Physicist. The review shall assess if the staff radiation exposure levels are within "As Low As Reasonably Achievable" (ALARA) levels set by the US Nuclear Regulatory Commission's 10 CFR 20 Standards for Protection Against Radiation regulation.
13. The Radiation Safety Committee may monitor surgery staff with a dosimeter if it is deemed necessary. Consideration shall be made after a three (3) month trial period. If it is found that the staff exposure is minimal, monitoring may be deemed unnecessary. If it is found that a staff member does have radiation exposure levels, the staff member shall be required to wear his/her dosimeter.
14. Occupational workers approaching maximum allowable exposure shall be counseled. A physicist shall review exposures for accuracy and explanation.

15. NRC regulations prohibit the occupational worker who reaches maximum allowable radiation exposure from additional exposure to occupational sources of radiation for the duration of the period (quarter/annual). NIHD shall ensure the occupational worker receives no additional occupational radiation from registered or licensed sources.
16. Control badges shall be kept in an area free from radiation exposure. Control badges are used by the radiation badge company to monitor background radiation at the facility. Control badges are used to accurately calculate occupational exposure.

Pregnant workers:

1. While it is not required for a radiation worker to declare pregnancy, it is highly recommended. The choice of whether or not to declare your pregnancy is voluntary.
2. If you choose to declare your pregnancy, you must do so in writing. A lower radiation dose limit will apply to your embryo/fetus if you declare. If you choose not to declare your pregnancy, you and your embryo/fetus will continue to be subject to the same radiation dose limits that apply to other occupational workers.
3. Declare your pregnancy in writing using attached "Declaration of Pregnancy Form Letter."
4. All pregnant worker information is confidential. Pertinent information will be disseminated on a need-to-know basis. The RSO will be informed of your declaration so that a fetal radiation badge may be ordered.
5. The Nuclear Regulatory Commission (NRC) has concluded that the 500 mrem limit provides an adequate margin of protection for the embryo/fetus, however, all exposure should follow ALARA principles.
6. Workers declaring pregnancy will be provided "U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999" to read including a question and answer section to ensure understanding. Any questions or concerns shall be addressed by the RSO.
7. Fetal radiation monitoring badges shall be worn at the waist level, under protective lead apparel.
8. Pregnant radiation workers shall wear appropriate protective equipment or remain behind lead barriers when exposure to radiation may occur.
9. Pregnant personnel may not hold patients during exposure.
10. The Radiation Safety Officer shall review the records monthly, and all employees shall have access to their records at any time.

Minimizing Radiation Exposure:

1. During radiology examinations, employees shall remain behind protective barriers as much as possible. If an employee must remain in the room during radiation exposure, he/she must wear an apron and not have any body part in the primary beam. Every effort must also be made to maximize the distance between the employee and the radiation source.
2. Lead gloves shall be worn any time someone's hand is placed in the primary radiation beam.
3. During portable examinations, a lead apron shall be worn during all portable and c-arm examinations. The technologist shall make every effort to maximize the distance between himself/herself, other people, and the radiation source.
4. A verbal announcement shall be made prior to radiation exposure.

5. During surgical procedures, all OR staff during examinations involving x-ray exposures shall wear lead aprons. It shall be the responsibility of the radiology technologist to see that all individuals in the OR room are properly shielded and aware when an exposure is being made.
6. Non-compliance with proper personnel protective equipment or radiation monitoring badge use shall be communicated to the RSO.
7. When using patient restraints, mechanical devices shall be used as much as possible. If staff must be in the room, they must wear a lead apron.

ATTACHMENTS:

1. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999
2. Declaration of Pregnancy Form Letter

REFERENCES:

1. US Nuclear Regulatory Commission (USNRC), NRC Library, Document Collections, NRC Regulations (10 CFR), *Part 20 - Standards for Protection Against Radiation*,, http://www.nrc.gov/reading-rm/doc-collections/cfr/part020/
2. 10 CFR 20→ Subpart C → §20.1201
3. U.S. Nuclear Regulatory Commission Regulatory Guide 8.13, Rev. 3, June 1999

CROSS REFERENCE P&P:

1. ALARA Program

Approval	**Date**
Radiation Safety Committee	5/17/2016
Radiology Services Committee	6/7/2016
Medical Executive Committee	
Board of Directors	6/15/16
Last Board of Director review	1/18/17

Developed: 11/18/2015
Reviewed: 4/11/2016; 6/20/2018
Revised: 4/11/2016
Supersedes: 11/18/2015
Index Listings: Film badges, radiation badges, radiation exposure

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiation Policy for Management of Patients with Excessive Exposure**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Radiology, Surgery**
Source: Radiology Director	Effective Date:

Management of Patients exposed to excessive Ionizing Radiation

IF IN CRITICAL CONDITION, PERFORM LIFE SAVING MEASURES BEFORE DECONTAMINATION IS CARRIED OUT, BUT WITH PATIENT AND MEDICAL PERSONNEL GOWNED AND GLOVED.

Prearrival:

Upon notification by the ambulance or rescue squad of impending arrival of a victim of radiation exposure, notify emergency room physician on duty and hospital administrator. Office of Emergency Services is notified (916-391-7716) of the radiation accident. Contact the Radiological Technologist on call and alert them to the need of a beta gamma survey detector (Geiger counter)

1. If contamination is expected, prepare a separate room or cubicle as an isolation room EXCEPT cover the floor with an absorbent disposable paper (like Chux **or** blue pad) and tape it to the floor.

2. If a separate space is not available, cover a floor area immediately adjacent to the entrance to the emergency room with absorbent paper. The area must be adequate for stretcher cart, disposal hampers and working space for professional attendants. Mark and close off this area with portable screens.

3. If dust is involved, have Maintenance shut off air circulation to prevent spread of contamination.

On Arrival:
On ambulance arrival, the responsible physician or nurse in the emergency room should:

1. Have the patient checked by Radiology Services members while on the stretcher for contamination (preferably as stretcher is removed from the ambulance) by the use of a survey-meter (beta-gamma survey detector).

2. If the patient is seriously injured, give emergency Life-saving assistance immediately.

3. Handle contaminated patient and wound as one would a surgical procedure, i.e. gown, gloves, cap, mask, etc.

4. If possible external contamination is involved, save all clothing and bedding from ambulance, blood, urine, stool, vomitus, and all metal objects (i.e. jewelry, belt buckles, dental plates, etc). Label with name, location on the body, time and date. Save each in leak proof containers (removed from all occupied areas) mark containers clearly 'Radioactive - Do Not Discard." Save all water in holding tank until proper disposal is available.

Responsibility for Review: X-ray Manager Revised/Reviewed: 2/98

Title: **Radiation Policy for Management of Patients with Excessive Exposure**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Radiology, Surgery**
Source: Radiology Director	Effective Date:

5. Decontamination should start if medical status permits, with cleansing and scrubbing the area of highest contamination first. If an extremity alone is involved, clothing may serve as an effective barrier and the affected limb alone may be scrubbed and cleansed. Initial cleansing should be done with bar or liquid soap and warm water. If the body as a whole is involve or clothing generally premeated by contaminated material, showering and scrubbing will be necessary. Pay special attention to hair, body orifices and body fold areas. Remeasure and record measurement after each washing or showering.

   If wound is involved, prepare and cover the wound with self-adhering disposable surgical tape. Cleanse neighboring surfaces of the skin. Seal off cleansed areas with self-adhering disposable surgical drapes. Remove wound covering and irrigate wound with sterile water, catching and irrigating fluid in a basin or can to marked and handle as described in Rule 4 above. Each step in the decontamination should be preceded and followed by monitoring and recording of the location and extent of contamination.

6. Save physician's, nurses' and attendants' scrub or protective clothing, as described or patients.

7. The physician in attendance in the emergency room, if confronted with a grossly contaminated wound with dirt particles and crushed tissue, should be prepared to do a preliminary simple debridement. Further measurements may necessitate sophisticated wound counting detection instruments supplied by the consultant who will advise if further definitive debridement is necessary.

Decontamination of Hospital Personnel

1. Following decontamination of the last victim, all staff personnel except one individual should follow the decontamination procedure and leave the area. The procedure includes stripping to the skin with all clothes placed in a labeled plastic bag, extensive showering nth an abrasive soap, and checking for contamination nth a Geiger counter.

2. The last remaining staff person should remove all plastic sheeting and covers and place them in labeled leak proof plastic bags and stored away from all personnel.

3. The final "contaminate" staff person shall remove all clothing, drop them in a labeled bag and then double bag this bag with the help of a "clean person." The last staff person will then shower and be checked with a Geiger counter before leavingthe decontamination area.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiation Policy for Management of Patients with Excessive Exposure**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Radiology, Surgery**
Source: Radiology Director	Effective Date:

Policy: Instructions to **All** Personnel exposed to "Intermittent Ionizing Radiation"

Procedure: In the case of all diagnostic radiography (this includes CT, Portable X-ray, Portable C-arm procedures, and all routine fluoroscopy and radiography as performed in the Radiology department) there are three primary rules to limiting your Radiation dosage. They are: Time, distance and shielding. "Although every attempt is made to limit the radiation in all procedures, operative or otherwise, the following should be adhered to:"

Time: Limit your exposure to as short a time as possible. If you are involved in surgery cases that require prolonged use of the C-arm than divide those case loads equally among your fellow workers, exclude those who might be pregnant.

Distance: Whenever possible increase the distance between you and the source of the radiation eg. (Portable or C-arm). Here is an example of how you can limit your radiation dosage significantly. If you are one foot away from the radiation source and move a distance of two feet from your radiation source your dose is cut to 1/4, if you move a distance of 4 feet from the source your dose is reduced to 1/16! This is called the Inverse Square Law and simply states that as you double the distance from any radiation source you quarter the amount of radiation received.

Shielding: Always use the Lead aprons supplied. There is NO excuse for not wearing one of these devices. The protective lead aprons supplied at Northern Inyo Hospital can effectively reduce the radiation dosage 99% to those areas covered by the apron.

Pregnant Personnel: The following facts must be considered:

1. Any unborn child, is proportionately more susceptible to the effects of ionizing radiation.
2. The long term effects of low-level radiation are not fully known.
3. Radiation exposure effects are cumulative over a person's lifetime.

Therefore, if possible, all pregnant personnel should avoid exposure to ionizing radiation.

Responsibility for Review: X-ray Manager

Index listing: Radiololy-Intermittent Ionizing Radiation Reviewed/Revised: 2/98, 9/9/09

Last Board of Directors Review Date: 1/16/19; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Radiation Safety Committee*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

PURPOSE:
This guideline is to establish a Radiation Safety Committee (RSC) to review and/or establish radiation safety policies and procedures in accordance with California Title 17 regulations.

POLICY:
Northern Inyo Hospital shall have a Radiation Safety Committee (RSC) to review and/or establish radiation safety policies and procedures.

PROCEDURE:

The NIH RSC should consist of at least:

1. A physician specializing in nuclear medicine or diagnostic radiology
2. A person with special competence in radiation safety/Radiation Safety Officer
3. A representative of the hospital's management
4. A representative of the nursing service

The RSC may also consist of:

1. Nuclear medicine technologists
2. Manager or team leaders who are radiologic technologists

The RSC shall meet at least annually per regulation.
Minutes of all such meetings shall be maintained for review and inspection.
The RSC should develop and review all policies pertaining to the use of radioactive materials and radiation producing equipment within the facility.

REFERENCES:

1. CA Title 17
2. CA-RHB "Guide for the preparation of an application for a radioactive materials license authorizing medical use"
3. 10 CFR 35, 10 CFR 20

Approval	**Date**
Radiation Safety Committee	9/22/2015
Radiology Services Committee	9/22/2015
Medical Executive Committee	11/3/2015
Board of Directors	11/18/2015
Last Board of Director review	1/18/17

Developed: 8/16/2005
Reviewed: 9/12/2015; 6/20/2018
Revised: 9/12/2015
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiology Services Pregnant Personnel**	
Scope: Departmental	Department: **Radiology**
Source: Radiology Director	Effective Date:

Purpose: Teratogenic effects of ionizing radiation in the first trimester of pregnancy have long been known. Although the reported epidemiological association of excess risk in childhood cancer with prenatal radiation exposure of 1 to 10 Rem to the embryo, or fetus, is still uncertain, it is conservative radiation protection philosophy to assume that such a risk may exist. This policy will define NIH's response to this condition.

Policy:
Northern Inyo Hospital will take all necessary steps to reduce the exposure of pregnant personnel to as low as reasonably achievable.

As soon as a radiology technologist believes that she is pregnant, she must notify the Radiology Department Manager.

The following assignments will be allowed:

1. General radiography and fluoroscopy in the department
2. Computed Tomography, mammography, MRI and ultrasound
3. Surgery and portable radiography.

Under no circumstances will pregnant technologists be allowed to hold patients.

Management will notify all appropriate personnel of the pregnancy so that all staff may make every reasonable attempt to ensure that pregnant technologists and technologists in general perform examinations prior to the administration of radionuclides from nuclear medicine.

A second body dosimetry badge shall be acquired for pregnant personnel. It shall be worn at the midsection. When a lead apron is worn, it shall be a wrap-around, and the badge shall be worn under the apron. The dosimetry company shall be informed of the badge's purpose for proper record keeping.

The RSO shall be notified so that potential radiation exposure to the pregnant individual can be evaluated.

1. The occupational exposure of the expectant mother shall not exceed 500 mRem during the full gestational period. (Source: National Council on Radiation Protection and Measurements)
2. Pregnant personnel shall read the pregnancy advisory literature (Appendices A and B, 8.13-3 through 8.13-7, see attachments on left sidebar) and document that fact on the Declaration of Pregnancy form.

Approval	**Date**
Radiology Services Committee	**2/15/2011**
Revised date	
Reviewed date	**6/20/2018**

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiology Services Pregnant Personnel**	
Scope: Departmental	Department: **Radiology**
Source: Radiology Director	Effective Date:

Declaration of Pregnancy

To: _____, Radiology Department Manager

In accordance with the NRC's regulations at 10 CFR 20.1208, "Dose to an Embryo/Fetus," I am declaring that I am pregnant. I believe I became pregnant in _____ (only the month and year need to be provided).

I understand the radiation dose to my embryo/fetus during my entire pregnancy will not be allowed to exceed 500 mrem (millirem) (unless that dose has already been exceeded between the time of conception and submitting this letter). I also understand that meeting the lower dose limit may require a change in job or job responsibilities during my pregnancy.

I have received and read Appendices A and B, "Effects on the Embryo/Fetus of Exposure to Radiation and Other Environmental Hazards" and "Pregnant Worker' Guide.

_____
Your Signature

_____
Your printed name

_____
Date

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Responsibilities and Duties of Radiation Safety Committee (RSC)*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

PURPOSE:
The purpose of this guideline is to establish responsibilities and duties of the Medical Radiation Safety Committee at Northern Inyo Hospital, in accordance with all State and Federal guidelines.

POLICY:
Responsibility
The committee is responsible for:

1. Ensuring that all individuals who work with or in the vicinity of radioactive materials or radiation machines have sufficient training and experience to enable them to perform their duties safely and in accordance with California regulations and the conditions of the license.
2. Ensuring that all uses of radioactive material and of radiation machines are conducted in a manner consistent with ALARA philosophy and in accordance with California regulations and the conditions of the license.

Duties
The committee shall:

1. Be familiar with all pertinent California regulations, the terms of the license, and information submitted in support of the request for the license and its amendments.
2. Review the licensee's ALARA program annually.
3. Review the training and experience of any individual who uses radioactive material or radiation machines (including physicians, physicists, and pharmacists) and determine that the qualifications are sufficient to enable them to perform their duties safely and in accordance with California regulations and the conditions of the license.
4. Establish a program to ensure that all individuals whose duties may require them to work in the vicinity of radioactive material or radiation machines (e.g., nursing, security, and environmental services workers) are properly instructed as required by section 30280.
5. Review and approve all requests for use of radioactive material within the institution prior to forwarding the request to the Department.
6. Prescribe special conditions that will be required during a proposed use of radioactive material or radiation machines such as requirements for bioassays, physical examinations of users, and special monitoring procedures.
7. Review and approve or disapprove, with advice and consent of the Radiation Safety Officer (RSO) and the management representative, minor changes in radiation safety procedures.
8. Review quarterly, with the assistance of the RSO, a summary of all radiation dose records and all incidents involving radioactive materials and radiation-producing equipment with respect to cause and corrective actions.
9. Establish a table of investigational levels of individual occupation radiation exposures.
10. Review the entire radiation safety program at least annually to determine that all activities are being conducted safely and in accordance with California regulations and the conditions of the license. The review shall include shall include an examination of all records, reports from the RSO, results of California inspections, written safety procedures, and management control system.
11. Recommend remedial action to correct any deficiencies identified in the radiation safety program.
12. Maintain written records of all committee meetings, actions, recommendations, and decisions.

Title: Responsibilities and Duties of Radiation Safety Committee (RSC)*	
Scope: Departmental	Manual: Administrative
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date: 11/19/15

13. Ensure that the radioactive material license is amended, when necessary, prior to any changes in facilities, equipment, policies, procedures, and personnel.

Meeting Frequency
The Radiation Safety Committee shall meet as often as necessary to conduct its business, but not less than once in each calendar year (updated pursuant to amendment RAML 3384-14 Amendment number 30, provision 13 (b) dated Feb. 2015).

To establish a quorum, at least one-half of the committee membership must be present, including the Radiation Safety Officer.

REFERENCES:
1. CA Title 17
2. CA-RHB "Guide for the preparation of an application for a radioactive materials license authorizing medical use"
3. 10 CFR 35, 10 CFR 20

CROSS REFERENCE P&P:
1. Radiation Safety Committee

Approval	**Date**
Radiation Safety Committee	9/22/2015
Radiology Services Committee	9/22/2015
Medical Executive Committee	11/3/2015
Board of Directors	11/18/2015
Last Board of Director review	1/18/2017

Developed: 8/16/2005
Reviewed: 6/20/2018
Revised: 9/12/2015
Supersedes:
Index Listings:

CALL TO ORDER	The meeting was called to order at 5:30 pm by Jean Turner, Chair.
PRESENT	Jean Turner, Chair Robert Sharp, Vice Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Topah Spoonhunter, Member At Large Stacey Brown MD, Vice Chief of Staff Kelli Davis MBA, Interim Chief Executive Officer Tracy Aspel RN, BSN, Chief Nursing Officer John Tremble, Chief Financial Officer
ABSENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner stated that due to Covid 19 (Coronavirus) health concerns, the meeting has been made available for attendance via WebEx and phone dial-in. She stated at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda. Director Kilpatrick expressed apologies to those constituents she told would be prohibited from physically attending the meeting, which was previously her understanding. No other comments were heard.
ADJOURNMENT TO CLOSED SESSION	At 5:37 pm Ms. Turner stated the meeting would adjourn to Closed Session to allow the District Board of Directors to: A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2*)). B. Conference with Labor Negotiator: Unrepresented Employee, Chief Operating Officer/Interim Chief Executive Officer (*Government Code Section 54957.6*) C. Conference with Legal Counsel regarding existing litigation, Inyo County Local Agency Formation Commission and Northern Inyo Healthcare District v. Southern Mono Healthcare District (*pursuant to Government Code Section 54956.9*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 6:02 pm the meeting returned to Open Session. Ms. Turner reported that the Board took no reportable action.
SECOND OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner again asked if any members of the public wished to comment on any matters within the jurisdiction of the District Board. No comments were heard.

BUILDING SEPARATION CONSTRUCTION PROJECT CHANGE ORDER	Louis Varga and Francisco Garcia with Colombo Construction Company (Bakersfield) presented a construction change order necessary for completion of the building separation project needed to bring the Northern Inyo Healthcare District (NIHD) Pharmacy into compliance. Discussion of the proposed change order included the following: - The fire containment requirement for the walls of the building separation is a minimum of 2 hours of containment - Additional electrical work is necessary to complete the project - A fire alarm upgrade is being required by the Office of Statewide Healthcare Planning and Development (OSHPD) - The total cost of this change order is $723,409. It was noted that this will be the final cost to complete the project. It was moved by Robert Sharp, seconded by Jody Veenker, and unanimously passed to approve the proposed construction change order from Colombo Construction as presented. Mr. Varga stated that Colombo expects to be back on site to resume work the first week of April 2020, and that the project is expected to be completed in May of 2020.
TIER ONE BENEFIT POLICY AND PROCEDURE	Chief Financial Officer John Tremble called attention to a proposed *Tier One Benefit* Policy and Procedure allowing for 100% coverage for benefited employees and their covered dependents for covered medical services received at NIHD or any NIHD clinic while covered under NIHD's group health plans. It was moved by Mary Mae Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the proposed *Tier One Benefit* Policy and Procedure as presented.
ANNUAL COMPLIANCE PROGRAM REVIEW FOR PIONEER HOME HEALTH & HOSPICE OF THE OWENS VALLEY	NIHD Compliance Officer Patty Dickson called attention to a Compliance Department Annual Report for Pioneer Home Health (PHH) and Hospice of the Owens Valley, as requested by District Administration. Ms. Dickson presented an Executive Summary that identified compliance recommendations among which is the need for PHH to appoint a Corporate Compliance Officer. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the PHH and Hospice of the Owens Valley Annual Compliance Report as presented.
APPOINTMENT OF CORPORATE COMPLIANCE OFFICER FOR PIONEER HOME HEALTH	Ms. Dickson then called attention to the possibility of appointing NIHD's Compliance Officer (herself) to serve as Corporate Compliance Officer for Pioneer Home Health and Hospice of the Owens Valley. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to appoint Ms. Patty Dickson to be Corporate Compliance Officer for Pioneer Home Health and Hospice of the Owens Valley.
PIONEER HOME HEALTH UPDATE AND REQUEST FOR ONGOING SUPPORT	Pioneer Home Health Administrator Ruby Allen, RN provided an update on operations and an overview of current financial conditions at PHH. PHH has grown services significantly since partnering with NIHD, however they continue to operate at a deficit. PHH is looking for ways to increase revenue, however at this time Ms. Allen requests $85,000 in support from the District in order to carry the organization through its

April 5 payroll. The District Board emphasized the immediate need to create a business model and timeframe to help see PHH through their current transition period and bring them to a point where they are financially sustainable. The Board acknowledged the importance of the services Pioneer Home Health and Hospice of the Owens Valley provide, but emphasized the need for creating an action plan intended to bring them out of an operating deficit. A motion was made by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve $145,000 of financial support for Pioneer Home Health to cover their finances until the time of the April NIHD regular Board meeting. The $145,000 in additional funding was approved with the provision that PHH will provide the NIHD Board with an action plan for business operations in writing, by the time of the April 2020 NIHD District Board regular meeting.

COVID 19 (CORONAVIRUS) UPDATE

NIHD Infection Preventionist Robin Christensen, RN and Vice Chief of Staff Stacey Brown, MD provided a status update on Coronavirus (Covid 19) in the local community, and an overview of management efforts and workflows in place at NIHD to help address this public health crisis. The District has run daily Incident Command meetings on the subject of Covid 19 since March 9. Hospital supplies are being carefully monitored, non-essential services have been suspended, and the District is doing everything possible to preserve the health and safety of members of this community. The District is working with trusted healthcare partners including Toiyabe Indian Health project and the County of Inyo to prevent the spread of Covid 19, and is going to great lengths to educate the community and provide essential information necessary to preventing the spread of the virus. The NIHD Rural Health Clinic has implemented drive through testing for possible Covid patients; hospital inpatient visitation has been curtailed; and the District has adopted a policy of following the most stringent of the California Department of Public Health and Centers for Disease Control guidelines.

PROPOSED CHANGES TO CHIEF OPERATING OFFICER/INTERIM CHIEF EXECUTIVE OFFICER SALARY AND BENEFITS

NIHD Human Relations Generalist Lori Bengochia recommended changes be made to the salary and benefits of Chief Operating Officer/Interim Chief Executive Officer (CEO) Kelli Davis, as has been past practice for District Executives during times when they assume interim roles. Ms. Bengochia recommended that Ms. Davis's pay be raised to the lowest level of the CEO pay scale, noting that she will not assume responsibilities or receive any compensation associated with the Chief Medical Officer (CMO) role. It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to increase the salary of the Chief Operating Officer/Interim Chief Executive Officer to the lowest level of the pay scale for the Chief Executive Officer.

APPROVAL OF BBRAUM SMART PUMP IV PUMPS

Ms. Turner called attention to a proposal to purchase BBraun Smart pump IV Pumps and software licenses for the Healthcare District. Following brief discussion of the importance of the equipment purchase it was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously

passed to approve the purchase of BBraun Smart IV Pumps as requested. It was noted that the District has put extensive time and research into selecting the best smart pump product available, and that it also negotiated the best possible price for the equipment.

OLD BUSINESS

GOVERNANCE CONSULTANT UPDATE

Ms. Turner reported that due to travel restrictions and social distancing concerns raised by the Covid 19 crisis, Governance Consultant Jim Rice will postpone his trip to Bishop to provide governance training for the District Board until later in the year. The training will hopefully be re-scheduled to take place sometime in the month of May or June.

PIONEER MEDICAL ASSOCIATES LEASE FOR OFFICE SPACE

Compliance Officer Patty Dickson called attention to a proposed lease agreement between NIHD and Pioneer Medical Associates (PMA) for office space located at 152 Pioneer Lane, Bishop. Ms. Dickson explained the history of the lease negotiation as well as the factors considered when arriving at the reasonable market rate for the agreement, which has been vetted by both NIHD and PMA legal counsel. Director Sharp requested that a Memorandum of Understanding (MOU) be added to the agreement to allow subleasing of the space if the District Board desires to sublease it in the future. It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve the proposed office space lease between NIHD and PMA, with the provision that an MOU allowing for subleasing of the space be added, signed, and notarized prior to the signing of the lease agreement.

COMPLIANCE DEPARTMENT QUARTERLY REPORT

Ms. Dickson also called attention to the NIHD Compliance Department Quarterly Report which was presented at the February 18, 2020 District Board meeting, noting that it was presented previously as an information item and it is now being presented as an action item for Board approval. It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the NIHD Compliance Department Quarterly Report as presented.

LEGAL SERVICES RFP UDATE

Ms. Turner reported that the deadline for responses to the NIHD Legal Services Request For Proposal (RFP) has been extended through the end of March 2020, and that no new submissions have been received at this time.

APPROVAL OF WIPFLI AUDIT DOCUMENTS

Chief Financial Officer John Tremble called attention to a Subsequent Events Letter and an NIHD Representation Letter for Wipfli LLP, that requires Board approval and signature in order to finalize the details of NIHD's previous fiscal year audit. It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the signing of both Wipfli audit documents as requested.

RHC BUILDING UPDATE

Vice Chief of Staff Stacey Brown MD and Interim Chief Executive Officer Kelli Davis provided an update on the status of the NIHD Rural Health Clinic (RHC) rebuild project. The NIHD rebuild team has

conducted a first interview with an architectural team, and meetings with Sam Walker and NIHD Administration have continued in an attempt to finalize the details of the Opportunity Zone project to the satisfaction of both legal teams. A special meeting of the District Board on the subject of the RHC rebuild project will be held during the first week of the month of April.

CHIEF OF STAFF REPORT

MEDICAL STAFF APPOINTMENT

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

1. Casey Graves, MD (*emergency medicine*) - Provisional Active Staff

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the credentialing of Casey Graves, MD as requested.

POLICY AND PROCEDURE APPROVALS

Doctor Brown also reported following careful review and consideration the Medical Executive Committee recommends approval of the following District-wide Policies and Procedures:

1. *Cleaning and Disinfecting of Transesophageal Echo (TEE) Probe using Glutaraldehyde Use Station (GUS) Disinfection Soak Station*
2. *Misoprostol for Cervical Ripening*
3. *Naloxone (Narcan) Distribution*
4. *Oxytocin (Pitocin) Administration*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and passed to approve Policies and Procedures 1 through 4 as presented, with Ms. Kilpatrick abstaining from the vote.

ANNUAL APPROVALS AND RECRUITMENT REPORT TABLED

Doctor Brown also requested that Medical Staff agenda items C and D be tabled for approval at a future meeting. No action was taken on Chief of Staff Report agenda items 8C or 8D.

CONSENT AGENDA

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

- *Approval of minutes of the February 13 2020 special meeting*
- *Approval of minutes of the February 18 2020 regular meeting*
- *Financial and statistical reports as of January 2020*
- *Policy and Procedure annual approvals*
- *Interim Chief Executive Officer Report*
- *Chief Operating Officer Report*
- *Chief Nursing Officer Report*
- *Chief Financial Officer Report*

It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve all 8 Consent Agenda items as presented.

REPORTS FROM BOARD MEMBERS

Ms. Turner asked if any members of the Board of Directors wished to report on any items of interest. Topah Spoonhunter expressed his

appreciation of District staff and everything they do in the interest of the health and welfare of this community. He additionally reported that he found the Association of California Healthcare Districts (ACHD) leadership meeting in Sacramento of great value, stating that it was a worthwhile educational opportunity for members of the District Board. Director Turner also expressed her appreciation of the ACHD training.

ADJOURNMENT The meeting was adjourned at 8:25 pm.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

Overview: Organizational billed charges were on budget in February with continued slowness in Operating Room cases. March revenues dropped significantly in the last two weeks of the month.

	Charges	Budget
October, 2018	12,311,788	12,324,875
November, 2018	12,965,830	13,205,209
December, 2018	11,320,722	13,205,209
January, 2019	13,649,585	13,645,381
February, 2019	11,808,879	12,324,875
March, 2019	12,927,842	13,645,381
April, 2019	14,479,237	13,205,209
May, 2019	13,190,872	13,645,381
June, 2019	12,985,554	13,205,327
July, 2019	14,142,468	13,645,381
August, 2019	14,486,110	14,095,678
September, 2019	12,636,290	13,640,980
October, 2019	14,348,923	14,095,678
November, 2019	12,900,439	13,640,980
December, 2019	13,526,106	14,095,678
January, 2020	15,822,001	14,095,678
February, 2020	13,488,506	13,186,280
March, 2020	11,127,060	14,095,678

Gross Accounts Receivables in Athena continue to be high at $54,252,254; 115.4; Gross Days in AR. Remaining Gross Accounts Receivable in Paragon is $1,995,406 and Centricity is $297,885.

Salaries and Wages for Hospital operations were up 4.7% over January and December levels.

	Salaries & Wages	Cost Per Day
January, 2019	2,550,818	82,284
February, 2019	2,457,730	87,776
March, 2019	2,674,515	86,275
April, 2019	2,555,902	85,199
May, 2019	2,616,111	84,391
June, 2019	2,509,763	83,659
July, 2019	2,585,146	83,392
August, 2019	2,638,465	85,112
September, 2019	2,530,883	84,363
October, 2019	2,536,968	81,838
November, 2019	2,496,760	83,224
December, 2019	2,468,754	79,638
January, 2020	2,406,843	77,640
February, 2020	2,389,539	82,398
March, 2020	2,565,295	82,751

February 2020 Financial Results: Volumes slowed in the hospital and ended near budget.

Submitted by John Tremble

March, 2020 Preliminary Results:

Revenues during the first 16 days of March were on budget. With the Governor's order; volumes began to drop steadily and during the last week of March dropped to (55%); only $200,000 per day. As such, total Revenues were nearly ($3,000,000) below plan for the month.

During the last week, average daily census was 5 and daily emergency room visits were 14. Clinic visits for acute only patients dropped to less than 80 per day across all clinics.

Expenditures in both staffing and supplies did not decrease at the end of March. Additional supplies for COVID-19 were acquired while staff training to handle such patients was incurred. Daily Incident Command was initiated during the month. Business office operations transitioned to be primarily home based without significant decreases in productivity. The Medicare settlement for Fiscal 2019 was received totalling $2.1 million which improved cash on hand. The annual Inter-Governmental transfers of ($3.6 million) to the State occurred also during March related to managed Medicaid.

It is expected that the month of March will result in a net loss of ($1.5 million), dropping the year to date to a loss of ($1.0 million). This will make the District potentially not in compliance with its Debt Service Coverage ratio of 1.5:1 on the Bonds.

A review was started in March to investigate a new Group Purchasing Organization; HealthTrust, the pitch from the GPO's representative is that we could see savings of 8% to 12% on overall supplies cost.

April, 2020 Significant Challenges:

We will get direct reimbursement on new Covid expense and some staff time, but that will not make up for the 55% reduction in revenues we expect in April ($7,000,000)revenues. If the last 10 days are the trend for April, revenues will be $6.4 million gross for April while our expenses are budgeted to be $7.3 million. After discounts of ($3.2 million); I project we will lose ($4.1 million) in April if we do nothing about our expenses.

The following quote from another District really accurately describes our volume situation and what that District had to do to survive:

Starting today, Clay County Medical Center (CCMC) will temporarily furlough around 25 percent of their employees due to low patient volumes in many departments related to the COVID-19 pandemic. Patient volumes at CCMC have dropped over 50 percent in surgery, lab, radiology, therapies, and associated primary care clinics. Team members affected by the furlough will remain CCMC employees, will have the ability to apply for unemployment benefits, and will keep their CCMC insurance benefits during this furlough. The continuation of health insurance benefits will ensure furloughed employees and their covered family members can continue their medications and seek medical care.

Over the weekend and this week, CCMC attorneys at Foulston Siefkin reviewed the CARES Act to see how CCMC could benefit from this $2.2 trillion stimulus. "Unfortunately, the CARES Act was put together quickly and excluded governmental hospitals from qualifying for the SBA

Submitted by John Tremble

Loans via the "Paycheck Protection Program", which are forgivable loans. This forgivable loan would have helped offset around $3 million in payroll and benefit expense. We are extremely disappointed that only around 700 out of the 5,000 plus hospitals in the United States will be able to take advantage of the Paycheck Protection Program," said Austin Gillard, CEO of CCMC.

We in fact are not seeing much in the way of any income to replace the drop in patient volumes, the RHC may be made whole on 30% of its business (Medicare), but that is about it.

The Federal and State governments have not stepped up; to date; in a meaningful way. The $100 Billion for hospitals appears to be just $25,000 per bed per the American Hospital Association which means $625,000 for NIHD. Our situation is exactly the same as that of Clay County Medical Center and many rural CAHs where meaningful Covid-19 patient volumes have not occurred. I expect many rural hospitals to be closed by the end of July if the Government does not open the economy at the end of April.

We will have used 30 days cash on hand by the end of April and if May does not turn around, another 15 to 20 in that month. We are looking at reducing expenses across all fronts; we need the ability to low census employees and discussions with the union on this issue are occurring. Discussions with the main physician group are occurring today (April 3rd) on this very topic. Organizations such as Inter-Mountain Health have reportedly reduced physician compensation during this time.

Two letters have been sent Senator's Feinstein's office asking for specific actions which will help during the Covid-19 outbreak. Another letter will be sent in regards to legislative actions which could help the District with legacy debt (Capital Appreciation Bonds).

Submitted by John Tremble

Northern Inyo Healthcare District - Summary of Key Ratios & Debt Covenants

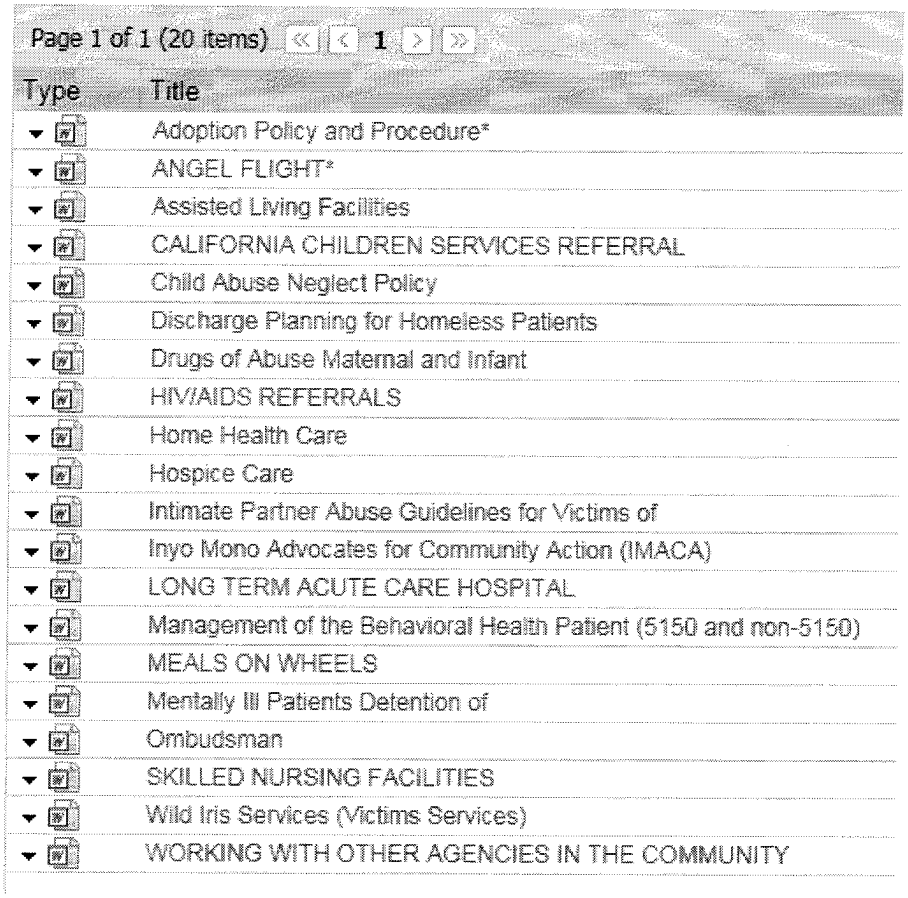
Unit of Measure	2/29/2020	1/31/2020	12/31/2019	11/30/2019	10/31/2019	9/30/2019	8/31/2019	7/31/2019	6/30/2019
Cash, CDs & LAIF Investments:	$ 18,242,439	$ 19,278,468	$ 20,037,907	$ 20,282,130	$ 21,751,578	$ 24,551,976	$ 24,237,671	$ 26,353,608	$ 27,264,480
Days Cash on Hand	78.01	82.44	85.69	86.74	93.02	105.00	103.65	112.70	116.60
Athena Gross Accounts Receivable	$ 54,252,254	$ 54,252,254	$ 50,609,241	$ 51,533,089	$ 50,776,886	$ 48,766,032	$ 48,766,032	$ 44,505,205	$ 42,891,066
Average Daily Revenue	$ 470,292	$ 459,223	$ 443,212	$ 437,962	$ 444,616	$ 430,894	$ 440,084	$ 432,425	$ 420,533
Gross Days in AR	115.36	118.14	114.19	117.67	114.20	113.17	110.81	102.92	101.99
Key Statistics									
Acute Census Days	228	218	247	203	203	211	191	240	2,803
Swing Bed Census Days	7	10	16	14	14	23	15	7	454
Observation Days	35	47	27	32	44	36	38	39	485
Total Inpatient Utilization	270	275	290	249	261	270	244	286	3,742
Average Daily Inpatient Census	9.31	8.87	9.35	8.02	8.43	8.71	7.87	9.23	10.25
Average Acute Daily Charge	$ 11,948.71	$ 13,325.87	$ 12,959.53	$ 14,251.94	$ 13,682.15	$ 10,846.13	$ 10,281.36	$ 11,472.19	$ 10,982.78
Adjusted Daily Census (with OP)	40.95	45.07	38.53	36.75	40.88	35.91	41.27	41.54	38.29
Emergency Room Visits	758	826	703	726	767	641	868	889	9,153
Emergency Room Visits Per Day	26.1	26.6	23.4	24.2	24.7	21.4	28.0	28.7	25.1
Operating Room Inpatients	17	21	21	16	23	20	19	23	230
Operating Room Outpatient Cases	83	104	82	92	118	104	90	93	1,240
RHC Clinic Visits	2,795	2,989	2,546	2,423	2,377	2,439	2,377	2,675	29,446
NIA Clinic Visits	1,844	2,034	1,829	1,951	2,030	1,864	2,027	1,924	
Outpatient Hospital Visits	4,652	5,196	4,279	4,203	4,878	4,222	4,549	4,678	
Hospital Operations									**Fiscal 2019**
Inpatient Revenue	$ 2,807,947	$ 3,038,298	$ 3,408,357	$ 3,092,670	$ 2,969,027	$ 2,537,994	$ 2,117,960	$ 2,833,630	$ 35,770,899
Outpatient Revenue	9,901,586	12,213,684	9,581,304	9,301,405	10,838,533	9,608,636	11,774,827	10,843,405	110,939,678
Clinic (RHC) Revenue	738,973	570,019	536,445	506,364	541,363	458,568	593,322	465,433	6,784,060
Total Revenue	$ 13,448,506	$ 15,822,001	$ 13,526,106	$ 12,900,439	$ 14,348,923	$ 12,605,198	$ 14,486,109	$ 14,142,468	$ 153,494,636
Revenue Per Day	$ 463,742	$ 510,387	$ 436,326	$ 430,015	$ 462,868	$ 420,173	$ 467,294	$ 456,209	$ 420,533
% Change (Month over Month)	-9.1%	17.0%	1.5%	-7.1%	10.2%	-10.1%	2.4%	1.8%	
Salaries	$ 2,389,539	$ 2,406,843	$ 2,469,711	$ 2,496,760	$ 2,536,958	$ 2,422,139	$ 2,528,362	$ 2,476,554	$ 25,697,886
PTO Expenses	292,280	364,101	190,609	294,562	266,736	254,834	254,720	269,335	3,255,428
Total Salaries Expense	$ 2,681,819	$ 2,770,944	$ 2,660,320	$ 2,791,322	$ 2,803,694	$ 2,676,974	$ 2,783,082	$ 2,745,889	$ 28,953,314
Expense Per Day	$ 92,477	$ 89,385	$ 85,817	$ 93,044	$ 90,442	$ 89,232	$ 89,777	$ 88,577	$ 79,324
% Change	3.5%	4.2%	-7.8%	2.9%	1.4%	-0.6%	1.4%	2.8%	
Operating Expenses	$ 3,891,415	$ 4,119,352	$ 4,014,639	$ 4,198,689	$ 4,370,650	$ 4,330,335	$ 3,930,250	$ 4,051,730	$ 49,294,043
Operating Expenses Per Day	$ 134,187	$ 132,882	$ 129,504	$ 139,956	$ 140,989	$ 144,344	$ 126,782	$ 130,701	$ 135,052
Capital Expenses	$ 575,560	$ 574,402	$ 630,855	$ 604,834	$ 589,185	$ 590,014	$ 589,257	$ 560,212	$ 7,103,119
Capital Expenses Per Day	$ 19,847	$ 18,529	$ 20,350	$ 20,161	$ 19,006	$ 19,667	$ 19,008	$ 18,071	$ 19,461
Total Expenses	$ 7,148,794	$ 7,464,698	$ 7,305,814	$ 7,594,845	$ 7,763,529	$ 7,597,323	$ 7,302,590	$ 7,357,830	$ 85,350,476
Total Expenses Per Day	$ 246,510	$ 240,797	$ 235,671	$ 253,162	$ 250,436	$ 253,244	$ 235,567	$ 237,349	$ 233,837
Gross Margin	$ 253,999	$ 624,508	$ 358,996	$ 53,621	$ 724,122	$ (522,456)	$ 435,083	$ 522,819	$ 1,772,471
Gross Margin Per Adjusted Day	$ 213.86	$ 446.94	$ 300.53	$ 48.63	$ 571.43	$ (484.97)	$ 340.09	$ 406.01	$ 126.82
Debt Compliance									
Current Ratio (ca/cl) > 1.50	2.47	2.47	2.19	2.29	2.21	2.20	2.26	2.19	2.12
Quick Ratio (Cash & Net AR/cl) >1.33	1.88	1.88	1.77	1.78	1.76	1.87	1.96	1.93	1.87
Days Cash on Hand > 75	78.01	82.44	85.69	86.74	93.02	105.00	103.65	112.70	116.60
Debt Service Coverage > 1.5	1.56	1.56	1.34	1.37	1.54	1.38	2.18	2.19	1.54
Debt Service Coverage > 1.25 > 75 cash	1.56	1.56	1.34	1.37	1.54	1.38	2.18	2.19	1.54

Northern Inyo Healthcare District
Income Statement
As of February 29, 2020

	Month To Date 2/29/2020	Month To Date 1/31/2020	Month To Date 12/31/2019	Year To Date 2/29/2020	Year To Date Budget	Year To Date 2/28/2019
Patient Services Revenue						
Inpatient Revenue	2,807,947	3,038,298	3,408,357	22,805,883	23,326,400	22,200,179
Outpatient Revenue	9,901,586	12,213,684	9,581,304	84,063,382	76,664,800	73,162,696
Clinic Revenue	738,973	570,019	536,445	4,410,485	4,800,000	4,309,690
Total Gross Patient Service Revenue	13,448,506	15,822,001	13,526,106	111,279,750	104,791,200	99,672,565
Deductions from Revenue	(7,178,930)	(8,421,383)	(6,606,120)	(55,789,324)	(52,719,867)	(52,100,852)
Other Patient Revenue	804	28,403	383	95,068	40,000	(19)
Total Net Patient Revenue	6,270,380	7,429,021	6,920,369	55,585,494	52,111,333	47,571,694
Income/Expense from Cost Reporting	476,468	0	(1)	523,600	800,000	3,788,062
Other Operating Revenue	655,945	660,183	744,442	5,934,816	9,280,000	6,884,178
Gross Operating Profit	7,402,793	8,089,204	7,664,810	62,043,910	62,191,333	58,243,934
Operating Expenses						
Repairs and Maintenance	7,858	-1,956	12,468	120,450	260,000	329,710
Leases and Rental Expenses	58,554	31,745	50,901	244,492	400,000	574,895
Salary & Wages	2,389,539	2,406,844	2,469,711	19,726,868	20,008,000	19,409,442
Benefits	1,359,142	1,697,593	1,504,288	12,827,845	13,360,000	13,036,697
Non-Benefit Expenses	5,502	23,001	24,068	122,597	112,000	109,111
Professional Fees	815,891	897,413	918,617	6,827,755	7,760,000	7,554,889
Supplies	983,531	898,459	775,256	6,775,055	6,934,000	6,835,740
Contract Services	534,202	344,948	317,220	4,626,323	3,200,000	3,418,515
Other Department Expenses	108,263	98,514	180,293	910,320	800,000	744,179
Hospital Insurance Expenses	36,143	36,143	37,488	260,749	240,000	281,806
Utilities	116,030	120,303	120,727	1,025,238	960,000	1,023,904
Depreciation and Amortization	350,499	346,649	374,459	2,873,762	2,800,000	2,681,779
Other Fees	158,579	337,290	287,208	1,231,795	1,200,000	985,402
Interest Expense - Operating	225,061	227,752	233,110	1,846,352	1,800,000	1,873,836
Total Operating Expenses	7,148,794	7,464,698	7,305,814	59,419,601	59,834,000	58,859,905
Total Net Operating Profit (Loss)	253,999	624,506	358,996	2,624,309	2,357,333	(615,971)
Non-Operating Revenue						
Tax Payer General Support	52,608	52,608	48,743	397,673	420,000	447,656
Bond/ Tax Payer Bond Support	157,115	157,115	137,596	1,139,805	1,145,600	1,143,054
Fin Chgs-Pt Ar - Int Incm-Payors	0	4	2	2,904	14,000	17,531
Interest Income	28,816	45,970	34,560	359,570	300,000	459,300
Interest on Patient Account	3,811	1,827	1,367	13,994	0	636
Total Other Income	242,350	257,524	222,268	1,913,946	1,879,600	2,068,177
Grant Revenue	13,550	0	25,000	75,018	1,780,000	2,054,613
Other Non-Operating Income	1,596	1,596	1,596	11,172	8,000	39,696
Net Medical Office Activity	(547,290)	(544,652)	(689,191)	(4,370,668)	(4,000,000)	(4,226,603)
340b Net Activity	58,384	56,245	26,783	395,996	216,000	195,638
Donations	0	50,000	0	113,773	10,400	6,300
Rental Income	4,880	4,882	5,460	39,630	38,400	23,797
Gain/Loss on Sale of Assets	0	0	0	(31,762)	0	0
Gain - Investments - Other Income	0	0	(1,697)	17,213	0	5,081
Net Non-Operating Revenue	(468,880)	(431,929)	(632,049)	(3,749,628)	(1,947,200)	(1,901,478)
Non-Operating Expenses	(75,000)	0	(45,000)	(300,000)	(200,000)	0
Total Net Non-Operating Profit	(301,530)	(174,405)	(454,781)	(2,135,682)	(2,147,200)	166,699
Total Net Income	(47,531)	450,101	(95,785)	488,627	210,133	(449,272)

Northern Inyo Healthcare District
Balance Sheet
As of February 29, 2020

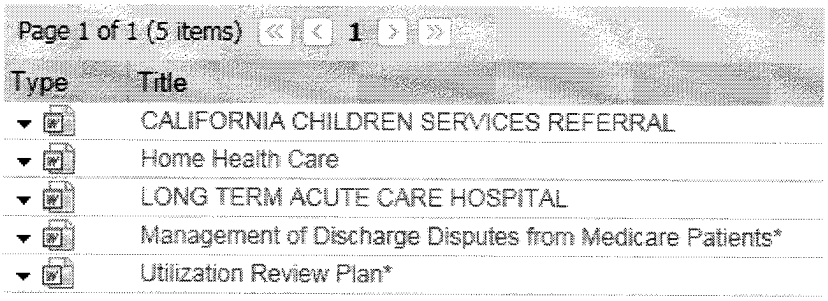
Assets	
Current Assets	
Cash and Liquid Capital	3,194,451.01
Short Term Investments	12,095,162.82
PMA Partnership	801,030.00
Accounts Receivable, Net of Allowance	
Accounts Receivable	57,957,239.69
Allowances against Receivables	(34,397,694.22)
NIA Accrued Allowances	(957,751.90)
Total Accounts Receivable, Net of Allowance	22,601,793.57
Other Receivables (Inter-Governmental)	9,405,573.70
Inventory	2,075,079.29
Prepaid Expenses	1,484,119.13
Total Current Assets	51,657,209.52
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,193,798.87
Short Term - Restricted	150,576.55
Limited Use Assets	
LAIF - DC Pension Board Restricted	746,697.00
DB Pension	13,632,410.00
PEPRA	5,338.00
Total Limited Use Assets	14,384,445.00
Revenue Bonds Held by a Trustee	2,741,543.09
Total Assets Limited as to Use	18,470,363.51
Long Term Assets	
Long Term Investment	1,759,028.15
Fixed Assets, Net of Depreciation	
Fixed Assets	126,959,375.84
Accumulated Depreciation	(52,419,576.01)
Construction in Progress	2,655,332.98
Total Fixed Assets, Net of Depreciation	77,195,132.81
Total Long Term Assets	78,954,160.96
Total Assets	149,081,733.99
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	2,500,715.15
Accounts Payable	6,171,436.41
Accrued Payroll and Related	6,159,414.73
Accrued Interest and Sales Tax	349,330.06
Due to 3rd Party Payors	2,341,874.36
Due to Specific Purpose Funds	8,182.91
Other Deferred Credits - Pension	3,481,539.70
Total Current Liabilities	21,012,493.32
Long Term Liabilities	
Long Term Debt	39,253,947.15
Bond Premium	444,154.72
Accreted Interest	14,404,654.00
Other Non-Current Liability - Pension	32,705,323.00
Total Long Term Liabilities	86,808,078.87
Suspense Liabilities	(123,319.12)
Total Liabilities	107,697,253.07
Fund Balance	
Fund Balance	39,806,491.39
Temporarily Restricted	1,625,520.33
Net Income (Loss) for Month	(47,530.80)
Total Fund Balance	41,384,480.92
Liabilities + Fund Balance	149,081,733.99



Page 1 of 1 (20 items) « ‹ 1 › »

Type	Title
	Adoption Policy and Procedure*
	ANGEL FLIGHT*
	Assisted Living Facilities
	CALIFORNIA CHILDREN SERVICES REFERRAL
	Child Abuse Neglect Policy
	Discharge Planning for Homeless Patients
	Drugs of Abuse Maternal and Infant
	HIV/AIDS REFERRALS
	Home Health Care
	Hospice Care
	Intimate Partner Abuse Guidelines for Victims of
	Inyo Mono Advocates for Community Action (IMACA)
	LONG TERM ACUTE CARE HOSPITAL
	Management of the Behavioral Health Patient (5150 and non-5150)
	MEALS ON WHEELS
	Mentally Ill Patients Detention of
	Ombudsman
	SKILLED NURSING FACILITIES
	Wild Iris Services (Victims Services)
	WORKING WITH OTHER AGENCIES IN THE COMMUNITY

Utilization Review:



Page 1 of 1 (5 items) « ‹ 1 › »

Type	Title
	CALIFORNIA CHILDREN SERVICES REFERRAL
	Home Health Care
	LONG TERM ACUTE CARE HOSPITAL
	Management of Discharge Disputes from Medicare Patients*
	Utilization Review Plan*