Northern Inyo Hospital

March 18 2020 Regular Meeting

March 18 2020 Regular Meeting - March 18 2020 Regular Me

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
March 18, 2020 at 5:30 p.m.
2957 Birch Street, Bishop, CA

Northern Inyo Healthcare District invites you to join this Webex meeting:

Link to Join the Meeting: https://nihd-it.my.webex.com/nihd-it.my/j.php?MTID=m09fb1ff7e2c9e3df6f3fd9f55254e3e6
Meeting number (access code): 627 680 945
Meeting password: fyN9rhHX

To Join by Phone: 1-510-338-9438
Access Code: 627 680 945

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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. Adjournment to Closed Session to/for (approximately 6pm):
   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*).
4. Return to Open Session and report of any action taken in Closed Session.
5. New Business:
   A. Building separation construction project change order funding (*action item*).
   B. Tier One Benefit Policy and Procedure approval (*action item*).
   C. Annual Compliance Program Review for Pioneer Home Health and Hospice of the Owens Valley (*action item*).

D. Approval of appointment of District Compliance Officer to be Corporate Compliance Officer for Pioneer Home Health (*action item*).

E. Pioneer Home Health update and request for ongoing support (*action item*).

F. COVID 19 (Coronavirus) update (*information item*).

G. Oral recommendation regarding proposed changes to salary and/or fringe benefits of Chief Operating Officer/Interim Chief Executive Officer (*action item*).

H. Approval of the purchase of BBraun Smartpump IV Pump and software licenses as discussed in attached contracts. (*action item).*

6. Old Business:
   A. Governance consultant update (*information item*).
   B. Pioneer Medical Associates Lease (*action item*).
   C. Compliance Department quarterly report (*action item*).
   D. Update on responses to NIHD Legal Services RFP (*information item*).
   E. Approve audit documents, Wipfli Management Representations and Subsequent Events, as submitted by Chief Financial Officer and authorize Chairperson to sign *(action item).*
7. Reports (*information items*):
   A. RHC Building update
8. Chief of Staff Report, William Timbers, MD:
   A. Medical Staff Appointment (*action item*):
      1. Casey Graves, MD (*emergency medicine*) – Provisional Active Staff
   B. Policy and Procedure approvals (*action items*):
      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*
   C. 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)*

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

Consent Agenda (action items)

9. Approval of minutes of the February 13 2020 special meeting
10. Approval of minutes of the February 18 2020 regular meeting
11. Financial and statistical reports as of January 2020
12. Policy and Procedure annual approvals
13. Interim Chief Executive Officer Report
14. Chief Operating Officer Report
15. Chief Nursing Officer Report
16. Chief Financial Officer Report

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17. Reports from Board members (*information items*).
18. 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.

Colombo Construction Co., Inc.
3211 Rio Mirada Dr.
Bakersfield, California 93308-4945
Phone: (661) 316-0100
Fax: (661) 316-0101

Project: 18-014 - NIHD HOSPITAL DECOM
150 Pioneer Lane
Bishop, California 93514

Prime Contract Potential Change Order #008: Additional Costs Due to Code Corrections & Unforeseens

TO:	Northern Inyo Healthcare District 150 Pioneer Lane Bishop, California 93514	**FROM:**	Colombo Construction Co Inc 3211 Rio Mirada Drive Bakersfield, California 93308-4945
PCO NUMBER/REVISION:	008 / 0	**CONTRACT:**	18-014.01 - NIHD HOSPITAL DECOM Prime Contract
REQUEST RECEIVED FROM:		**CREATED BY:**	Briana Wilkinson **(Colombo Construction Co Inc)**
STATUS:	Pending - In Review	**CREATED DATE:**	3/6/2020
REFERENCE:		**PRIME CONTRACT CHANGE ORDER:**	None
FIELD CHANGE:	No		
LOCATION:		**ACCOUNTING METHOD:**	Amount Based
SCHEDULE IMPACT:		**PAID IN FULL:**	No
		TOTAL AMOUNT:	$723,409.00

POTENTIAL CHANGE ORDER TITLE: Additional Costs Due to Code Corrections & Unforeseens

CHANGE REASON: No Change Reason

POTENTIAL CHANGE ORDER DESCRIPTION: *(The Contract Is Changed As Follows)*
CE #019 - Additional Costs Due to Code Corrections & Unforeseens
Additional Costs Due to Code Corrections & Unforeseens

ATTACHMENTS:

#	Cost Code	Description	Type	Amount
1	01-00-000 - General Conditions	General Conditions	Other	$218,969.00
2	16-00-901 - Electrical - Allowance 2	Fire Alarm System	Subcontracts	$104,440.00
3	09-21-900 - Mtl Stud & Gyp Bd - Allow	ACD 7	Subcontracts	$200,000.00
4	15-50-000 - Heat-Generation Equipment	Re-Route of Underground Utilities	Subcontracts	$200,000.00
			Subtotal:	$723,409.00
			Grand Total:	**$723,409.00**

Morris Davoudpour (RBB Architects Inc)

SIGNATURE **DATE**

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

SIGNATURE **DATE**

Colombo Construction Co Inc
3211 Rio Mirada Drive
Bakersfield, California 93308-4945

SIGNATURE **DATE**

PCO 008: Additional Cost Due to Code Corrections and Unforeseens			
Changes	Amount		Notes
Fire Alarm System	$	104,440.00	The Original plan only accounted for minimal fire alarm work, but during demo it was discovered that the system was being fed from the non compliant building. This required that a new code compliant system be added.
ACD 7 (Allowance)	$	200,000.00	ACD 7 covers the separation of an existing wall that was built around during the build out of building ICU building.
Re-route of Underground Utilities (Allowance)	$	200,000.00	This covers the re-route of underground utilities entering the building through an existing shear wall. Requiring additional excavation, piping, framing and plaster finishes.
Extended Time (GC'S)	$	218,969.00	This cover the cost for the added time caused by the added scope of work.
Total Add	$	723,409.00	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Tier One Benefit	
Scope: Northern Inyo Healthcare District Benefited Employees	Manual:
Source: CFO	Effective Date: 01/01/2020

PURPOSE:
Provide medical benefits of 100% coverage to benefited employees, and their covered dependents, for covered medical services received at Northern Inyo Healthcare District Hospital, or any Northern Inyo Healthcare District clinic, while covered under Northern Inyo Healthcare District's group health plans.

POLICY:
Effective, January 01, 2020, Permanent Part-Time, or Full-Time benefited employees, and their covered dependents, covered under one of Northern Inyo Healthcare District's group health plans, Basic Plus plan, or Basic plan, are covered under Tier One Benefit.

Tier One Benefit provides benefited employees, and their dependents insured with Northern Inyo Healthcare District group health, Basic Plus, or Basic, 100% coverage for covered medical services they receive at Northern Inyo Healthcare District Hospital, or at any Northern Inyo Healthcare District clinic.

PROCEDURE:
The Tier One Benefit is an automated process included in the covered claim original adjudication by the plan administrator.

There is no responsibility or action necessary by the employee or dependent.

REFERENCES:

Committee Approval:	**Date**
Revenue Cycle:	**02/19/2020**
Executive Committee:	**02/19/2020**
Board of Directors:	

Developed: 02/19/2020
Reviewed:
Revised:
Supercedes:

NIHD Board of Directors

Upon the request of Dr. Flanigan and Pat West (Administrator for PHH), I performed a Compliance Annual Report for Pioneer Home Health and Hospice of the Owens Valley (PHH & HOV). Since NIHD is the sole corporate member of the PHH corporation, I feel it is appropriate to present the Compliance Report for a District entity to the NIHD Board of Directors.

1. PHH & HOV Annual Compliance Program Review and Report, including an executive summary, is attached.
2. PHH & HOV Board appointed a Compliance Officer, as required by their Compliance Program. They selected the District Compliance Officer. If appropriate, please take action to confirm this appointment.
3. There are no specific instructions from the NIHD Board as to whether they would like to see the PHH & HOV Annual Compliance Program review and report. If the NIHD Board would like to see this report, please provide instruction or guidance to Compliance. The PHH & HOV Compliance Program has been amended to include a Compliance Program Review and Report no less than annually.
4. For proper accounting, a contract should be executed for Compliance work between NIHD and PHH & HOV.

3/4/2020

Pioneer Home Health & Hospice of the Owens Valley, Inc.

Annual Compliance Program Review and Report

Executive Summary

1. Records are well organized and maintained. Employees were very open and helpful
2. Pioneer Home Health Board of Directors needs to appoint a Corporate Compliance Officer
3. NIHD or PHH may want to seek a legal opinion regarding the placement of a PHH employee in the NIHD Interdisciplinary meeting
4. May want to update the Corporate Compliance Program verbiage for compliance reviews to "no less than annually" based on the size and resources of the corporation
5. PHH should post a phone number for anonymous compliance reporting
6. Recommend a coding audit within the next 6 months
7. Please review the required questions for the Board to discuss and document (2-039.14)
8. We have reviewed the Federal exclusions and State suspended and ineligible lists with Ms. Rogers and provided additional information to ensure this check occurs annual and for all employees, vendors, and contractors, etc.
9. Recommend completion of a Security Risk Assessment as required by HIPAA for all Covered Entities
10. Recommend a fax verification process be implemented
11. Recommend creation of a comprehensive list of Business Associate Agreements

8·18·2020

Pioneer Home Health & Hospice of the Owens Valley, Inc.

Annual Compliance Program Review and Report

1. Annual Review of the Corporate Compliance Plan, Policy 2-039 (attached)
    a. Need documentation for name of Corporate Compliance Officer
        i. Page 2-039.10 -"The Board of Directors shall appoint a Fraud and Abuse Corporate Compliance Officer from among the employees of the Agency who is not a member of the senior management team." (attached)
        ii. If the Board desires to appoint non-employee as Compliance Officer, the Plan will need to be amended.
        iii. Currently, NIHD Compliance Officer is performing review per Pat West, Administrator.
    b. Page 2-039.3 and 2-039.4 provides a list of potential violations. Specifically, but not limited to:
        i. Improper influence over referrals by hospitals that own home health agencies.
        ii. Providing hospitals with discharge planners, coordinators, or liaisons in order to induce referrals.
        iii. Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other.
    c. Page 2-039.11 (I) "The Corporate Compliance Officer will make reports to the board of Directors regarding compliance activities, risk areas, etc. on at least a quarterly basis. These reports will be documented in the minutes of the meetings of the Board of Directors.
        i. Unsure if the quarterly basis has been met in the past, will need to check Board minutes.
        ii. Prefer for actual compliance report to be attached to the Board Packet/Minutes.
        iii. May want to update verbiage to "no less than annually"
    d. Page 2-039.12 (M) " The Corporate Compliance Officer or Alternate Corporate Compliance Officer shall interview employees whose employment is terminating, preferably before their employment has actually terminated." Lists specific questions.
        i. Patty Dickson, District Compliance Officer, has not interviewed terminating employees.
        ii. Need to update plan.
    e. Page 2-039.12 (2B) – Employee reporting
        i. A compliance lockbox is located in a general and accessible area.
        ii. Need to post number for anonymous compliance reporting. If appropriate, PHH could ask the NIHD Board of Directors if PHH could share their anonymous reporting hotline.
        iii. There are no reported compliance concerns. Review whether the process works.
    f. Page 2-039.13 (4B) – The Board of Directors shall ensure that an audit is conducted at least annually by a neutral third party knowledgeable in the area of healthcare fraud and abuse to ensure compliance with applicable civil and criminal laws.
        i. Have not seen an audit by a neutral third party

g. Page 2-039.14 List of required questions for the Board of Directors to discuss and document in the Board Minutes.
h. Page 2-039.15 OIG list of individuals excluded... "the Agency will review this list at least annually and document the results of this review to help to ensure that no current employees, subcontractors, agents, or contractors are included on these lists.
    i. Exclusions have been reviewed for employees prior to hire. Just-in-time training was provided to Marianne Rogers regarding annual re-check for exclusions, in addition to the review of all vendors, contractors, and subcontractors.
    ii. Medi-Cal also requires that the CA Suspended and Ineligible list be checked. Provided education for Marianne Rogers regarding CA S&I lists.

2. HIPAA Security Risk Assessment (SRA) is mandatory for covered entities.
    a. Suggest requesting Security Officer and Privacy Officer for District complete SRA using tool provided by United States Department of Health and Human Services (HHS).
3. Pioneer Home Health Audit Checklist (Page 2-039.D) –
    a. Items of note
        i. #2 - one personnel file was missing an updated CPR document.
        ii. #8 - Diagnosis and billing codes could not be assessed as "accurately reflect[ing] patient's condition and coding rules.
            1. Documentation was reviewed and appears to match diagnosis codes.
            2. Would need to have certified home health/hospice coder audit.
        iii. #14 – Fiscal management policies need more in depth review to determine if they are being followed.
        iv. #17 – Evidence of HIPAA Compliance
            1. No fax verification process in place
            2. No reported breaches – staff members may need additional training on identifying potential breaches
4. Business Associate Agreements (BAA)
    a. There is not a comprehensive list of BAAs and contracts, as required by HIPAA/HITECH regulations.
    b. BAAs are created and are filed in a paper folder with contracts.
5. Personnel File Audit
    a. 6 employee files were audited
    b. 141 of 144 documents were located. Files are exceptionally well organized.
    c. 1 CPR card was expired. CPR was current, however, file had not been updated.
    d. 2 long-term employees were hired before exclusions were required to be checked. Exclusions for these two employees have been checked and placed into their files.
6. Record and Claim audits
    a. A review of a small sample of Home Health and Hospice charts demonstrated that documentation appears to be appropriate and in order. Notices, plans of care, documentation supporting visits, diagnosis, treatment, certification, face to face encounter with an attestation, homebound status and other required documents are readily accessible and legible.

Pioneer Home Health Care, Inc.

Corporate Compliance Audit Checklist

Date Completed: 1/24/2020

Adequate	Deficit		
✓		1.	Patient/family representative will receive, sign and acknowledge understanding of patient's rights
(98%)	✓ (2%)	2.	Personnel licenses, certifications, CPR are up to date
✓		3.	Signed/informed consent to elect Medicare Hospice Benefit is complete at/prior to SOC and reflects Local Coverage Determination eligibility
		4.	Required Face-to-Face encounters completed and signed timely
✓			a. Home Health – 90 days prior or 30 days after SOC
✓			b. Hospice – recertification prior to 180 days
✓		5.	Physician orders/plan of care signed timely
		6.	Treatment follows Plan of Care
✓			a. Home Health
✓			b. Hospice
		7.	Compliance with quarterly utilization review of charts shows patients needs being met
✓			a. Home Health
✓			b. Hospice
Not Assessed		8.	Diagnosis and billing codes accurately reflect patient's condition and coding rules
✓		9.	Hospice program is correctly providing all meds, medical supplies and equipment related to treatment of identified terminal illness
Not fully Assessed		10.	Hospice billing reflects appropriate level of care required
		11.	Documentation of Certified Home Health Aide supervision visits is done per time standards
Not fully Assessed			a. Home Health
Not Assessed			b. Hospice
✓		12.	Hospice documentation supports terminal illness/diagnosis
✓		13.	Regularly scheduled Hospice Interdisciplinary Group meeting occurs with proper documentation of coordination of patient's needs
Not Assessed		14.	Fiscal management policies are being followed
✓		15.	No kickback issues have been reported/found for purpose of inducing referrals
Not Assessed		16.	Hospice volunteer utilization is appropriate and done under adequate supervision
		17.	Evidence of HIPAA Compliance
✓			a. Patient records secure
	✓		b. Confidentiality maintained
✓			c. Business Agreements current

The audit was completed by: [signature] Patty Dickson

Comments on ~~reverse side:~~ next page ___✓___ Yes _____ No

S:\PHHC Secure Documents\phhcforms\2-039.D OM Corp Compliance Audit Chklst.docx

Identified Deficit:

① Need additional shred box.
② Will need external claim audit w/in next 6 mo.
③ Additional training re: breaches.
④ Fax verification process NOT in place.

#2 Personnel Files - 141/144 documents were correct
1 updated CPR card and 2 exclusions verifications
Missing out of 6 employee files audited

Plan of Correction:

☆ HR Records ~~are~~ organized and well-maintained.

Policy No. 2-039.1

PURPOSE

Agency is committed to prevention, detection, and to taking all appropriate action to assure compliance with all legal and regulatory statutes and to promote honest and ethical behavior in all work-related activities.

POLICY

Agency has established this plan to ensure that quality patient care is provided in a manner that fully complies with all applicable state and federal laws and regulations. It is the policy of Agency that (1) all employees are educated about the applicable laws and trained in matters of compliance, (2) there is periodic auditing, monitoring and oversight of compliance with those laws, (3) there exists an atmosphere that encourages and enables the reporting of non-compliance without fear of retribution, (4) responsibility is not delegated to persons with a propensity to act in a non-compliant manner, and (5) mechanisms exist to investigate, discipline and correct non-compliance.

The plan provides for the existence of a Corporate Compliance Officer (CCO) who has ultimate responsibility and accountability for compliance matters. **However, each individual employee of Agency remains responsible and accountable for his or her own compliance with applicable laws.** Confirmed acts of non-compliance will be disciplined, including termination.

COMPLIANCE

The Board of Directors and Management of the Agency recognizes that there are two (2) primary areas of potential fraud and abuse in the Medicare and Medicaid Programs that are particularly relevant to the Agency and, therefore, require specific efforts to ensure compliance: (1) Illegal remuneration or kickbacks and rebates and (2) False claims.

APPLICABLE STATUTES

Illegal Remuneration or Kickbacks and Rebates

1. Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind:

   A. in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or services for which payment may be made in whole or in part under this subchapter, or

   B. in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under this subchapter,

   shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

2. Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person:

   A. to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

   B. to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter,

   shall be fined not more than $25,000 or imprisoned for not more than five years, or both..."

False Claims

Whoever--

1. knowingly and willfully makes or causes to be made any false statement or a representation of a material fact in any application for any benefit or payment under this subchapter,

2. at any time knowingly and willfully makes or causes to be made any false statement or representation of material fact for use in determining rights to any such benefit or payment,

3. having knowledge of the occurrence of any event affecting (A) the initial or continued right to any payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

4. having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall

   A. in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this subchapter, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or

   B. in the failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year or both

Policy No. 2-039.3

POTENTIAL VIOLATIONS

Management and the members of the Board of Directors recognize and acknowledge that the following activities may constitute potential fraudulent and/or abusive conduct:

- Claims for home care and hospice services provided to Medicare/Medicaid beneficiaries who do not meet the criteria of the benefit such as claims for services to ineligible patients, including those who are not homebound and/or do not have a skilled need or do not have a life expectancy of six (6) months or less. Patients are not admitted who do not need home health or hospice care and who do not meet all of the requirements of the Medicare and/or Medicaid Programs for the home care and hospice benefit and other payors.

- Claims for services that were never provided, including services rendered by subcontractors.

- Inadequate management and oversight of subcontracted services that results in improper billing.

- Discriminatory admission and discharge of patients.

- Billing for unallowable costs associated with the acquisition and sale of home health agencies and hospices.

- Making unreasonable and unnecessary visits in violation of compensation programs that may be based on the number of visits performed and/or revenue generated. Practitioners will not make unnecessary visits in order to obtain an episodic payment under the Prospective Payment System (PPS) instead of a LUPA.

- Improper influence over referrals by hospitals that own home health agencies.

- Patient abandonment in violation of applicable statutes, regulations, and federal health care program requirements.

- Knowing misuse of provider certification numbers resulting in improper billing.

- Knowing and reckless disregard of willing and able caregivers when providing home health services. When family members or other persons are providing or will provide services that adequately meet a patient's needs, it is unreasonable and unnecessary for the Agency to furnish such services. Therefore, if the Agency has firsthand knowledge of a person who is able and willing to provide the services being rendered by the Agency, or patients or their families object to the provision of services, the Agency will not provide or bill for such services.

- Failure to adhere to licensing requirements applicable to the Agency and Medicare Conditions of Participation (COP's), including requirements for criminal background checks, if any.

- Failure to return overpayments made by federal health care programs within sixty (60) calendar days of discovery.

- Failure to provide for sufficient and timely documentation of all services, including services provided by subcontractors, *prior* to billing to ensure that only accurate and timely documented services are billed.

- A pattern of duplicate claims submitted for the same service that are not isolated instances and are not mistakes in billing.

- Claims for services that health care providers know were medically unnecessary. Billing for medically unnecessary services involves knowingly seeking reimbursement for a service that is not warranted by the patient's current and documented medical condition, i.e. overutilization.

- Claims for services not authorized by a physician or other appropriately licensed individual. Claims are submitted only for services that were ordered by physicians or other appropriately licensed individuals. Prior to billing for services, the plan of care is established, dated, and signed by a qualified physician or other appropriately licensed individual.

- Placement of patients in inappropriate Home Health Resource Groups (HHRG's) in order to receive a higher level of reimbursement.

- Claims for inappropriate care, even if authorized by a physician. The Agency will not file claims for services that are not provided consistent with orders from physicians and other practitioners that are based on medically unnecessary or inappropriate care.

- Violations of patients' right to freedom of choice of providers.

- Payments to physicians for each plan of care signed by physicians.

- Disguising referral fees as salaries by paying referring physicians or their family members for services not rendered or in excess of fair market value for services actually rendered.

- Providing hospitals with discharge planners, coordinators, or liaisons in order to induce referrals.

- Offering free services or services at or below fair market value, such as transportation and meals, to beneficiaries if they agree to receive services or switch providers. Agency staff will not engage in prohibited or inappropriate conduct to carry out their initiatives and activities designed to maximize business growth and patient retention. Information offered by the Agency to patients is generally clear, correct, non-deceptive, and fully informative.

- Providing free services to retirement homes, physicians, hospitals, adult congregate living facilities, nursing facilities, and other potential referral sources in return for referrals.

- Subcontracting with retirement homes or adult congregate living facilities for provision of services to induce the facility to make referrals to the Agency.

- Billing for services provided based upon inaccurate or incomplete documentation. The Agency will not bill for services when there is insufficient documentation to evidence that services were performed and to support reimbursement. Such documentation must be appropriately organized in a legible form and available for audit and review. Documentation must record the activity leading to the entry in patients' medical records, the identity of individuals providing the services, and any information needed to support medical necessity and other applicable reimbursement coverage criteria.

- Claims for items on cost reports submitted to the Medicare/Medicaid Programs including:

  - Salaries paid to employees and/or consultants who do not exist.

  - Lumping non-patient-related expenses with patient-related expenses in an attempt to bury non-reimbursable costs.

  - Inappropriate shifting of non-Medicare related costs to Medicare cost centers.

  - Failure to properly disclose the existence of related organizations/parties.

  - Claiming costs that are not reimbursable, unreasonable, and based on inappropriate and inaccurate documentation.

  - Inaccurate allocation of costs to various cost centers that are unsupported by verifiable and auditable data.

  - Failure to analyze accounts that contain both allowable and unallowable costs to determine the unallowable amounts that should not be claimed for reimbursement.

  - Improper classification of costs.

  - Failure to implement Medicare fiscal intermediary audit adjustments made in previous years, and to either not claim reimbursement or, if claimed for reimbursement, clearly identify such items as protested amounts on the cost report.

  - Failure to make allocations accurately and to adequately support such allocations by verifiable and auditable data.

  - Claims for management fees that are not reasonable or necessary, or that include unallowable costs.

  - Failure to properly reflect return of overpayments in cost reports.

- Failure to notify the Agency's intermediary promptly in writing of errors discovered after submission of the Agency's cost reports.

- Filing improper claims for services to individuals in assisted living facilities when the Agency has not done all of the following:

  - Contacted appropriate state licensing authorities to determine any applicable state licensure and service requirements for the specific facilities involved.

  - Made reasonable attempts to verify the specific license(s), if any, held by the facility.

  - Requested to review the service agreements between the facility and patients during the initial assessment visit to determine the extent and type of services that facilities are contractually obligated to provide to residents.

  - Provided home health services to residents only to the extent that they are appropriate and not duplicative of those services provided or required to be provided by facilities.

- Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other.

- Violations of the Stark physician self-referral law. The Agencies will not provide services certified or recertified by physicians who have a significant ownership interest in or a significant financial or contractual relationship with the Agency, unless appropriate criteria are met.

- Failure to refund credit balances. A credit balance is an improper or excess payment made to a health care provider that may occur as a result of patient billing or claims processing errors.

- Underutilization of home care services, i.e. knowing denial of needed care in order to keep costs low.

- Billing for inadequate or substandard care.

- Billing for services provided by unqualified or unlicensed clinical personnel.

- False dating of amendments to nursing notes or other documents in patients' medical records.

- Falsified plans of care.

- Untimely and/or forged physician certifications on plans of care.

- Forged beneficiary signatures on visit slips/logs that are intended to verify services that were performed.

- Improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services.

- Failure to ensure that claims for reimbursement are based on patients' medical records and other documentation, and are in compliance with all applicable official coding rules and guidelines, any Centers for Medicare and Medicaid (CMS) Common Procedure Coding System (HCPCS), International Classification of Disease (ICD), Home Health Agency's Current Procedural Terminology (CPT) or revenue code or successor codes used by the billing staff accurately describe services ordered by physicians and performed by staff. Documentation necessary for accurate billing is available to billing staff.

- Compensation for billing staff and consultants that includes financial incentives to submit claims, regardless of whether they meet applicable coverage criteria for reimbursement or accurately represent the services rendered.

- Failure to establish and maintain a process for pre- and/or post-submission review of claims to ensure that claims submitted for reimbursement accurately represent medically necessary services actually provided, supported by sufficient documentation, and in conformity with any applicable coverage criteria for reimbursement. The Agency will review a valid sample of claims before and/or after billing is submitted.

- Informing Medicare beneficiaries that Medicare will no longer pay for services because the patient no longer meets the eligibility criteria of the Medicare home health benefit when there are current orders from the patient's attending physician, without providing an Advance Beneficiary Notice to the patient.

- Discharging patients for inappropriate reasons before the plan of care is complete.

- Refusing to admit certain Medicare patients based on payment rates while admitting similar non-Medicare patients.

- Modifications to patients' plans of care without physicians' orders.

- Performing therapy visits regardless of diagnosis or medical necessity.

- Misinforming patients about what the Medicare Program covers.

- Failing to base diagnosis and procedures codes for home health services as reported on the reimbursement claim form on the beneficiary's medical record, OASIS assessments, and other documentation.

- Compensating independent contractors who provide marketing services to the Agency on a commission-only basis.

- Submission of RAP's prior to receipt of verbal orders from physicians.

- Submission of final claims prior to receipt of signed orders from physicians.
- Failure to immediately self-disclose violations to regulators if there is:
  - A clear violation of criminal law;
  - A significant adverse effect on the quality of care provided to Program beneficiaries; or
  - Evidence of a systemic failure to comply with applicable laws or an existing corporate integrity agreement, regardless of the financial impact on federal health care programs.
- Inappropriate payments under Part B of the Medicare Program for services and medical supplies.
- Inappropriate outlier payments from the Medicare Program, especially for insulin injections.
- Inappropriate provision of diabetes self-management services.
- Submission of inaccurate and/or incomplete OASIS data.
- Using a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
- Knowingly making or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services under a federal health care program.
- Obstructing any government investigation or audit.
- Miscoding of resource group codes.
- Failure to comply with requirements regarding face-to-face encounters and documentation of face-to-face encounters.
- Failure to perform periodic therapy assessments required by payors.
- High average outlier payment amounts per beneficiary.
- High number of visits per beneficiary, i.e. more than ninety-one (91) visits per beneficiary.
- High number of late episodes per beneficiary i.e. billing for more than two (2) late episodes per beneficiary.
- High number of therapy visits per beneficiary that exceed twenty-four (24) therapy visits per beneficiary.

- High payments per beneficiary that exceed eleven thousand six hundred fifty-three dollars ($11,653) per beneficiary.
- High average number of therapy visits per beneficiary, i.e. more than sixty-one percent (61%) of beneficiaries for whom other HHA's billed Medicare.
- Failure to make changes to OASIS assessments consistent with guidance from the Centers for Medicare and Medicaid Services (CMS).
- Overlap in the services that nursing homes provide which results in insufficient care provided by the Agency to nursing home residents receiving hospice care.
- Improper relinquishment of core hospice services and professional management responsibilities to nursing homes, volunteers and privately-paid professionals.
- Providing hospice services in nursing homes before written agreements have been finalized, if required.
- Sales commissions based on length of stay in hospice.
- Deficient coordination of hospice volunteers.
- Improper indication of locations where hospice services were delivered.
- Non-response to late hospice referrals from physicians.
- Pressure on patients to revoke the Medicare Hospice Benefit when patients are still eligible for and desire care, but the care has become too expensive for the hospice to deliver it.
- Inadequate or incomplete services rendered by the hospice Interdisciplinary Group.
- Incentives to actual or potential referral sources such as physicians, nursing homes, hospitals patients, etc. that may violate the anti-kickback statute or other similar Federal or State statute or regulation, including improper arrangements with nursing homes.
- Insufficient oversight of patients especially patients receiving more than six (6) consecutive months of hospice care.
- Uninformed consent to elect the Medicare Hospice Benefit.
- Arrangement with other health care providers who the Agency knows are submitting claims for services already covered by the Medicare Hospice benefit.

Policy No. 2-039.10

PROCEDURE

1. Assignment and duties of the Corporate Compliance Officer (CCO).

   The Board of Directors and Management have agreed that the following actions are appropriate in order to prevent and/or correct potential violations:

   A. The Board of Directors shall appoint a Fraud and Abuse Corporate Compliance Officer from among the employees of the Agency who is not a member of the senior management team. The Chief Financial Officer shall not serve as the Compliance Officer under any circumstances.

   B. Corporate Compliance Officer shall receive specialized training related to types of violations and effective tools to utilize to avoid fraudulent or abusive conduct.

   C. Corporate Compliance Officer shall know and understand all aspects of the Corporate Compliance Plan.

   D. Corporate Compliance Officer shall take action to identify potential fraudulent and/or abusive activity in the Medicare/Medicaid Programs.

   E. The Corporate Compliance Officer shall also receive information from other employees regarding potential violations. Verbal reports shall be promptly reduced to writing by the Corporate Compliance Officer. The anonymity of reporting employees will be protected to the maximum extent possible consistent with appropriate compliance activities. No promises will be made to the party making the disclosure regarding liability or what steps the Agency may take in response to the report of wrongdoing. Retaliation against individuals who make reports is not permitted.

   F. The Corporate Compliance Officer shall have the authority to conduct internal investigations of alleged violations independent of influence by the Board of Directors and Management. Internal investigations shall ordinarily be completed within sixty (60) calendar days from the date on which the Corporate Compliance Officer received initial information regarding a potential violation. Overpayments, if any, will be reported and repaid to applicable government contractors, intermediaries, carriers, state or the Secretary of the Department of Health and Human Services (HHS) within sixty (60) days after the overpayment is identified or the date any corresponding cost report is due, whichever is later.

   G. Corporate Compliance Officer shall prepare written reports of the results of investigations that, at a minimum, shall include the following information:

      - Description of how the practice was identified and the origin of the information that led to the disclosure.

- Description of efforts to investigate and document the practice, such as use of internal or external legal and/or audit resources.

- Detailed description and chronology of the investigative steps taken in connection with the Corporate Compliance Officer's inquiries into the potential violation, including:

    - A list of all individuals interviewed; the dates of those interviews; the subject matter of each interview; business and home addresses and telephone number of each witness interviewed; and the positions and titles in the Agency, both currently and during the relevant time period.

    - A description of the files, documents, and records reviewed.

    - A summary of auditing activity undertaken and a summary of the documents relied upon in support of cost impact determinations, if any.

H. Based upon this review, the Corporate Compliance Officer shall make recommendations directly to the Administrator and the Board of Directors regarding corrective actions needed in order to prevent or remedy possible fraudulent or abusive conduct, including, but not necessarily limited to, disciplinary action that may be reasonably imposed on responsible employees consistent with the Agency's policy on progressive discipline and restitution to the Government. Disciplinary action may be taken that includes termination for violation of these policies and/or requirements.

I. The Corporate Compliance Officer will make reports to the Board of Directors regarding compliance activities, risk areas, etc. on at least a quarterly basis. These reports will be documented in the minutes of the meetings of the Board of Directors.

J. The Corporate Compliance Officer shall be responsible for continuous education of the staff regarding compliance. These activities may include, but are not necessarily limited to: bulletins with compliance updates and reminders, distribution of audiotapes or videotapes on various risk areas, lectures at management and employee meetings, and circulation of recent health care articles covering fraud and abuse in the health care industry.

K. The Corporate Compliance Officer may delegate responsibilities under the Corporate Compliance Plan in writing only to persons reasonably believed to be morally fit, honest, and capable of making judgments called for in the Corporate Compliance Plan, including an Alternate Corporate Compliance Officer.

L. The Corporate Compliance Officer shall bring to the attention of Legal Counsel all changes in circumstances that could reasonably suggest that the Plan should be modified.

M. The Corporate Compliance Officer or Alternate Corporate Compliance Officer shall interview employees whose employment is terminating, preferably before their employment has actually terminated. These interviews are in addition to those exit conferences that may be conducted by human resources and other staff. At a minimum, the Corporate Compliance Officer/Alternate Corporate Compliance Officer should ask each departing employee the following questions:

- Have you ever been asked to engage in conduct that you believe was either unethical or illegal? If so, please provide details.
- Have you ever witnessed conduct by an employee, contractor, or agent of the Agency that you believe was unethical or illegal? If so, please provide the names of the individuals involved and details of the conduct you observed.
- Have you ever removed Agency documents, including those created by you, without returning them to the Agency? If so, do you still have the documents? If so, the Corporate Compliance Officer will ask the individual to return them to the Agency immediately.
- Have you ever given Agency documents to a non-Agency employee other than for business reasons, or to a contractor or agent of the Agency? If so, to whom?
- While employed by the Agency, did you or any family member own, operate, invest in, assist, or otherwise have an interest in any company or enterprise that competed with the Agency or with which the Agency had a business relationship?
- Have you ever engaged in conduct that you believe was either unethical or illegal? If so, please describe that conduct.
- What recommendations can you make for improving the Agency?

N. At the end of the interview, the Corporate Compliance Officer/Alternate Corporate Compliance Officer will ask each departing employee to complete and sign a form confirming the results of the interview. The Corporate Compliance Officer shall also promptly document the results of every exit conference. This documentation shall be kept confidential to the greatest extent possible consistent with this Corporate Compliance Plan.

2. Employee Reporting

A. All employees have the responsibility to comply with applicable laws and regulations and to report any acts of non-compliance.

B. Any employee who perceives or learns of an act of non-compliance should either speak to his/her supervisor, call the CCO, or place information in the Corporate

Compliance lockbox located in an easily accessible area. Supervisors are required to report these issues through established management channels and/or the CCO. Reports may be made anonymously, although giving a name and phone number generally makes investigating reports easier and more effective. All employees are encouraged to call the CCO if they have any question about whether their concern should be reported. A written record of every report received will be kept for a period of six (6) years. Every effort will be made to preserve the confidentiality of reports of non-compliance (although calls made anonymously will always preserve the autonomy of the caller). All employees must understand, however, that circumstances may arise in which it is necessary or appropriate to disclose information. In such cases, disclosures will only be made as necessary.

C. All employees are required to report acts of non-compliance. Any employee found to have known of such acts, but who failed to report them, will be subject to discipline.

D. No employee shall, in any way, retaliate against another employee for reporting an act of non-compliance. Acts of retaliation should also be reported to the lockbox and will be investigated by the CCO or his/her designee. Any confirmed act of retaliation shall result in discipline.

3. Performance Improvement (PI).

A. Management and employees responsible for PI activities within the Agency shall develop appropriate risk indicators to continuously monitor, evaluate, detect, and remedy circumstances that led to commission of fraudulent or abusive conduct.

B. Monitoring activities shall include, at a minimum, both concurrent and retrospective review of patients' charts for appropriateness of patients for the Medicare benefit and appropriate utilization of therapy services.

C. Both Management and the Board of Directors shall receive regular written reports on PI activities related to prevention and/or correction of possible fraudulent or abusive conduct.

4. Board of Directors

A. The Board of Directors shall be charged with responsibility to ensure that the Agency complies with all civil and criminal laws pertaining to health care fraud.

B. The Board of Directors shall ensure that an audit is conducted at least annually by a neutral third party knowledgeable in the area of healthcare fraud and abuse to ensure compliance with applicable civil and criminal laws.

C. The Board of Directors shall review the Corporate Compliance Plan at least annually and shall make appropriate modifications to the Plan in consultation with Legal

Counsel. At a regularly scheduled meeting of the Board of Directors, on at least an annual basis, the members of the Board of Directors will address the following questions as reflected in minutes of meetings of the Board of Directors:

- How is the Compliance Program structured and who are the key employees responsible for its implementation and operation? How is the Board structured to oversee compliance issues?

- How does the Agency's compliance reporting system work? How frequently does the Board receive reports about compliance issues?

- What are the goals of the Agency's compliance program? What are the inherent limitations in the compliance program? How does the Agency address these limitations?

- Does the compliance program address the significant risks of the Agency? How were those risks determined and how will new compliance risks be identified and incorporated into the Program?

- What will be the level of resources necessary to implement the compliance program as envisioned by the Board? How has management determined the adequacy of the resources dedicated to implementing and sustaining the compliance program?

- How has the Plan been incorporated into corporate policies across the Agency? How does the Board know that the Plan is understood and accepted across the Agency? Has management taken affirmative steps to publicize the importance of the Plan to all its employees?

- Has the Agency implemented policies and procedures that address compliance risk areas and establish internal controls to counter those vulnerabilities?

- Does the Compliance Officer have sufficient authority to implement the compliance program? Has management provided the Compliance Officer with autonomy and sufficient resources necessary to perform assessments and respond appropriately to misconduct?

- Have compliance-related responsibilities been assigned across the appropriate levels of the Agency? Are employees held accountable for meeting these compliance-related objectives during performance reviews?

- What is the scope of compliance-related education and training across the organization? Has the effectiveness of such training been assessed? What policies/procedures have been developed to enforce training requirements and to provide remedial training as warranted?

- How is the Board kept apprised of significant regulatory and industry developments affecting the Agency's risk? How is the compliance program structured to address such risks?

- How are "at risk" operations assessed from a compliance perspective? Is conformance with the Agency's program periodically evaluated? Does the Agency periodically evaluate the effectiveness of the compliance program?

- What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?

- What is the process by which the Agency evaluates and responds to suspected compliance violations? How is the reporting system monitored to verify appropriate resolution of reported matters?

- Does the Agency have policies that address the appropriate protection of "whistleblowers" and those accused of misconduct?

- What is the process by which the Agency evaluates and responds to suspected compliance violations? What policies address the protection of employees and the preservation of relevant documents and information?

- What guidelines have been established for reporting compliance violations to the Board?

- What policies govern the reporting to government authorities of probable violations of the law?

D. At a regularly scheduled meeting of the Board of Directors, on at least an annual basis, the members of the Board of Directors will also address the Agency's Quality Improvement Program.

5. Training and Education of All Employees

A. The Agency will not employ, retain, or contract with individuals who have been convicted of a crime involving fraudulent or abusive conduct or suspended or excluded from participation in the Medicare/Medicaid Programs or other federal health care programs. The Agency will check the OIG list of individuals excluded from participation in federal health prior to hiring staff members. The results of this review will be documented in the personnel file of any individuals who are employed by the Agency. Likewise, the Agency will review this list at least annually and document the results of this review to help to ensure that no current employees, subcontractors, agents, or contractors are included on these lists.

B. Agency staff will conduct a reasonable and prudent background investigation prior to offering permanent employment to employees.

C. As a condition of employment, new employees will sign an affirmative statement that they are not under investigation or suspended or excluded from participation in the Medicare/Medicaid or other state and federal health care programs. All employees will sign a statement that they will inform the Agency in writing if they are under investigation for alleged fraud and abuse or if they are suspended or excluded from participation in the Medicare/Medicaid Programs or other state or federal programs.

D. All current and new employees of the Agency shall sign an acknowledgement that they have reviewed a copy of the Corporate Compliance Plan and have read and understood it, as a condition of initial or continued employment. Each time revisions are made to the Compliance Plan or additional policies and procedures related to implementation of the Plan are adopted, every employee will be provided a written copy of the revised Plan or new policy and procedure for review. In order to continue their employment at the Agency, employees will be required to sign an acknowledgement indicating that they have received, read, and understood the revision and/or policies and procedures. The Agency will retain all such acknowledgements in a separate file that shall be reviewed by the Corporate Compliance Officer.

E. At least annually, all employees of the Agency shall receive training and education regarding potential fraudulent and abusive activity. Participation in such training is a condition of continued employment. Failure to participate in training activities may result in disciplinary action, up to and including termination of employment. Adequate records of such training, including attendance logs and copies of materials distributed at such training sessions, will be maintained in inservice meeting attendance and minutes.

F. Adherence to the Compliance Program shall be one (1) element used to evaluate all employees of the Agency.

G. Managers and supervisors will be sanctioned for failure to adequately instruct their subordinates or for failing to detect noncompliance with applicable policies and requirements when reasonable diligence on the part of managers or supervisors would have led to the discovery of any problems or violations and given the Agency the opportunity to correct them earlier.

6. Relationships with Independent Contractors

A. A copy of the then current Corporate Compliance Plan shall be provided to each independent contractor of the Agency.

B. Each independent contractor will sign an acknowledgement that states that he/she has read and understands the Corporate Compliance Plan of the Agency. The receipt of this signed statement shall be a prerequisite to payment for services rendered and/or continuation of contractual relationships.

7. Retention of Records

A. The Agency will develop and/or maintain policies and procedures for the creation, distribution, retention, storage, retrieval, and destruction of documents related to compliance and the requirements of the Corporate Compliance Plan.

B. Records are maintained for the length of time required by federal and state law and private payors, or by the Agency's records retention policies, whichever is longer, including:

- All records and documentation required either by Federal or State law for participation in Federal health care programs or other applicable Federal and State laws and regulations; all records necessary to protect the integrity of the Agency's compliance process and confirm the effectiveness of the Program; documentation that employees were adequately trained; reports of potential noncompliance, including the nature and result of any investigation that was conducted; documentation of corrective action, including any disciplinary action taken; and policy improvement introduced in response to any internal investigation or audit, modifications to the compliance program, self-disclosures, and the results of auditing and monitoring efforts.

8. Self Disclosure of Violations.

A. If the Agency self-reports violations to regulators, the Agency will provide the following information:

- A complete description of the circumstances surrounding the overpayment.

- A full explanation of how review criteria used to identify violations were determined.

- A complete explanation of how the problem was corrected.

9. Compliance with Deficit Reduction Act (DRA).

A. If the Agency receives annual payments from the State Medicaid Program of at least $5,000,000.00, as a condition of receiving such payments, the Agency shall:

- Establish written policies for all employees of the Agency; including management, and any contractor or agent of the Agency; that provide detailed information about the False Claims Act, any State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, abuse in Federal health care programs. The Agency will include as part of such written policies, detailed provisions regarding the Agency's policies and procedures for detecting and preventing fraud, waste and abuse; and include in any employee handbook for the entity, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers and the Agency's policies and procedures for detecting and preventing fraud, waste, and abuse.

Modifications to this Corporate Compliance Plan may be made only upon a vote of an appropriate number of the members of the Board of Directors of Pioneer Home Health Care, Inc.

ACHC HSP 2-9A.01, 3-4D.01

Addendum 2-039.A

Employee/Volunteer Acknowledgement of the Corporate Compliance Plan

Pioneer Home Health Care, Inc.

Employee/Volunteer Acknowledgement of the Corporate Compliance Plan

Employee/Volunteer Name (printed): _____

Re: Corporate Compliance Plan, Policy # 2-039

I, _____, have received a copy of the Pioneer Home Health Care, Inc. Corporate Compliance Plan, Policy # 2-039.

I have read, understand, and will abide by the Plan.

_____ _____

Employee/Volunteer Signature Date

Addendum 2-039.A

Independent Contractor Acknowledgement of the Corporate Compliance Plan

Pioneer Home Health Care, Inc.

Independent Contractor Acknowledgement of the Corporate Compliance Plan

Contractor Name (printed): _____

Re: Corporate Compliance Plan, Policy # 2-039

On behalf of _____,

I, _____, have received a copy of the Pioneer Home Health Care, Inc. Corporate Compliance Plan, Policy # 2-039.

I have read, understand, and will abide by the Plan relative to the contract with Pioneer Home Health Care, Inc.

I understand that this signed statement shall be a prerequisite to payment for services rendered and/or continuation of the contractual relationships.

_____ _____

Independent Contractor Signature Date

Addendum 2-039.C

Corporate Compliance Report

Pioneer Home Health Care, Inc.

Corporate Compliance Report

(confidential)

Report Date: _____ Received by: _____

Made by: _____

Method of Reporting: ☐ In Person ☐ Telephone Contact ☐ Letter Contact/Drop Box

Full description of issue (use back of form if necessary):

_____

_____

_____

_____

_____

_____

Action Taken by Corporate Compliance Officer:

☐ Not a compliance issue - redirect individual to appropriate manager. Discuss with Administrator/CEO.

☐ Begin investigative process (describe process below)

☐ Share on a need-to-know basis. List individuals who have knowledge of incident

☐ Contact legal counsel

Comments:

_____

_____

_____

_____

Resolutions:

☐ Re-education effort Date completed: _____

☐ Disciplinary action Date completed: _____

☐ Changes in Policy/Procedure Date completed: _____

☐ Disclosure to appropriate Agency Date completed: _____

Comments:

_____

_____

_____

_____

Addendum 2-039.D

Corporate Compliance Audit Checklist

Pioneer Home Health Care, Inc.

Corporate Compliance Audit Checklist

Date Completed: _____

Adequate	Deficit		
_____	_____	1.	Patient/family representative will receive, sign and acknowledge understanding of patient's rights
_____	_____	2.	Personnel licenses, certifications, CPR are up to date
_____	_____	3.	Signed/informed consent to elect Medicare Hospice Benefit is complete at/prior to SOC and reflects Local Coverage Determination eligibility
		4.	Required Face-to-Face encounters completed and signed timely
_____	_____		a. Home Health – 90 days prior or 30 days after SOC
_____	_____		b. Hospice – recertification prior to 180 days
_____	_____	5.	Physician orders/plan of care signed timely
		6.	Treatment follows Plan of Care
_____	_____		a. Home Health
_____	_____		b. Hospice
		7.	Compliance with quarterly utilization review of charts shows patients needs being met
_____	_____		a. Home Health
_____	_____		b. Hospice
_____	_____	8.	Diagnosis and billing codes accurately reflect patient's condition and coding rules
_____	_____	9.	Hospice program is correctly providing all meds, medical supplies and equipment related to treatment of identified terminal illness
_____	_____	10.	Hospice billing reflects appropriate level of care required
		11.	Documentation of Certified Home Health Aide supervision visits is done per time standards
_____	_____		a. Home Health
_____	_____		b. Hospice
_____	_____	12.	Hospice documentation supports terminal illness/diagnosis
_____	_____	13.	Regularly scheduled Hospice Interdisciplinary Group meeting occurs with proper documentation of coordination of patient's needs
_____	_____	14.	Fiscal management policies are being followed
_____	_____	15.	No kickback issues have been reported/found for purpose of inducing referrals
_____	_____	16.	Hospice volunteer utilization is appropriate and done under adequate supervision
		17.	Evidence of HIPAA Compliance
_____	_____		a. Patient records secure
_____	_____		b. Confidentiality maintained
_____	_____		c. Business Agreements current

The audit was completed by: _____

Comments on reverse side: _____ Yes _____ No

Identified Deficit:

Plan of Correction:

Addendum 2-039.E

Corporate Compliance Employee Exit Interview

Pioneer Home Health Care, Inc.

Corporate Compliance Employee Exit Interview

1. Have you ever been asked to engage in conduct that you believe was either unethical or illegal? If so, please provide details.

2. Have you ever witnessed conduct by an employee, contractor, or agent of the Agency that you believe was unethical or illegal? If so, please provide the names of the individuals involved and details of the conduct you observed.

3. Have you ever removed Agency documents, including those created by you, without returning them to the Agency? If so, do you still have the documents? If so, the Corporate Compliance Officer will ask the individual to return them to the Agency immediately.

4. Have you ever given Agency documents to a non-Agency employee other than for business reasons, or to a contractor or agent of the Agency? If so, to whom?

5. While employed by the Agency, did you or any family member own, operate, invest in, assist, or otherwise have an interest in any company or enterprise that competed with the Agency or with which the Agency had a business relationship?

6. Have you ever engaged in conduct that you believe was either unethical or illegal? If so, please describe that conduct.

7. What recommendations can you make for improving the Agency?

I confirm the results of the interview.

_____
Exiting Employee Name (printed)

_____ _____
Exiting Employee Signature Date

The interview was completed by: _____

Issues of Concern:

Identified Deficit:

Plan of Correction:

Addendum 2-039.F

Annual Corporate Compliance Plan Audit

Pioneer Home Health Care, Inc.
Annual Corporate Compliance Plan Audit

1. How is the Compliance Program structured and who are the key employees responsible for its implementation and operation? How is the Board structured to oversee compliance issues?

2. How does the Agency's compliance reporting system work? How frequently does the Board receive reports about compliance issues?

3. What are the goals of the Agency's compliance program? What are the inherent limitations in the compliance program? How does the Agency address these limitations?

4. Does the compliance program address the significant risks of the Agency? How were those risks determined and how will new compliance risks be identified and incorporated into the Program?

5. What will be the level of resources necessary to implement the compliance program as envisioned by the Board? How has management determined the adequacy of the resources dedicated to implementing and sustaining the compliance program?

6. How has the Plan been incorporated into corporate policies across the Agency? How does the Board know that the Plan is understood and accepted across the Agency? Has management taken affirmative steps to publicize the importance of the Plan to all its employees?

7. Has the Agency implemented policies and procedures that address compliance risk areas and establish internal controls to counter those vulnerabilities?

8. Does the Compliance Officer have sufficient authority to implement the compliance program? Has management provided the Compliance Officer with autonomy and sufficient resources necessary to perform assessments and respond appropriately to misconduct?

9. Have compliance-related responsibilities been assigned across the appropriate levels of the Agency? Are employees held accountable for meeting these compliance-related objectives during performance reviews?

10. What is the scope of compliance-related education and training across the organization? Has the effectiveness of such training been assessed? What policies/procedures have been developed to enforce training requirements and to provide remedial training as warranted?

11. How is the Board kept apprised of significant regulatory and industry developments affecting the Agency's risk? How is the compliance program structured to address such risks?

12. How are "at risk" operations assessed from a compliance perspective? Is conformance with the Agency's program periodically evaluated? Does the Agency periodically evaluate the effectiveness of the compliance program?

13. What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?

14. What is the process by which the Agency evaluates and responds to suspected compliance violations? How is the reporting system monitored to verify appropriate resolution of reported matters?

15. Does the Agency have policies that address the appropriate protection of "whistleblowers" and those accused of misconduct?

16. What is the process by which the Agency evaluates and responds to suspected compliance violations? What policies address the protection of employees and the preservation of relevant documents and information?

17. What guidelines have been established for reporting compliance violations to the Board?

18. What policies govern the reporting to government authorities of probable violations of the law?

_____

Printed Name of Board Member

_____ _____

Signature of Auditing Board Member Date

Addendum 2-039.G

Annual OIG Audit

Pioneer Home Health Care, Inc.
Annual OIG Audit

For Year:

Employee, Volunteer, or Contractor Full Name	Date Audited	Listed on OIG ? Yes	No	Comments/Followup

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Subsequent Events Representation Letter

Wipfli LLP
201 W. North River Drive, Suite 400
Spokane, Washington 99201

We are writing to confirm that Northern Inyo Healthcare District had none of the following events occur during the time period starting with our most recent fiscal year-end June 30, 2019 to the date of the letter. There have been no:

1. Subsequent settlements of a contingent liability or litigation at an amount that is different from the amount recorded in the draft year-end financial statements, if applicable.

2. New (previously undisclosed to Wipfli LLP) pending or threatened litigation, claims, or assessments, or unasserted claims or assessments.

3. Substantive consultations with the attorneys, selected for confirmation by you, since the effective date of the respective legal confirmations.

4. Material adverse changes in financial position of the District since year-end.

5. Material changes to any significant estimates in the draft year-end financial statements.

6. Sales of any assets subsequent to year-end at a price significantly less than the carrying value in the draft financial statements.

7. Shutdowns or strikes.

8. Changes to previously disclosed substantial contingent liabilities or commitments that existed at the date of the balance sheet, and no new substantial contingent liabilities or commitments have become known since the balance sheet date.

9. Significant changes in the capital stock, long-term debt, or working capital.

10. Changes in the current status of items in the financial statements being reported on that were accounted for on the basis of tentative, preliminary, or inconclusive data.

11. Unusual adjustments made during the period from the balance sheet date to the date of this inquiry.

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
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12. Significant undisclosed (in the draft year-end financial statements) financial commitments.

13. Commitments or plans for major purchases of capital assets or inventory exist, and consideration was given to possible losses due to price changes.

14. Changes in accounting or financial policies.

15. Events that caused a decline in the value of any assets or that made any significant portion of fixed assets idle or obsolete.

16. Expiration or cancellation of significant insurance coverage.

17. New regulatory requirements or laws that could adversely affect the entity.

18. Liabilities in dispute or being contested.

19. Losses of major suppliers or key executive employees.

20. New, or change to, related-party transactions since year-end.

21. Minutes (or summaries in place of approved minutes) from director meetings have been prepared and not provided to you for the period under audit through the date of this letter.

22. Meetings of directors where minutes have not yet been prepared.

Sincerely,

NORTHERN INYO HEALTHCARE DISTRICT

_____
Signed

_____
John Tremble, CFO

_____
Date

Northern Inyo Healthcare District

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March 10, 2020

Wipfli LLP
201 W. North River Drive, Suite 400
Spokane, Washington, 99201

This representation letter is provided in connection with your audits of the financial statements of Northern Inyo Healthcare District (the District) and its discretely presented component unit, which comprise the statements of net position as of June 30, 2019 and 2018, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements for the purpose of expressing opinions as to whether the financial statements are presented fairly, in all material respects in accordance with accounting principles generally accepted in the United States (GAAP).

Certain representations in this letter are described as being limited to matters that are misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement. An omission or misstatement that is monetarily small in amount could be considered material as a result of qualitative factors.

We confirm, to the best of our knowledge and belief as of date of this letter, the following representations made to you during your audits.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated May 9, 2019.

2. The financial statements referred to above are fairly presented in conformity with GAAP.

3. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

4. We acknowledge our responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud.

5. Significant assumptions we used in making accounting estimates, including those measured at fair value, are reasonable.

6. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of GAAP.

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7. All events subsequent to the date of the financial statements and for which GAAP requires adjustment or disclosure have been adjusted or disclosed.

8. We agree with the adjusting journal entries proposed by you and which are given effect to in the financial statements.

9. You did not communicate to us and we are not aware of any uncorrected misstatements.

10. We are not aware of any pending or threatened litigation, claims, or assessments or unasserted claims or assessments that are required to be accrued or disclosed in the financial statements in accordance with GAAP, and we have not consulted a lawyer concerning litigation, claims, or assessments.

11. Material concentrations have been properly disclosed in accordance with GAAP.

12. Guarantees, whether written or oral, under which the District is contingently liable, have been properly recorded or disclosed in accordance with GAAP.

Information Provided

13. We have provided you with:

    a. Access to all information, of which we are aware, that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters.

    b. Additional information that you have requested from us for the purpose of the audit.

    c. Unrestricted access to persons within the District from who you determined it necessary to obtain audit evidence.

14. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

15. We have no knowledge of any fraud or suspected fraud affecting the District involving:

    a. Management.

    b. Employees who have significant roles in internal control.

    c. Others where the fraud could have a material effect on the financial statements.

16. We have no knowledge of any allegations of fraud or suspected fraud affecting the District's financial statements communicated by employees, former employees,

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regulators, or others.

17. We have disclosed to you all known instances of noncompliance or suspected noncompliance with laws and regulations whose effects should be considered when preparing financial statements. Specifically:

    a. There are no violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (the Stark law), and the False Claims Act, in any jurisdiction, whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

    b. Billings to third-party payors comply in all material respects with applicable coding guidelines (for example, ICD-10-CM and CPT-4) and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies, if required; and properly rendered.

    c. There have been no communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

18. Receivables recorded in the financial statements represent valid claims for charges arising on or before the balance sheet date and have been appropriately reduced to their estimated net realizable value as follows:

    a. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to prospective payment system assignments.

    b. Recorded valuation allowances are necessary, appropriate, and properly supported.

    c. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available to you.

19. Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements. In regards to cost reports filed with third-parties:

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a. All required Medicare, Medicaid, and similar reports have been properly filed on a timely basis.

b. Management is responsible for the accuracy and propriety of all cost reports filed.

c. All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payors.

d. The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

e. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

f. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the cost report.

g. Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations. While management believes the entity is entitled to all amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate.

20. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

21. We are not aware of any pending or threatened litigation, claims, or assessments or unasserted claims or assessments that are required to be accrued or disclosed in the financial statements in accordance with GAAP.

22. We have disclosed to you the identity of the District's related parties and all the related party relationships and transactions of which we are aware.

23. Provisions have been made for losses to be sustained in the fulfillment of, or from inability to fulfill, any sales commitments.

24. Provisions have been made for losses to be sustained as a result of purchase commitments for inventory quantities in excess of normal requirements or at prices in excess of the prevailing market prices.

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25. Provisions have been made for losses to be sustained as a result of the reduction of excess or obsolete inventories to their estimated net realizable value.

26. Provisions have been made for losses which may be sustained in the collection of notes receivable.

27. Inventories fairly represent the value of inventories at average cost on the first-in, first-out method, or net-realizable value.

28. The District has properly classified equity securities with readily determinable fair values and all debt securities as other-than-trading securities and reported these investments at fair value.

29. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.

30. The District has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any material asset been pledged, except as disclosed in the notes to the financial statements.

31. The District has complied with all aspects of contractual agreements, including debt agreements, that would have a material effect on the financial statements in the event of noncompliance.

32. The District is in compliance with bond and/or debt covenants.

33. For each of the District's outstanding bond issues, the District is in compliance with post issuance requirements, as specified in the Internal Revenue Code, including, but not limited to, the areas of arbitrage and private business use.

34. The District has maintained an appropriate composition of net position in amounts needed to comply with all donor restrictions.

35. The District has classified net position as unrestricted, net investment in capital assets, or restricted based on its assessment. Reclassifications between net position classes are proper.

36. The internal controls over receipt and recording of received contributions are adequate.

37. The allocation of functional expenses reported in the notes to the financial statements is reasonable based on the District's current operations.

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38. The District has identified all accounting estimates that could be material to the financial statements, including the key factors and significant assumptions underlying those estimates, and I we believe the estimates are reasonable in the circumstances.

39. There are no estimates that may be subject to a material change in the near term that have not been properly disclosed in the financial statements. We understand that near term means the period within one year of the date of the financial statements. In addition, we have no knowledge of concentrations existing at the date of the financial statements that make the District vulnerable to the risk of severe impact that have not been properly disclosed in the financial statements.

40. The District is not subject to the requirements of *Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance)* because it did not expend more than $750,000 in federal awards during the year.

41. We acknowledge our responsibility for presenting the combining statements of net position of the district and component units, the combining statements of revenues, expenses, and changes in net position of the district and component units, and statistical information, in accordance with GAAP, and we believe the combining statements of net position of the district and component units, the combining statements of revenues, expenses, and changes in net position of the district and component units, and statistical information, including its form and content, is fairly presented in accordance with GAAP. The methods of measurement and presentation of the combining statements of net position of the district and component units, the combining statements of revenues, expenses, and changes in net position of the district and component units, and statistical information, have not changed from those used in the prior period, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the supplementary information.

Sincerely,

Northern Inyo Healthcare District

_____
Jean Turner - Chair, Board of Directors

_____
John Tremble - CFO

March 12, 2020

Here is some information in response to your inquiry about Pioneer Home Health Care, Inc.

1. **Pat's date of retirement and how PHHC has been operating since her departure.**

   Pat's retirement date was February 28, 2020. She is continuing her employment as a Senior Advisor paid hourly on an as-need basis.

   All employees are continuing their normal work flow under Ruby Allen, Administrator.

   Ruby Allen – Administrator
   Marianne Rogers – Administrative Assistant
   Sandra Johnson – Internal Services Coordinator
   Trisha Smith – Accounts Receivable Coordinator
   Tracy Watterson – Personal Care Program Coordinator
   Rosalie Dondero – Audit Clerk
   Royce Cornett, RN – Case Manager
   Nicholas Hall, RN – Case Manager
   Amanda Michener, RN – Field Nurse
   Ilah Cavanaugh, PT – Therapy Case Manager/Supervisor
   Patric Magee, MSW – Medical Social Worker
   Annette Barnes – Certified Home Health Aide

   Since Pat has been gone (8 work days), Ruby has prepared, Sandra has entered, Trisha has checked insurances and Ilah has been training with 9 new referrals (3 of them from NIH). Not all will/have panned out for various reasons, but time-consuming for all to prepare them. Ruby has also fielded all calls regarding new and current patients.

   Sandra has:
   - Reconciled clinician daysheets and timecards
   - Completed a regular payroll cycle including paying all taxes
   - Continued daily billing Medicare for home health and hospice services through NDoc to National Government Services
   - Has handled numerous NDoc issues, submitted Oasis and HIS submissions to the State of California
   - Entered a Home Health Gold update on all laptops and desktops.

   Trisha has:
   - Billed all private insurances for February services
   - Made continual calls on past account receivables
   - Ordered medical supplies and office supplies

   Marianne has:

- Been working on 2019 CA OSHPD Annual Utilization Report for Home Health due March 13th
- Been working on 2019 CA OSHPD Annual Utilization Report for Hospice due March 13th
- Preparing information on PHHC bills needing payment in March
- Posted and prepared bank deposits as necessary
- Has worked with Ruby to prepare information on NIHD financial inquiries

Tracy
- Has continued scheduling our 26 clients and supervising her 18 employees
- Has made visits to potential client homes for assessments of need
- Has met with several entities in Bishop to promote our Personal Care Program and scheduled several presentations for next week

Note: When the partnership with NIHD began, it was hoped that the Personal Care Program would grow its weekly hours from approximately 400 up to 450-500 with more referrals from the NIH Discharge Planning department as Pioneer would now be a partner. However, this has not been the case and the referrals are not coming to us. We have been told by community members that they were referred to private providers as opposed to a licensed agency and partner of NIHD. We see this as a risk for the hospital district and have mentioned it to several as such. Pioneer could probably meet the goals with additional referrals from NIH.

Clinicians:
- Have had their regular Team Conference meetings on Tuesdays
- Have continued their patient care visits out in the field and charting thereafter

Hospice Volunteers and Clinicians involved in Hospice:
- Have had their regular Interdisciplinary Group meetings on Tuesdays

2. Day-to-day financial operation focus

Due to our new Patient Driven Grouping Model reimbursement system under Medicare, we are processing the billing daily versus billing weekly.

The Administrator, Administrative Assistant and the Internal Services Coordinator are keeping a close eye on monies coming in and what is needed to make payroll and taxes on March 20th and the March bills that need to be paid by 3/31/20.

3. Upcoming anticipated costs to operate

The March 5th payroll (for a 10-day period only), along with Federal, State and participant 401k amounts came to a total of $57, 483.27. The upcoming March 20th payroll should be about the same (another 10-day period). With what we currently have

available ($34,390.08) along with an upcoming NIHD payment for MSW services ($13,496.25) and an early PCP client payment of $8,207.50, we will be very close to covering the 3/20/20 payroll. On 3/6/20, the PCP program billed out approximately $13,781.25 to be paid within 10 days. This amount comes in incrementally from clients, and we are still due approximately $11,050.00 from that billing. So we believe there will be enough to cover the March 20th payroll expenses.

As we are holding all money to make payroll, the monthly bills have not been paid. Please see attached detailed "To Pay in March 2020" document.

Pioneer's average payroll with taxes is approximately $60,000 twice a month, and monthly bills including those to repair and maintain the building are approximately $30,000 - $50,000 per month.

Regarding the 401k match. In 2018, employees received 7% of their salary for the last four months of the year as the NIH partnership began in September of that year. However, while employees had been told there would be a 7% match of their salary in 2019, earlier this year it was determined that Pioneer could not afford that rate – it came to an employer total of $60,735.37. Instead, an amount equal to 50% of what each employee had contributed to their own plan with a max of $2,500.00 has been calculated which has brought the total employer match down to $15,472.25 – yet to be paid.

4. Deficit PHHC is facing for the next 30 days

See attached "To Pay in March 2020" document.

To note on this document:

- American Express amount varies – will range from $250 up. Use this for online webinars, conferences, etc.
- 6 items to pay listed on the bottom right column are NOT monthly amounts due. They are specific to March 2020 only.

5. Amount of money being requested

See attached "To Pay in March 2020" document

6. What the monies will be used to pay

See attached "To Pay in March 2020" document, and will need to consider April 5th payroll coverage. Due to daily home health, hospice and personal care census variations and new government billing model, our needs are not clear at this time.

To Pay in March 2020

Regular Monthlies				Additionals		
Payee	Batch	Amount		Payee	Batch	Amount
Pay on the 1st						
Claudia Buchanan (ML)		1,503.10		Ability		
Blue Shield (group plan)		17,472.75		Airway Medical (HOS DME)		160.00
HUB (prof liability)		1,467.00		Alex Printing		
VSP (group plan)		146.98		American Busi Machine		
Delta Dental (group plan)		1,220.87		Bishop Heating & Air		
Worker's Comp EFT	eft	-		CAHSAH		
				CDPH		
Bishop Public W rks (sewer)		131.00		Channing Bete		
Dale Hooper (yard)		120.00		Community Printing		
DexYP		35.00		Craigs Book		
DWP		327.20		DAT		
ES Propane		183.69		DeltaCareRX #1 (HOS pharm)		334.28
HealthCare1st Deyta (CAHPS)		115.76		DeltaCareRX #2 (HOS pharm)		389.35
McKesson (med supplies)				Dwaynes		
Quill (office supplies)		323.82		EDD (qtr)		
PhoneWorks (PCP prog EMR)		78.00		High Country Lumber		
Preferred Septic		165.72		Inyo Register		
Simione (Medicare CPAs)		750.00		KIBS		
Suddenlink (tele lines/internet)		369.37		Mountain Studio		
Thornberry EMR		1,302.62		Mutual of Omaha (DT Ins)		594.43
Union Bank Visa		72.00		NIHD (contract therapy)		1,929.66
Verizon Wireless (cells)		327.08		NIHD (drug testing)		
Yeager Storage (HOS storage)		85.00		Pitney Bowes (qtr) lease		221.85
				Sterling Talent Solutions		542.08
American Express (misc. mo,)		2,238.05		(background checks)		
AT&T (1 cell)		77.04				
Canon lease (copier)		142.29		CLIA Waiver		180.00
S. Johnson (cleaning)		200.00		Bishop Chamber (membership)		130.00
				Inyo County Prop Txs		2,149.83
				CDPH - PHHC CA License		2,762.00
				W/C new term deposit		3,379.00
				401k Employer Match for 2019		15,472.00
		$28,854.34				$28,244.48

*est = estimated

Total to Pay in March 2020	**$**	**57,098.82**

NORTHERN INYO HEALTHCARE DISTRICT
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SURGE MANAGEMENT PLAN

COVID-19

1. Open Incident Command 3/9/2020 at 0900

   Roles to initially include: Incident Commander, Public Liason Officer, Logistics Officer, Fiscal Officer and Infection Control Officer.

   Plan to evaluate the following daily: PPE stock and usage rate, Volume of patients seeking care with fever/respiratory illness, projected upcoming surgical cases (% elective), latest CDC/CDPH update on COVID-19, Staff and Community communication updates, and staffing concerns/continued training needs.

   Current Status: fully operational as of 3/8/2020

2. Application for Program Flexibility to utilize unassigned space pending CDPH Licensing and Certification approval.

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Screening for Possible Coronavirus (2019 -nCoV)

COVID-19 STANDARD WORKFLOW

Patient Arrival at Emergency Department for Triage:

A. Patients are triaged in ED Lobby by ED RN (competent in triage)

1. If patient screens positive (presents with fever and or acute respiratory illness) follow steps below.

    a. Place surgical mask on patient.

    b. Route patient out ED lobby exit door and thru traditional ambulance entrance door to corridor. Place into unassigned space. (Cohort of respiratory illness patients in this space with 6-foot distance between gurney/chairs).

    c. ED RN staff in CDC recommended PPE will remain in this area to provide care to patients.

        i. Follow Airborne and Contact Precautions (including face shield)

        ii. Use decontamination shower room as "ante-room" for staff donning and doffing PPE

d. Unassigned space accommodations for patients
    i. Bathroom available in this area within the radiology room
    ii. Hand hygiene station to be deployed in hallway outside of unassigned space along with alcohol based hand sanitizer stations in the patient care room
    iii. Place Airborne Isolation + Contact Isolation signage
    iv. Follow Airborne and Contact Precautions (including face shield)

2. Patient at ED Triage is negative for fever and/or respiratory illness is moved into the ED for further work-up/medical screening exam and treatment.
3. Ambulance transitions into and out of the ED changed from traditional entrance to ED Lobby door and main door from lobby into ED suite after triage by RN to rule out fever/respiratory illness.

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Perinatal Triage Screening for Possible Coronavirus (2019 -nCoV)

1. Triage perinatal patients greater than 20 weeks gestation for with fever acute respiratory symptoms upon arrival at Perinatal Department.
2. If patient screens positive (presents with fever and or acute respiratory illness) follow steps below.
    a. Place surgical mask on patient.
    b. Staff to use N-95 masks
    c. Call House Supervisor
    d. With House Supervisor coordination, transport patient to MS Room #5
        i. OBGYN/CNM will manage patient while on MS.
        ii. With House Supervisor coordination, OB RN will be deployed to care for patient while on MS
        iii. Place Airborne Isolation signage
        iv. Follow Airborne and Contact Precautions (including face shield)
3. Refer to Coronavirus Workflow for next steps
4. Below are supplies that will need to be taken to MS Room #5

Triage Patient	**Plan to Deliver Patient**
Flying Monitor with TOCO/US and straps (Throw away US gel and disinfect prior to taking back to perinatal)	Flying Monitor with TOCO/US and straps (Throw away US gel and disinfect prior to taking back to perinatal)
Sterile Gloves	Labor Bed
Disposable Speculum	Delivery Table
lubricant	Hemorrhage cart (to be kept outside of room unless needed)

WOW for Documentation	WOW for Documentation
	Infant Warmer

Sandy Blumberg

From: Robin Christensen
Sent: Thursday, March 05, 2020 6:48 PM
To: ED Nursing; ED Physicians; House Supervisors
Subject: FW: COVID-19 New PUI Criteria and Lab ordering

Good evening,

If a patient becomes suspicious for COVID 19 (a person under investigation), notify me, and I will come in and assist with the paperwork and notifying Inyo County. The labs cannot be ordered until the Inyo County Health Department gives the OK. Tomorrow several NIHD team members will be meeting to discuss workflow and processes. There will be a Talking Points that will outline appropriate steps. If you are suspecting COVID-19, the patient must be placed in an Airborne Infection Isolation Room (Med-Surg 5 or ICU 1). The link below has the PUI form to be completed; this may guide you in determining if a patient is suspicious for COVID-19.

Robin Christensen
After hours home 760-872-7004
Personal cell 760-920-5464
Work cell 760-920-8860

Inyo County Medical Director.
Jim Richardson # 760-920-0433

Please see updated Human Infection with 2019 Novel Coronavirus Persons Under Investigation (PUI) and Case Report Form published by the CDC:
https://www.cdc.gov/coronavirus/2019-ncov/downloads/pui-form.pdf

Thanks Robin

Sandy Blumberg

From: Robin Christensen
Sent: Saturday, March 07, 2020 4:17 PM
To: Everyone On Email (Business Only)
Subject: Talking Points corona virus 3-7-20
Attachments: Talking Points corona virus 3-7-20.docx

Hello,
Please review attached Talking Points regarding NIHD preparedness for Coronavirus and the efforts taken by the Leadership Team to protect employees, patients, visitors, and community in order to minimize the risk of disruption to patient care

Most importantly, what can you do to be safe?

Please do your part to keep each other, our patients, and our communities safe by following guidelines from the CDC about prevention:

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Avoid touching your eyes, nose, and mouth.
- **Stay home when you are sick and avoid close contact with people who are sick.**
    - **NIHD will not be issuing an occurrence per the attendance policy for employees who do not come to work to care for themselves or family members who have flu like illnesses.**
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe while at home. At work, use approved germicidal cleaning agents per manufacturer's instructions.
- **Employees may not bring family members to the workplace if they are not at the district seeking medical treatment.**

Leadership team: Please share this information and post in areas where team members are regularly checking email.
Best Regards,
Robin

Robin Christensen, BSN, RN, HIC
Manager Quality Informatics /Clinical Informatics/Infection Preventionist/Employee Health
Office:760-873-5811 ext 3490
Work Cell: 760-920-8860
Fax: 760-873-2704
robin.christensen@nih.org

NORTHERN INYO HEALTHCARE DISTRICT

TALKING POINTS

TO: All NIHD Staff

FROM: Robin Christensen, Infection Preventionist

TOPIC: Update on the NIHD preparedness for Coronavirus (COVID-19)

DATE: March 7, 2020

Please share the following information

Here's what's happening:

As the COVID-19 situation evolves across the world and in the U.S., we at Northern Inyo Healthcare District are prepared to safely screen, diagnose and care for patients with respiratory illness, including Coronavirus – COVID-19. In the event a COVID-19 case presents at any care location across our District, NIHD has coordinated care plans in place, established in collaboration with Inyo County Public Health (https://www.inyocounty.us/services/health-human-services/public-health-and-prevention-division), which are based on the most current Centers for Disease Control and Prevention (CDC -- https://www.cdc.gov/) guidelines.

Preparations at NIHD:

Is NIHD ready for a COVID-19 case? Yes. NIHD is prepared to safely screen, diagnose and care for patients with respiratory illness, including Coronavirus – COVID-19. In the event a COVID-19 case presents at any care location across our District, NIHD has coordinated care plans in place, established in collaboration with Inyo County Health Department which are based on the most current Centers for Disease Control and Prevention (CDC) guidelines.

What is NIHD doing about the COVID-19 Outbreak? With continued issues and concerns associated with COVID-19 (Coronavirus), we at NIHD are doing everything we can to protect employees, patients, visitors, and community in order to minimize the risk of disruption to patient care.

How does NIHD prepare for infectious disease? When there is heightened concern around an infectious illness, we closely monitor the situation and implement enhanced infection prevention strategies, working closely with county and state health officials and the national Centers for Disease Control and Prevention.

Who monitors the COVID-19 situation at NIHD? Our organization-wide Leadership Team closely monitors the rapidly evolving situation with a particular focus on the issues presented by the virus including employee health and safety, patient and visitor health and safety, and international travel and operational issues.

NIHD is putting visitor and employee family member restrictions in place. In order to help protect our employees and our patients against flu and other respiratory illness, NIHD put visitor and employee family member restrictions in place. Please avoid visiting hospital patients if you have a cough, fever (100.4), sore throat, body aches, or gastrointestinal symptoms. In addition, employees may not bring family members to the workplace if they are not at the District seeking medical treatment.

NIHD is asking volunteers to stay home. We are informing our treasured volunteers that for their health and safety they are released from their volunteer service at all NIHD locations until further notice.

NORTHERN INYO HEALTHCARE DISTRICT

TALKING POINTS

NIHD is suspending the following non-critical activities until further notice based on CDC recommendations to avoid large crowds:

- Community Meetings
- Community Education Classes
- Healthy Lifestyle Talks
- Travel to approved conferences & seminars
- Project vendors coming on site

What is NIHD doing to keep employees and physicians healthy?

- Employees must not come to work if they are ill with a cough, fever (100.4), or shortness of breath. If they are suspected to be ill, their leader will send them home to recuperate.
    - NIHD will not be issuing an occurrence per the attendance policy for employees who do not come to work to care for themselves or family members who have flu like illnesses.
- NIHD strongly encourages employees to follow travel recommendations from the CDC. If you choose to travel, you may be asked by the Inyo County Health Department to quarantine based on CDC recommendations.

A word about patient and employee privacy:

HIPAA and California state confidentiality laws remain in full effect. All access of protected health information should be for work-related, need-to know purposes only. Chart access audits will be increased. Employee discussions should always remain professional. Again, patient information must remain confidential no matter the circumstances.

What can I do to be safe?

Please do your part to keep each other, our patients, and our communities safe by following guidelines from the CDC about prevention:

- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Avoid touching your eyes, nose, and mouth.
- Stay home when you are sick and avoid close contact with people who are sick.
    - NIHD will not be issuing an occurrence per the attendance policy for employees who do not come to work to care for themselves or family members who have flu like illnesses.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe while at home. At work, use approved germicidal cleaning agents per manufacturer's instructions.

Transmission Prevention at NIHD

When there is heightened concern around an illness, we implement enhanced infection prevention strategies and ensure we are ready with supplies and plans should the need arise. These plans include:

- Continuing to follow CDC recommended standard infection prevention measures including hand hygiene and respiratory etiquette.
- Updating and training staff regarding CDC transmission prevention guidelines specific to COVID-19.

NORTHERN INYO HEALTHCARE DISTRICT

TALKING POINTS

- Following CDC recommendations for isolation based on the site of care, for hospital patients this is airborne isolation.
- Routinely practicing and rehearsing for the potential of infectious disease outbreak in our community, in collaboration with Inyo County Health Department, to ensure we are prepared. Where particular public health risks are identified, we monitor the situation to ensure prevention and preparation strategies are the most contemporary, based on the most current clinical standards.
- Assessing our supply inventories and continuously monitoring current supplies on a routine basis. We are working with our supply chain vendors to replenish our supplies. We are implementing strategies for optimizing the supply of personal protective equipment (PPE) and utilizing alternative supplies when feasible.
- Putting visitor and employee family member restrictions in place (as of 3/7/20). Please avoid visiting patients at NIHD if you have a cough, fever, sore throat, body aches or gastrointestinal symptoms. In addition, employees may not bring family members to the workplace if they are not at the District seeking medical treatment.

Questions...

Call or email Robin Christensen at ext. 3490.

Admission Staff Coronavirus Scripting

Registration Staff: Please ask **ALL** patients the following questions upon patient check in. Have patient immediately put on a mask and inform the House Supervisor immediately if any of the answers are yes to both of the following questions and

Scripting:

"Northern Inyo Healthcare District is following CDC screening guidelines. I am required to ask you the following questions"

"Have you been in close contact with an individual who is under investigation for or confirmed coronavirus infection, and do you have a fever or symptoms of respiratory illness?"

- ☐ Yes
- ☐ No

OR

"Do you have a fever, cough, or shortness of breath?"

- ☐ Yes
- ☐ No

House supervisor cell phone: 760-920-3392

Patient Name:
Date of Birth:
Medical Record Number
Phone Number:

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

Coronavirus Hospital Admission Workflow (2019 -nCoV)

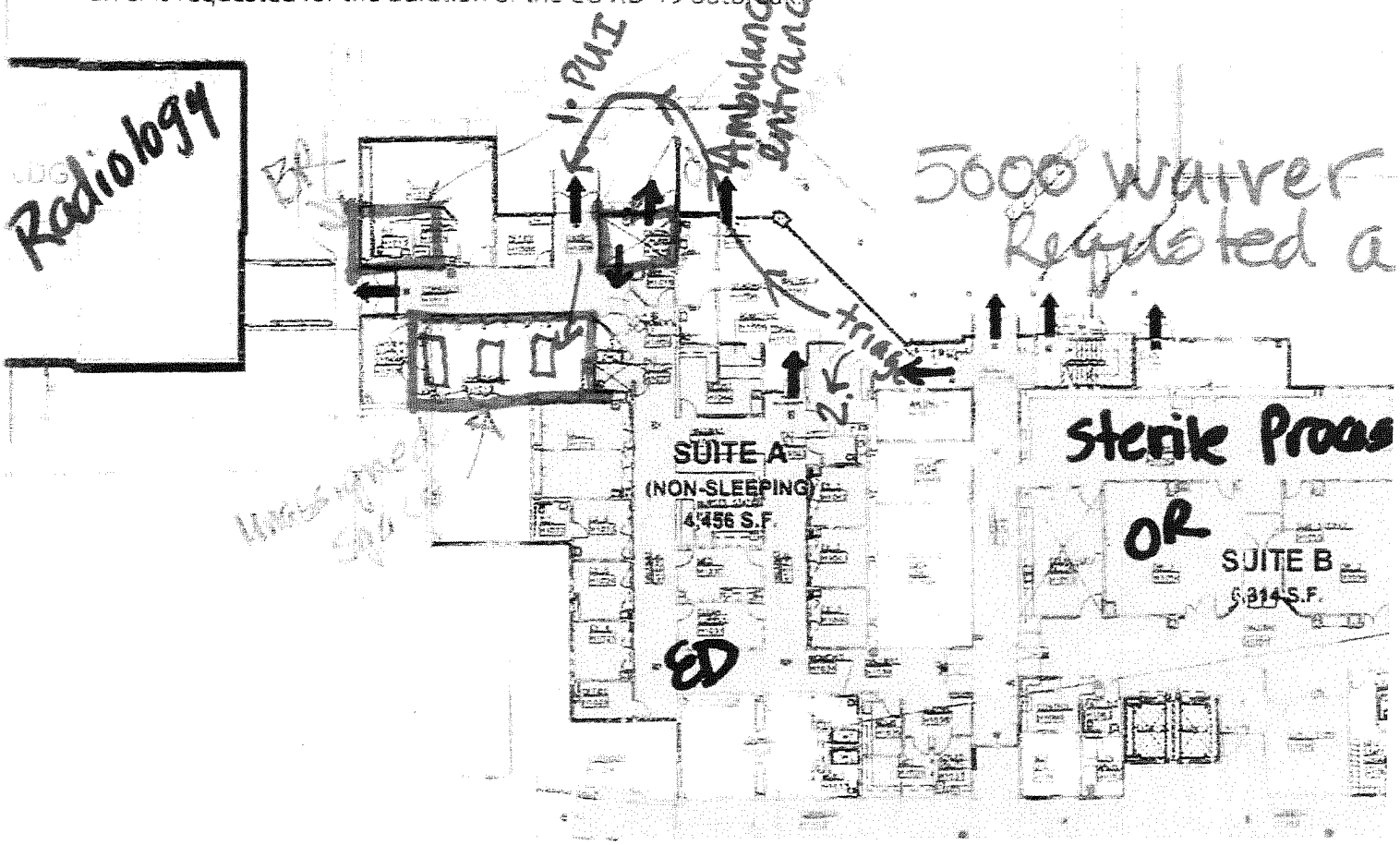
After Patient Is Transported To MS Room 5

1. House Supervisor will notify Administrator on Call (AOC)
2. House Supervisor will Notify Inyo County Public Health and Infection Prevention RN
    a. Normal Business Hours 760-873-7868
    b. After Hours House Supervisor to Notify Public Health Officer
3. Notify Lab for specimen collection instruction and supplies
    a. Lab will work with local health department for packaging and transport to CDC lab
4. For invasive procedures such as intubation or suctioning PAPR is recommended

Upon Discharge:

1. Notify House Supervisor of patients pending discharge
2. MD and House Supervisor coordinate discharge plan with County Public Health Department
3. Upon discharge notify EVS for terminal room cleaning

This waiver is requested for the duration of the COVID-19 outbreak



B BRAUN
SHARING EXPERTISE

Customer:	Proposal for Purchase	
Northern Inyo Hospital	Reference Number/Date:	26619326 / 03/12/2020
150 Pioneer Ln	Proposal Number:	26455328
BISHOP CA 93514	Valid from /Valid to:	03/12/2020 - 06/12/2020
Customer Number: 20052757	Payment Terms:	Within 30 days due net
	Shipping Terms:	F.O.B. origin, frgt ppd & add
	Bid ID:	

B. Braun Medical Inc. ("B.Braun") is pleased to offer Northern Inyo Hospital the option to purchase and/or license, as applicable, the products, services and software listed below.

The terms of our purchase option are set forth in our Infusion Systems Agreement included with our proposal for your review. In addition, software may be licensed in accordance with the terms of the corresponding software license agreement for such software, copies of which are also included with our proposal for your reference.

Conditions **Currency** USD

Material	Quantity	Description	Unit Price	Extended Price
ISP-WP	53 EA *	INFUSOMAT SPACE 2ND GEN WIRELESS PUMP KIT	2,250.00 EA	119,250.24[1]
		[1]The purchase price of $119,250.24 for 53 Infusomat™ Space 2nd Gen Wireless Pump Kits (Material No. ISP-WP) includes the following: 53 - 8713051U - Infusomat Space with Wireless Battery and License Key; 45 - 8713131 - Space Pole Clamp (Speed Clamp); 45 - 8713112D - Power Supply SP US III. 10 - 8713133 - Combi Cable SP 12 V.		
PSP-WP	4 EA *	PERFUSOR SPACE 2ND GEN WIRELESS PUMP	2,870.00 EA	11,480.00[2]
		[2]The purchase price of $11,480.00 for 4 Perfusor™ Space 2nd Gen Wireless Pump Kits (Material No. PSP-WP) includes the following: 4 - 8713031U - Perfusor Space with Wireless Battery and License Key; 4 - 8713131 - Space Pole Clamp (Speed Clamp); 4 - 8713112D - Power Supply SP US III.		
DLSP2G	57 EA *	DRUG LIBRARY SW KIT - SPACE 2ND GEN	289.93 EA	16,526.00[3]
		[3]The license fees of $16,526.00 for 57 Drug Library SW Kits - Space 2nd Gen (Material No. DLSP2G) include the following: 57 - DLDF - Drug Library Development Consultation Fee; 57 - DGFDB3N - DoseGuard 3 Year New; 1 - 876100U - Space Online Suite US; 1 - 8713303U - B.Braun Space Medication Safety USB, US; 1 - 8713230 - Interface Lead CAN Cable Space; 1 - OLSINSTAL - On Line Suite Installation.		
SPCOMKIT	3 EA *	SPACESTATION W/ SPACECOM KIT, INC KEY	2,555.00 EA	7,665.00[4]
		[4]The purchase price of $7,665.00 for 3 SpaceStation w/ SpaceCom Kits (Material No. SPCOMKIT) includes the following: 3 - 8713142U - SpaceStation with SpaceCom; 3 - 8713145U - SpaceStation Cover; 3 - 8713185U - Wireless LAN USB Stick; 6 - 8713180 - Battery Pack SP (NIMH); 3 - 876105A - OnlineSuite DLM Web License.		
DTSPTR4	1 EA *	DOSETRAC FOR SPACE TIER 4	25,000.00 EA	25,000.00

If the pricing hereunder constitutes a discount or other reduction in price under section 1128(b)(3)(a) of the social security act 42 U.S.C. 1320a-7b(b)(3)(a), and 42 C.F.R. § 1001.952(h), Customer shall disclose the discount or reduction in price to the full extent required under any state or federal program that provides cost or charge based reimbursement to Customer for products covered herein. This act requires, among other things, that Customer fully and accurately report on any claim or request for payment it submits to Medicare and Medicaid the actual purchase price paid by Customer for products, net of any discounts, rebates or allowances provided hereunder. Customer may also be required, upon request, to provide documentation of the discount or other reduction in price to the Secretary of Health and Human Services.

B|BRAUN
SHARING EXPERTISE

Customer:
Northern Inyo Hospital
150 Pioneer Ln
BISHOP CA 93514

Document No./Date
26619326 / 03/12/2020

ITEMS TOTAL	179,921.24
State Tax	10,795.27
County Tax	2,249.04
Local Tax	899.59
Total Tax	13,943.90
FINAL AMOUNT	193,865.14

***Denotes Taxable Item**

The purchase price of the pumps includes implementation support and training on the use of the pumps, subject to the provisions set forth herein.

B. Braun uses a blended curriculum approach for training, which includes a combination of online training, classroom training and on-site training at customer's facility. Customer agrees that at least 80% of its end users will pre-register and complete the B. Braun Space eLearning training module followed by a simulated classroom training prior to customer "Go Live."

Customers will receive up to 1¼ total hours of on-site training and implementation support per pump depending on the number of staff to be trained; provided, however, that on-site training and implementation support shall not exceed 9 business days unless otherwise agreed by B. Braun. On-site training and support will be provided during "Go Live" week and post implementation follow-up rounding and will not typically be scheduled on holidays or weekends. Customers that require product training and/or implementation support beyond 1¼ hours per pump can purchase additional on-site training and support at a price of $125/hour. Simulation-based classroom training, on-site "Go Live" support, and post implementation follow up rounding average between 4-12 total business days.

A B. Braun representative (Clinical Nurse Consultant and/or Project Manager) will be assigned to each customer to assist with project coordination and implementation. In addition, 24-hour clinical and technical phone support will be available for 1-3 days during customer "Go Live" to provide support on weekends when on-site training and support are not otherwise available.

If Customer does not comply with the provisions set forth herein, B. Braun reserves the right to charge Customer for product training and implementation support for the pumps at B. Braun's then-current pricing or at the pricing set forth in the contract between Customer and B. Braun, as applicable.

It is anticipated that delivery will generally be made within forty five (45) days following B.Braun's acceptance of a valid purchase order, depending upon implementation requirements; provided, however, that all shipping and delivery dates quoted are approximate only.

All pricing is exclusive of any applicable taxes and freight charges. Any customization for products, services or accessories not quoted in this proposal will be made available at an additional charge. All transactions are pending credit approval. Customer agrees to notify B.Braun of all delivery requirements at the time of order placement, including the need for a lift gate.

B.Braun's standard product warranty for Infusomat® & Perfusor® Space Infusion Devices and related accessories is one (1) year from the date of implementation. A copy of B.Braun's Space Infusion Devices Product Warranty is included with our proposal for your reference. In addition, Customer may choose to purchase one of B.Braun's available service programs described in the Service Programs summary included with our proposal for your review.

The pricing and terms set forth herein are confidential in nature, and Customer agrees to hold in confidence and refrain from disclosing such information to third parties.

If the pricing hereunder constitutes a discount or other reduction in price under section 1128(b)(3)(a) of the social security act 42 U.S.C. 1320a-7b(b)(3)(a), and 42 C.F.R. § 1001.952(h), Customer shall disclose the discount or reduction in price to the full extent required under any state or federal program that provides cost or charge based reimbursement to Customer for products covered herein. This act requires, among other things, that Customer fully and accurately report on any claim or request for payment it submits to Medicare and Medicaid the actual purchase price paid by Customer for products, net of any discounts, rebates or allowances provided hereunder. Customer may also be required, upon request, to provide documentation of the discount or other reduction in price to the Secretary of Health and Human Services.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Capitalization of Assets	
Scope: Departmental	Manual: Administration
Source: Controller	Effective Date: 8/18/2004

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:

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

   Major Movable Equipment will be capitalized at $2,000.

Approval	**Date**
Administration	8/11/04
Board of Directors	6/18/14
Last Board of Director review	3/15/17

Revised 7/1/14
Reviewed 6/21/14
Supersedes 8/18/2004

LEASE

PREAMBLE

THIS LEASE is entered into on October 1, 2019, by and between NORTHERN INYO HEALTHCARE DISTRICT (hereinafter "TENANT",) and Pioneer Medical Associates a General Partnership (hereinafter "LANDLORD").

RECITALS

A. TENANT is a California Health Care District, organized and existing pursuant to the Local Health Care District Law, *Health and Safety Code §32000, et. seq.*, with its principal place of business at Bishop, California.

B. TENANT owns and operates NORTHERN INYO HOSPITAL, (herein after "Hospital"), an acute care general hospital, at 150 Pioneer Lane, Bishop, California.

C. LANDLORD owns and operates a medical office building designed for the practice of medicine.

LEASE

Subject to and governed by the terms and conditions set forth below, Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, on the terms and conditions set forth in this lease a 12,971 square foot Medical building ("the PREMISES") located at 152 Pioneer Lane, in the City of Bishop, County of Inyo, State of California.

ARTICLE 1
TERM OF LEASE

1.01. Original Term. The term of this lease shall be for a period of three years, commencing at 12:01 A.M. on February 14th, 2020 and ending at 11:59 P.M. on February 13th, 2023, unless terminated sooner as provided in this lease

1.02. Renewal Term. The Original Term, described in Section 1.01 above, shall automatically renew for an additional three (3) year term unless either party has given written notice of the other, in the manner set forth in Section 10.03 below, of its intention not to renew. Said notice of non-renewal must be given no less than One Hundred Twenty (120) days prior to the expiration of the Original Term or it will be without effect.

1.03 Holding Over. If Tenant holds over and continues in possession of the Premises after termination of the term of this lease, including any renewed tern, Tenant's continued occupancy of the Premises shall be deemed merely a tenancy from month, to month at a minimum rental of $1.25 per square foot, per month subject to all other terms and conditions, contained in this lease.

ARTICLE II
RENT

2.01 Rental for Original Term. Tenant agrees to pay to Landlord as rent for the Original Term the sum of $194,565.00 payable in monthly installments of $16,213.75 commencing on the 14th day of February, 2020, and continuing on the 14th day of each calendar month thereafter through the Original Term. Tenant shall pay all installments without deduction to Landlord at the address set forth in this lease for mailing notices to Landlord, or at any other place or places that Landlord may from time to time designate by written notice given to Tenant.

2.02. Rental for Renewal Term. Tenant agrees to pay to Landlord as rent for the Renewal Term the sum of $194,565.00, payable in monthly installments of $16,213.75 commencing on the 14th day of February, 2023, and continuing on the 14th day of each calendar month thereafter through the Renewal Term. Tenant shall pay all installments without deduction to Landlord at the address set forth in this lease for mailing notice to Landlord, or at any other place or places that Landlord may from time to time designate by written notice given to Tenant.

ARTICLE III
REPAIRS, MAINTENANCE & IMPROVEMENTS

3.01. Improvements to be made by Landlord. NONE

3.02. Present Condition of Premises. Tenant has inspected the Premises and agrees and hereby stipulates with Landlord that the Premises are in good and tenantable condition for its purposes on the date of this lease.

3.03. Repairs by Landlord. During the term of this lease and any renewal or extension of the term of this lease, Landlord shall, at Landlord's own cost and expense, keep the exterior roof, sidewalls, structural supports, and foundation of the building on the Premises in good repair and make all necessary repairs to, or replacements of, the plumbing, and electrical systems on the Premises; provided, however, Landlord shall not:

(a) Be required to make any repairs to the exterior roof, sidewalls, structural supports, and foundations of the building on the Premises that are rendered necessary by the negligence of or abuse of that property by Tenant or any employees, agents, subtenants, or permittee of Tenant; or

(b) Be liable for any damages resulting from Landlord's failure to make any repairs required by this section to be made by Landlord, unless Tenant gives written notice to Landlord specifying the need for the repairs and Landlord fails to make the repairs or to commence making the repairs within 45 days after Tenant gives notice.

3.04. Repairs by Tenant; Removal of Hazardous Waste. Except as provided in Sections 3.03 and 3.04 above, Tenant shall, at Tenant's own cost and expense, during the term of this lease or any extension of the term of this lease:

(a) Keep and maintain the interior of the Premises in good order, repair, and tenantable condition;

(b) Properly remove from the premises, and dispose of, all hazardous waste in accordance with applicable federal, state, county and city laws, ordinances and regulations. Tenant shall defend, indemnify, and hold harmless Landlord from any liability for this failure to discharge his duties under this sub-section 3.04(b).

3.05. Tenant Alterations. Subject to the provision of Section 3.07 of this Lease, Tenant may make nonstructural alterations or improvements to the Premises deemed necessary by Tenant for Tenant's business without Landlord's approval, provided that Tenant notifies Landlord in writing at least three days before the date construction for alterations or improvements is to commence so that Landlord may post and record a notice of non-responsibility, and further provided that all construction complies with the requirements of all appropriate government agencies. Before making any nonstructural alterations or improvements to the interior of the building that are estimated to exceed in cost the sum of $2,000.00 or any structural alterations or improvements to the interior of the Building or any alterations or improvements to the exterior of the Building or before constructing any new improvements on the Premises, Tenant shall submit to and obtain Landlord's written approval on final construction plans and specifications for the alterations or improvements. Landlord shall not unreasonably withhold approval. All improvements or alterations made by Tenant on the Premises shall comply with the requirements of any federal, state, or municipal authority having jurisdiction.

3.06. Tenant Improvements and Trade Fixtures.

(a) Any alterations, improvements, or installations made by Tenant to the Premises shall at once become a part of the realty and belong to Landlord. On expiration or earlier termination of this Lease, Tenant shall surrender the Premises and all improvements thereon to Landlord in good sanitary, and near order, condition, and repair, excluding ordinary wear and tear.

(b) Tenant shall have the right to remove its trade fixtures from the Premises at the expiration or earlier termination of this lease term provided Tenant is not then in default under this lease and provided that Tenant shall repair any damage to the Premises caused by that removal.

3.07. Liens.

(a) Tenant agrees to keep all of the Premises and every part thereof and the building and other improvements at any time located on the Premises free and clear of any and all mechanics' material-men's, and other liens for or arising out of or in connection with work or labor done, services performed, or materials or appliances used or furnished for or in connection with any operations to Tenant, any alteration, improvements, or repairs or additions that Tenant may make or permit or cause to be made, or any work or construction by, for, or permitted by Tenant on or about the Premises, or any obligations of any kind incurred by Tenant. Tenant further agrees to pay promptly and fully and discharge any and all claims on which any such lien may or could be based, and to save and hold Landlord and all of the Premises and the building any other improvements on the Premises free and harmless from any and all such liens and claims of liens and suits or other proceedings pertaining thereto.

(b) If Tenant desires to contest any such lien, it shall notify Landlord of its intention to do so within ten (10) days after the filing of that lien. In such case, and provided that Tenant on demand of Landlord protect Landlord by a good and sufficient surety bond against any such lien and any costs, liability, or damage arising out of that contest, Tenant shall not be in default hereunder until five (5) days after the final determinations of the validity thereof, within which time Tenant shall satisfy and discharge that lien to the extent held valid. The satisfaction and discharge of any such lien shall not, in any case, be delayed until execution is had on any judgment rendered on the lien, and that delay shall be a default of Tenant under this Lease. In the event of any such contest Tenant shall protect and indemnify Landlord against all loss, cost, expense, and damage resulting from the contest.

3.07. Landlord's Right of Inspection. Landlord or Landlord's duly authorized agents may enter the Premises at any and all reasonable times during the term of this lease, including any extended term, to determine whether Tenant is complying with the terms and conditions of this lease or to perform any other acts authorized by this lease to be performed by Landlord or reasonably necessary to protect Landlord's rights under this lease.

3.08. Surrender of Premises. On expiration or earlier termination of this lease, Tenant shall promptly surrender possession of the Premises to Landlord in as good condition as the Premises are on the date of this lease, reasonable wear and tear excepted.

ARTICLE IV
USE OF PREMISES

4.01. Permitted and Prohibited Use of Premises. Tenant shall use the Premises for operating and conducting a practice of a medical specialty or other permitted use and for no other purpose without the written consent of Landlord. Landlord shall not unreasonably withhold consent.

4.02. Medical Staff membership. Tenant shall not allow or permit the practice of medicine on the Premises by any physician who is not licensed to practice medicine in the State of California and a member in good standing of either the Provisional or Active Medical Staff of the Hospital. Tenant acknowledges and agrees that compliance with the requirements of this Section 4.02 is a condition of this Agreement and not a covenant and that failure to comply with this condition shall be, notwithstanding any other term or provision of this Agreement, cause for termination and forfeiture of this Lease.

4.03 Compliance With Law. The Premises shall not be used or permitted by Tenant to be used in violation of any law or ordinance. Tenant shall maintain the Premises in a clean and sanitary manner and shall comply with all laws, ordinances, rules, and regulations applicable to the Premises, enacted or promulgated by any public or governmental authority or agency having jurisdiction over the Premises.

ARTICLE V
INSURANCE & TAXES

5.01. Liability Insurance. Tenant shall, at Tenant's own cost and expense, secure and maintain during the entire term of this lease and any extended term of this lease, public liability, property damage, and products liability insurance, insuring Tenant and Tenant's employees against all bodily injury, property damage, personal injury, and other loss or liability caused by or connected with Tenant's occupation and use of the Premises under this lease in amounts not less than:

(a) $300,000 for injury to or death of one person and, subject to the limitation for the injury or death of one person, of not less than $1,000,000 for injury to or death of two or more persons as a result of any one accident or incident; and

(b) $250,000 for property damage.

Landlord shall be named as an additional insured and the policy or policies shall contain cross-liability endorsements.

In the event that Landlord determines, in Landlord's reasonable judgment, that the limits of the public liability, property damage, or products liability insurance then carried by Tenant are materially less than the amount or type of insurance typically carried by owners or tenants of

properties located in the same county in which the Premises are located, which are similar to and operated for similar business purposes as the Premises, Landlord may elect to require Tenant to increase the amount of specific coverage, change the type of policy carried, or both. If Landlord so elects, Tenant shall be notified in writing of the specific change in policy amount or type required and shall have 30 days after the date of Landlord's notice to effect the change in amount or type of policy. Unless otherwise agreed by Landlord and Tenant, any adjustment under this section may be made not more often than every two years.

5.02 Tenant's Personal Property. Tenant shall at all times during the term of this Lease and at Tenant's sole expense, keep all of Tenant's personal property, including trade fixtures and equipment and all merchandise of Tenant that may be in the Premises from time to time, insured against loss or damage by fire and by a peril included within fire and extended coverage insurance for an amount that will insure the ability of Tenant to fully replace the trade fixtures, equipment, and merchandise.

5.03 Worker's Compensation Insurance. Tenant shall maintain in effect throughout the term of this lease, at Tenant's sole expense, Workers' Compensation insurance in accordance with the laws of California, and employers' liability insurance with a limit of not less than $1,000,000 per employee and $1,000,000 per occurrence.

5.04 Cancellation Clause. Any policy of insurance required under this Article shall be written by insurance companies authorized to do business in California.

5.05. Deposit of Insurance Policies With Landlord. Promptly on this issuance, reissuance, or renewal of any insurance policy required by this lease, including fire and liability insurance policies, Tenant shall cause a duplicate copy of the policy or a certificate evidencing the policy and executed by the insurance company issuing the policy or its authorized agent to be given to Landlord.

5.06. Taxes. Tenant shall promptly pay, and not allow to fall into arrears, all personal property taxes assessed against it by the County of Inyo, State of California, or by any other competent governmental authority.

5.07. Conditions. Tenant acknowledges and agrees that its obligations under this Article V are conditions, and not covenants, of its right to occupy the Premises under this Lease and that its failure to comply with any term or requirement of this Article shall be cause for termination and forfeiture of the Lease.

ARTICLE VI
DESTRUCTION OF PREMISES

6.01. Duty to Repair or Restore. If any improvements, including buildings and other structures, located on the Premises are damaged or destroyed during the term of this lease or any renewal or extension thereof, the damage shall be repaired as follows:

(a) If damage or destruction is caused by a peril against which insurance is not required to be carried by this lease, Landlord, subject to its right to terminate this lease described in Section 6.02, shall repair that damage as soon as reasonably possible and restore the Premises to substantially the same condition as existed before the damage or destruction.

(b) If the damage or destruction is caused either by a peril against which fire and extended coverage insurance is required by this lease to be carried by Tenant, or by a peril against which insurance is not required to be carried by this lease, Tenant expressly

waives any right under Civil Code Section 1931-1933 to terminate this lease for damage or destruction to the Premises.

6.02. Termination of Lease for Certain Losses.

(a) Tenant or landlord shall have the right to terminate this lease under either of the following circumstances:

(1) If the Premises are destroyed from any cause whatsoever, insured or uninsured, during the term of this lease (provided that destruction to extend the term of this lease in accordance with the provisions of Section 1.02) or during the extended tern, if any, of this lease.

(b) Either party may terminate this lease by giving written notice of termination to the other not later than four (4) days after occurrence of the event giving rise to termination under subsection (a), and termination shall be effective as of the date of the notice of termination. In the event of a termination under subsection (a), Tenant shall not be entitled to collect any insurance proceeds attributable to insurance policies covering the Premises or improvements, except those proceeds attributable to Tenant's personal property and trade fixtures.

(c) If this lease is terminated pursuant to either subsection (a) or (b) above, rent, taxes, assessments, and other sums payable by Tenant to Landlord under this lease shall be prorated as of the termination date. If any taxes, assessments, or rent have been paid in advance by Tenant, Landlord shall refund it to Tenant for the unexpired period for which the payment has been made.

6.03. Time for Construction of Repairs. Any and all repairs and restoration of improvements required by this Article shall be commenced by Landlord or Tenant, as the case may be, within a reasonable time after occurrence of the damage for destruction requiring the repairs or restoration, shall be diligently pursued after being commenced; and shall be completed within a reasonable time after the loss. If Landlord is required under this lease to perform the repairs and restoration, Landlord shall cause the repairs and restoration to be completed not later than 180 days after occurrence of the event causing destruction or Tenant shall have the right to terminate this lease.

6.04. Abatement of Rent.

(a) If the damage or destruction to the Premises is caused by a peril against which insurance is not required to be carried under this lease, rent shall be abated only for the time and to the extent Tenant is prevented from occupying the Premises for the uses authorized in this lease.

(b) If the damage or destruction is caused by a peril against which insurance is required to be carried by Section 5.01 of this lease, Tenant shall continue to pay the full amount of rent required under this lease notwithstanding the fact that damage or destruction renders the Premises either partially or completely uninhabitable for the uses authorized by this lease.

ARTICLE VII
CONDEMNATION

7.01 Total Condemnation Defined. The term "total condemnation" as used in this Article shall mean the taking by eminent domain ("condemnation") by a public or quasi-public agency or entity having the power of eminent domain ("contemnor") of either;

(a) More than 35 percent (35%) of the ground area of the Premises; or

(b) Less than 35 percent (35%) of the ground area of the Premises at a time when the remaining buildings or improvements on the Premises cannot reasonably be restored to a condition suitable for Tenant's occupancy for the uses permitted by this lease within 90 normal eight-hour working days under all laws and regulations then applicable; or

(c) Less than 35 percent of the ground area of the Premises is such a manner that Tenant is substantially prevented from carrying on operations of a permitted use under this lease on the remaining portion of the Premises.

7.02. Partial Condemnation Defined. The term "partial condemnation" as used in this Article shall mean any condemnation of a portion of the Premises that is not a total condemnation under Section 7.01 of this lease.

7.03. Termination for Total Condemnation. In the event of a total condemnation of the Premises during the term of this lease, this lease shall terminate without further notice as of 12:01 A.M. on the date actual physical possession of the condemned property is taken by the condemnor. All rent payable under this lease shall be prorated as of 12:01 A.M. on that date and a prompt refund or payment of rent for the unexpired period of this lease shall be made by Landlord to Tenant. On the making of that rent adjustment, both Landlord and Tenant will be released and discharged from any and all further obligations under this lease.

7.04. Effect of Partial Condemnation. In the event of a partial condemnation of the Premises, this lease shall terminate as to the portion of the Premises taken on the date actual physical possession of the portion is taken by the condemnor but shall remain in full force and effect as to the remainder of the Premises, provided, however, that promptly after the taking of actual physical possession by the condemnor of the portion taken by condemnation, Landlord shall restore, at Landlord's own cost and expense, the improvements on the remainder of the Premises to a condition making the Premises tenantable by Tenant for the uses permitted by this lease. Any rent payable under this lease after the date actual physical possession is taken by eminent domain bears to the total ground area of the Premises on the date of this lease. In addition, the rent payable under this lease shall be further abated during the time and to the extent Tenant is prevented from occupying all of the remainder of the Premises by the work of restoration required by this section to be performed by Landlord.

7.05. Landlord's Power to Sell in Lieu of Condemnation. Landlord may, without any obligation or liability to Tenant and without affecting the validity or continuation of this lease other than as expressly provided in this Article, agree to sell or convey to the condemnor, without first requiring that an action or proceeding for condemnation be instituted or tried, the portion of the Premises sought by the condemnor free from this lease and the rights of Tenant in the Premises other than as provided in this Article.

7.06. Condemnation Award. All compensation and damages awarded or paid for the condemnation of the Premises or any portion of the Premises, for any sale in lieu of condemnation as authorized by Section 7.05 of this lease, shall, except as otherwise expressly provided in this section, belong to and be the sole property of Landlord. Tenant hereby assigns to Landlord any claim Tenant might have except for this provision against Landlord, the leased Premises, or condemnor for diminution in value of the unexpired term of this lease; provided however, that Tenant is entitled to seek to recover from the condemnor, but not from Landlord.

(a) The cost of removing any trade fixtures, furniture, or equipment from the portion of the Premises taken by condemnation;

(b) The value of any improvements installed by Tenant on the portion of the Premises taken by condemnation that Tenant has a right to remove under this lease but that Tenant elects not to remove; and

(c) The then amortized value of all improvements made by Tenant on the portion the Premises taken by condemnation that could not be removed by Tenant on expiration of this lease either because of provisions of this lease or because the improvements would have no economic value on removal from the Premises.

ARTICLE VIII
INDEMNIFICATION

8.01. Tenant's Hold-Harmless Clause. Except as otherwise provided in Section 8.02. Tenant shall indemnify and hold Landlord and the property of Landlord, including the Premises, free and harmless from any and all liability, claims, loss, damages, or expenses, including counsel fees and costs, arising by reason of the death or injury of any person, including Tenant or any person who is an employee or agent of Tenant, or by reason of damage to or destruction of any property, including property owned by tenant or any person who is any employee or agent of Tenant, caused or allegedly cause by (1) any cause whatsoever while that person or property is in or on the Premises or in any way connected with the Premises or with any improvements or personal property on the Premises; (2) same condition of the Premises or some building or improvement on the Premises; (3) some act or omission on the Premises of Tenant or any person in, on, or about the Premises with the permission and consent of Tenant; or (4) any matter connected with Tenant's occupation and use of the Premises.

8.02. Landlord's Hold-Harmless Clause. Notwithstanding the provisions of Section 8.01 of this lease, Tenant shall be under no duty to indemnify and hold Landlord harmless from any liability, claims, or damages arising because of Landlord's failure to make any repairs required by this lease to be made by Landlord or because of any negligence or willful acts of misconduct by Landlord or by any person who is an agent or employee of Landlord acting in the course and scope of its agency or employment. Landlord agrees to indemnify, defend, protect, and hold Tenant free and harmless from and against any liability, claims, or damages arising from or in connection with Landlord's failure to make any repairs required by this lease to be made by Landlord or because of any negligence or willful acts of misconduct by Landlord or by any person who is an agent or employee of Landlord acting in the course and scope of its agency or employment.

ARTICLE IX
DEFAULT & REMEDIES

9.01. Remedies on Tenant's Default. If Tenant breaches this lease or breaches this lease and abandons the Premises before the natural exploration of the term of this lease, Landlord, in addition to any other remedy given Landlord by law or equity, may:

(a) Continue this lease in effect by not terminating Tenant's right to possession of the Premises, in which case Landlord shall be entitled to enforce all Landlord's rights and remedies under this lease, including the right to recover the rent specified in this lease as it becomes due under this lease.

(b) Terminate this lease and recover from tenant:

(1) The worth, at the time of award, or the unpaid rent that has been earned at the time of termination of the lease;

(2) The worth, at the time of award, of the amount by which the unpaid rent that would have been earned after termination of the lease until the time of award exceeds the amount of rental loss that Tenant proves could have been reasonably avoided;

(3) The worth, at the time of award, of the amount by which the unpaid rent for the balance of the term after the time of award exceeds the amount of rental loss that Tenant proves could be reasonably avoided; and

(4) Any other amount necessary to compensate Landlord for all detriment proximately caused by Tenant's failure to perform the obligations under this lease; or

(c) Terminate the lease and, in addition to any recoveries Tenant may seek under paragraph (b) of this section, bring an action to reenter and regain possession of the Premises in the manner provided by the laws of unlawful detainer then in effect in California.

9.02. Termination by Landlord. No act of Landlord, including but not limited to Landlord's entry on the Premises or efforts to relet the Premises, or the giving by Landlord to Tenant of a notice of default, shall be construed as an election to terminate this lease unless a written notice of the Landlord's election to terminate is given to Tenant or unless termination of this lease is decreed by a court of competent jurisdiction.

9.03. Default by Tenant. All covenants and agreements contained in this lease are declared to be conditions to this lease and to the term hereby leased to Tenant. The following constitute a material default and breach of this lease by tenant:

(a) Any failure to pay rent when due when the failure continues for three days after written notice to pay that rent or surrender possession of the Premises is served on Tenant by Landlord; or

(b) Any failure to perform any other covenant, condition, or agreement contained in this lease when the failure is not cured within three days after written notice of the specific failure is given by Landlord to Tenant.

(c) The bankruptcy or insolvency of Tenant, the making by Tenant of any general assignment for the benefit of creditors; the filing by or against Tenant of a petition to have Tenant adjudged a bankrupt or of a petition for reorganization or arrangement under the Bankruptcy Act (unless, in the case of a petition filed against Tenant, it is dismissed within 60 days); the appointment of a trustee or receiver to take possession of substantially all of Tenant's assets located at the Premises or of Tenant's interest in this lease; if possession is not restored to Tenant within 30 days; of the attachment, or other judicial seizure of substantially all of Tenant's assets located at the Premises or of Tenant's interest in this lease, when that seizure is not discharged within 15 days.

(d) The abandonment or vacating of the Premises by Tenant (which, for purposes of this lease, shall mean Tenant's failure to occupy and operate the Premises for business for a period of at least 30 consecutive days).

9.04. Cumulative Remedies. The remedies granted to Landlord in this Article shall not be exclusive but shall be cumulative and in addition to all other remedies now or hereafter allowed by law or authorized in this lease.

9.05. Waiver of Breach. The waiver by Landlord of any breach by Tenant of any of the provision of this lease shall not constitute a continuing waiver or a waiver of any subsequent default or breach by Tenant either of the same or a different provision of this lease.

ARTICLE X
MISCELLANEOUS

10.01. Assignment and Subletting. Tenant shall not encumber, assign, or otherwise transfer this lease, any right or interest in this lease, or any right or interest in the Premises or any of the improvements that may now or hereafter be constructed or installed on the Premises without first obtaining the written consent of Landlord. Tenant shall not sublet the Premises or any part of the Premises nor allow any other person, other than Tenant's agents, servants, and employees, to occupy the Premises or any part of the Premises without the prior written consent of the Landlord. Any encumbrance, assignment, transfer, or subletting without the prior written consent of Landlord, whether voluntary or involuntary, by operation of law or otherwise is void and shall, at the option of Landlord, terminate this lease.

10.02. Utilities. Tenant shall pay all charges incurred for utilities furnished to and/or used in Tenant's practice within, and occupancy of, the Premises including but not limited to propane, electricity, water, telephone service, internet connections, garbage or refuse service, and other public utilities during the term of this lease. All payments shall be made directly to the service provided before their delinquency.

10.03. Notices. Except as otherwise expressly provided by law, any and all notice or other communications required or permitted by this lease or by law to be served on or given to either party to this lease by the other party shall be in writing and shall be deemed duly served and given when personally delivered to the party to whom it is directed or to any managing employee or officer of that party or, in lieu of personal service, when deposited in the United States mail, first-class postage prepaid, addressed as follows:

TO TENANT: Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

TO LANDLORD: Pioneer Medical Associates
152 Pioneer Lane, Suite "C"
Bishop, California 93514

Either party, Landlord or Tenant, may change its address for purposes of this section by giving written notice of that change to the other party in the manner provided in this section.

10.04. Attorney's Fees. If any litigation, is commenced between the parties to this lease concerning the Premises, this lease, or the rights and duties of either in relation to this lease, the party prevailing in that litigation shall be entitled, in addition to any other relief that may be granted in the litigation, to a reasonable sum as and for its attorneys' fees in the litigation.

10.05. Binding on Heirs and Successors. This lease shall be binding on and shall inure to the benefit of the heirs, executors, administrators, trustees, conservators, personal representatives, successors, agents, and assigns of both Landlord and Tenant, but nothing contained in this section shall be construed as consent by Landlord to any assignment of this lease or any interest in this lease by Tenant.

10.06. Time of Essence. Time is expressly declared to be of the essence of this Lease, and each term or condition thereof.

10.07. Sole and Only Agreement. This instrument constitutes the sole and only agreement between Landlord and Tenant respecting the Premises, the leasing of the Premises to Tenant, and the lease terms contained in this lease, and correctly set forth the obligation of Landlord and Tenant to each other as of its date. Any agreements of representations respecting the Premises or their leasing by Landlord to Tenant not expressly set forth in this instrument are null and void.

EXECUTED at Bishop, California, on the day, month and year first above written.

PIONEER MEDICAL ASSOCIATES, a General Partnership, landlord

By _____
Managing Partner

NORTHERN INYO HEALTHCARE DISTRICT, Tenant

By _____

_____
Northern Inyo Healthcare District

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

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Compliance Report
February 2020

1. Comprehensive Compliance Program review
    a. As February 8, 2020, 98.1% District's employee (including temporary, traveler, and contract workers) workforce have reviewed the Compliance Program. This number fluctuates due to employee turnover.
    b. 92% of District workforce, including providers, have completed HIPAA training for CY 2019 (updated 11/2019, waiting for 2019 totals).
2. Breaches
    a. Calendar Year (CY) 2019 (Charts and graphs will return in future reports)
        i. 65 alleged breaches of PHI (Protected Health Information) potentially affecting approximately 500 patients have been investigated by the Compliance Office
        ii. 7 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and/or the Office of Civil Rights (OCR)
            1. CDPH has completed investigation of five cases. All 5 were substantiated, but assigned no deficiency.
            2. Two cases are still pending CDPH investigation.
            3. Several cases from prior years are still pending letters of findings, indicating that at least several may incur some level of deficiency and penalty.
        iii. 6 reported potential breaches/privacy concerns are currently under investigation by the NIHD Compliance Department.
3. Issues and Inquiries
    a. CY 2019 – Several hundred requests for research and input on a wide variety of compliance, ethics, and regulatory topics have been made to the Compliance Department.
    b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2019, Compliance has verified several hundred providers. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.

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   i. Compliance has identified two referring providers on an exclusions list in 2019. We have notified Administration, and have properly addressed the issues.

4. Audits
   a. Employee Access Audits (see tables, attachment A) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, "need to know," and "minimum necessary" basis.
      i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
      ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
      iii. Compliance has updated the methodology to ensure audits are done within days of patient visits rather than the beginning of the following month, as previously performed. This allows for thorough auditing within days of any event.
      iv. Compliance performs between 250-500 audits monthly.
         1. Each audit ranges from hundreds of lines of data to thousands of lines of data.
      v. Protenus has been selected to provide semi-automated auditing software services to NIHD, however, Athena is unable to meet its requirements for the data feeds. Protenus will be reassessed following implementation of a new EHR.
   b. Business Associates Agreements (BAA) audit
      i. Contracts will be reviewed in 2020 to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
      ii. We currently have approximately 140 Business Associates Agreements.
   c. PACS (Picture Archival and Communication System) User Access Agreements – Compliance is now processing access agreements for external entities/providers to gain access to the NIHD PACS Portal (electronic Imaging system).

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d. HIMS scanning audit – small sample audit of patient charts demonstrated 100% compliance with scanned document locations (12/2019)
e. Language Access Services Audit – Small sample audit of limited English proficiency (LEP) patient charts for 5-7 areas of documentation each found 0 charts with 100% correct documentation (11/2019). Compliance and Language Access Services working to develop plans for tools and additional education for workforce.
f. HIPAA Security Risk Assessment – Completed November 2019 (requires collaboration between Compliance Officer and Security Officer)
    i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.
    ii. Risk Management plan is currently in development
    iii. NIHD is currently in a "soft roll out" of the VendorMate (GHX) vendor credentialing software. This allows us to be compliant with our Vendor Credentialing Policy, and several facility security elements of 45 CFR 164. Hard go-live is tentatively scheduled for March 2020.
g. An audit of the 340B plan has been conducted. The report will go to the Compliance and Business Ethics Committee in February 2020 to provide a recommendation to NIHD Executive Team.
h. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is currently underway. This will provide organized historic data to the Board and allow the Board to determine if appropriate follow up has been taken for Action items and Resolutions.

5. Conflicts of Interest questionnaires
    a. Compliance will send the 2020 Conflict of Interest Questionnaires out in the month of March.
6. CPRA (California Public Records Act) Requests
    a. The Compliance office has responded to 21 CPRA requests in CY 2019.
        i. 4 requests throughout the year for companies that harvest purchasing data from healthcare organizations to aid their marketing products.
        ii. 1 request is from Transparent California
        iii. 9 are from District residents
        iv. 7 requests have been from the ASCFME organizer or their legal representatives.

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   b. The Compliance office is responding to 3 CPRA requests in CY 2020.
      i. 1 from the Center for Contract Compliance - Construction
      ii. 1 request is from a local journalist
      iii. 1 is from a local District resident
7. Compliance Workplan (attachment B)
   a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
   b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.
   c. The attached work plan was updated in February 2020 for progress and is scheduled for review in the Compliance and Business Ethics Committee.
8. Unusual Occurrence Reports (UOR) (Attachment C)
   a. All unusual events are reported through the UOR system. (complaints, med errors, unusual events, Corrective Action Plan tracking items, etc)
   b. See attached reports – please note while data has been validated, we are still getting the reports "dialed in"
      i. Some labeling needs to be corrected
      ii. Some layout features need to be corrected
   c. ComplyTrack- tracking software – system went live on 4/15/2019 and will be transitioning to Nursing Quality in April of 2020.
9. CDPH Licensing Survey Response Monitoring (Attachment D)
   a. Compliance has been working with Department leadership teams to follow corrective actions and monitor for sustained compliance. Those metrics will be reported here, no less than annually. Metrics that have already been reported to the Board of Directors as completed have been removed from this list.
      i. E 239 - Referral arrangements from non-staff ordering providers. – Monitoring in progress 11/2019
      ii. E 242 - Pediatric Consultations – Monitoring in progress 11/2019
      iii. E1363 - Expired supply in crash cart - Monitoring in progress 11/2019
      iv. E 2150 - Infection Prevention Program monitoring – Monitoring in progress 10/2019

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1. Cleaning Wet time – ongoing monitoring 11/2019

v. E 2151 - Workforce N95 mask fit testing – Goal achieved. Quarterly monitoring for 2 additional quarters.

10. The Joint Commission Survey Response
    a. Submitted and accepted
    b. Monitoring will be submitted to the Board in May 2020 Report.
11. Compliance and Business Ethics Committee
12. Auditing and Monitoring for CDPH 00580957 (ends March 2020)
    a. Audit of Surgeons for printing documents for intra-facility transport:
    No documents were printed for transport between office and Hospital between April 2018 and January 2020.

Employee Access Audits

A

	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
TOTAL ED SAME LAST NAME ENCOUNTERS	234	240	37	12	107	53
AUDITED ED SAME LAST NAMES ENCOUNTERS	234	240	37	12	107	53
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL ED HIGH PROFILE PT ENCOUNTERS	4	5	5	1	13	7
AUDITED ED HIGH PROFILE ENCOUNTERS	4	5	5	1	13	7
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL ED - EMPLOYEE ENCOUNTERS	2	10	13	7	8	17
AUDITED ED - EMPLOYEE ENCOUNTERS	2	10	13	7	8	17
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP SAME LAST NAME ENCOUNTERS	22	24	16	12	11	12
AUDITED IP SAME LAST NAMES ENCOUNTERS	22	24	16	12	11	12
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP HIGH PROFILE PT ENCOUNTERS	0	0	2	0	0	0
AUDITED IP HIGH PROFILE ENCOUNTERS	0	0	2	0	0	0
% AUDITED	#DIV/0!	#DIV/0!	100.0%	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL IP - EMPLOYEE ENCOUNTERS	0	0	10	3	0	2
AUDITED IP - EMPLOYEE ENCOUNTERS	0	0	10	3	0	2
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	100.0%
TOTAL OP SAME LAST NAME ENCOUNTERS			144	56	28	232
AUDITED OP SAME LAST NAMES ENCOUNTERS			144	56	28	232
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP HIGH PROFILE PT ENCOUNTERS			18	7	11	26
AUDITED OP HIGH PROFILE ENCOUNTERS			18	7	11	26
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP - EMPLOYEE ENCOUNTERS			91	125	128	178
AUDITED OP - EMPLOYEE ENCOUNTERS			91	125	128	178
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL NEW (<90 DAY) EMPLOYEES	2	6	16	7	11	15
AUDITED NEW (<90 DAY) EMPLOYEES	2	6	16	7	11	15
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FOR-CAUSE AUDITS	5	9	2	0	4	3
Total # monthly audits	269	294	354	230	321	545

Compliance changed the methodology to provide more effective and efficient auditing of high risk records in August of 2019.

Annual Compliance Workplan

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Completed Jan 2020
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17) Educational and instructional information on Board Oversight and Fiduciary Responsibilities sent to Board in December 2019 and January 2020.	Colin Coffey, Jan 2019. "Takeaways" from monthly HCCA magazine
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		In progress
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Annual review conducted on regular monthly schedule Throughout the year
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.	R-BAT created 7/2018. Currently working with Athena to update RBA controls.	Stalled due to lack of granularity of Athena access control security
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce	Completed at Orientation. Need to send to Med Staff. PPM and Relias for current workforce.	

Annual Compliance Workplan

	referrals and other current legal standards.		
Compliance Communication			
11.	Review investigation UORs. Prepare summary report for Compliance Committee on types of issues reported and resolution	Update for Complytrack	Feb 2020
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.		
13.	Document test and review of Compliance Hotline.		Completed 4/2019
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Completed 01/2020
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new providers. MSO verifies all medical staff. Accounting verifies all vendors.	Current through 02/2020
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		
17.	Audits		
	a. Telehealth audits		
	b. 340B Program	In progress	01/2020
	c. EMTALA		
	d. Cost reports	Wipfli	Completed at BOD 1/2020
	e. Payment patterns	PEPR report out in April	
	f. Bad debt/ credit balances		
	g. OPS – Home health and DME	HHS OIG target	
	h. PHH Annual Compliance Audit		02/2020
	i. Audit of District Board Agendas, Minutes, and Resolutions		12/2019 - ongoing
	j. Travel Reimbursement Audits		01/2020-ongoing
	k. Contract Audits		
	l. BAA audit		12/2019
	m. HIMS Scanned Document accuracy		12/2019

Annual Compliance Workplan

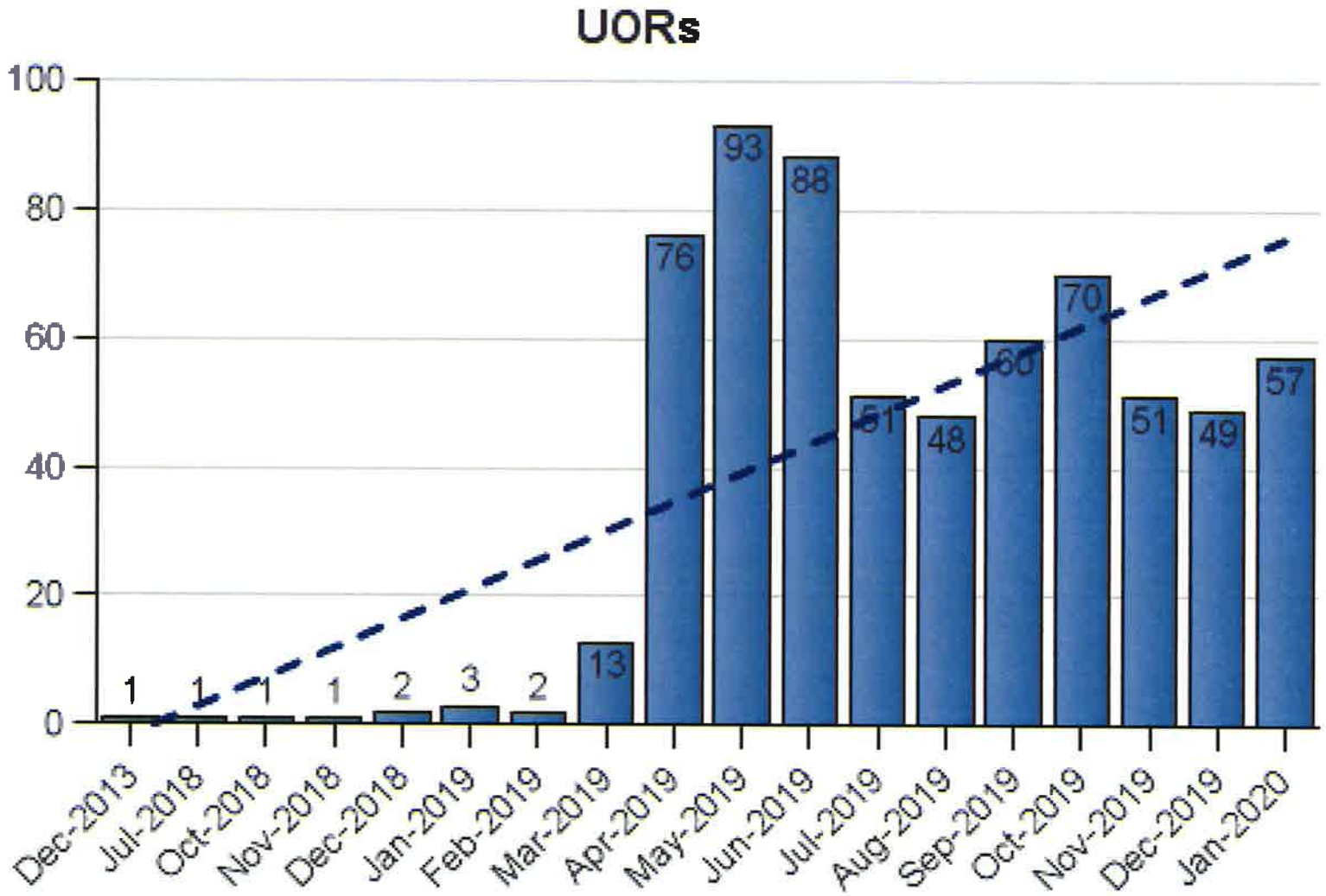
	n. Language access documentation accuracy		11/2019
	o. TJC corrective action plan		02/2020
	p. CMS Survey Corrective action plan		02/2020
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	Review of ABN usage, Authorizations in progress 02-2020
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		
	a. Annual Security Risk Assessment		Security Risk Assessment Completed 11/2019
	b. Periodic update to SRA		
	c. Monthly employee access audits		Current through 02/01/2020
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		
22.	Implement automated access monitoring/auditing software (Protenus)	On hold	Starts ~~January 2019~~ when we have an EHR that has the ability to interface data feeds.
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		01/2020
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		See TJC and CDPH monitoring plans - ongoing
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.	Working with WJ, MET, HIMS dept to review all audits, recoupments	02/2020
27.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function on the Compliance Department.	Complytrack – live 04/2019	UORs moving to Informatics/Nursing Quality
	a. Provide trend feedback to leadership to allow for data driven decision-making		On-going
	I. Overall UOR process		12/2019
	II. Workplace Violence		01/2020
	III. Sharps		02/2020
	IV. Overweight laundry		02/2020

Annual Compliance Workplan

29.	Patient complaints	On-going	moving to Informatics/Nursing Quality
30.	Breach Investigations	On-going	On-going – see Compliance report

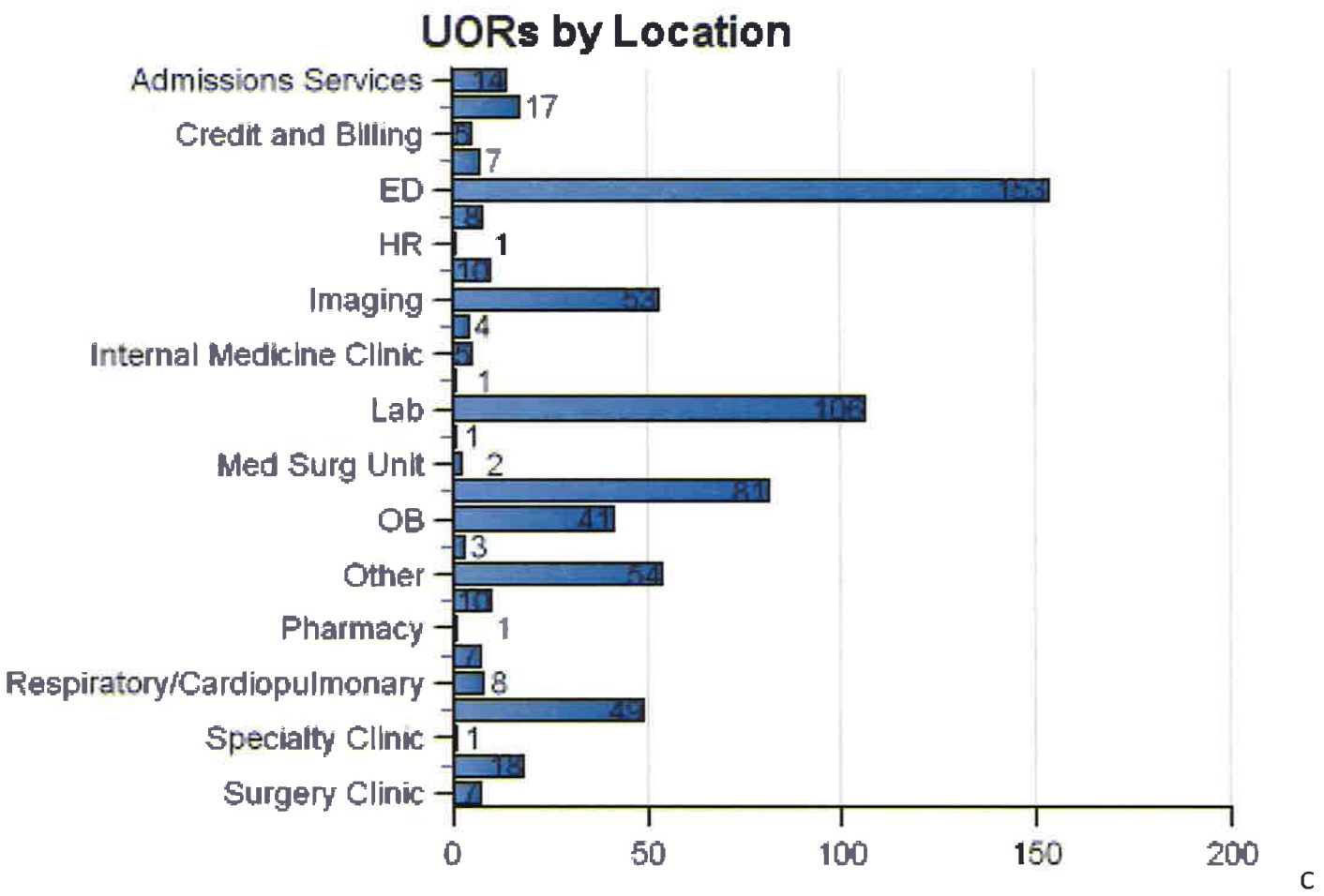
2020 Compliance Work Plan – updated 02/2020

Unusual Occurrence Trends



AMA is no longer a critical indicator for the ED, which explains the drop in reports following the June 2019 decision by Medical Staff.

Unusual Occurrence Trends



C

Unusual Occurrence Trends

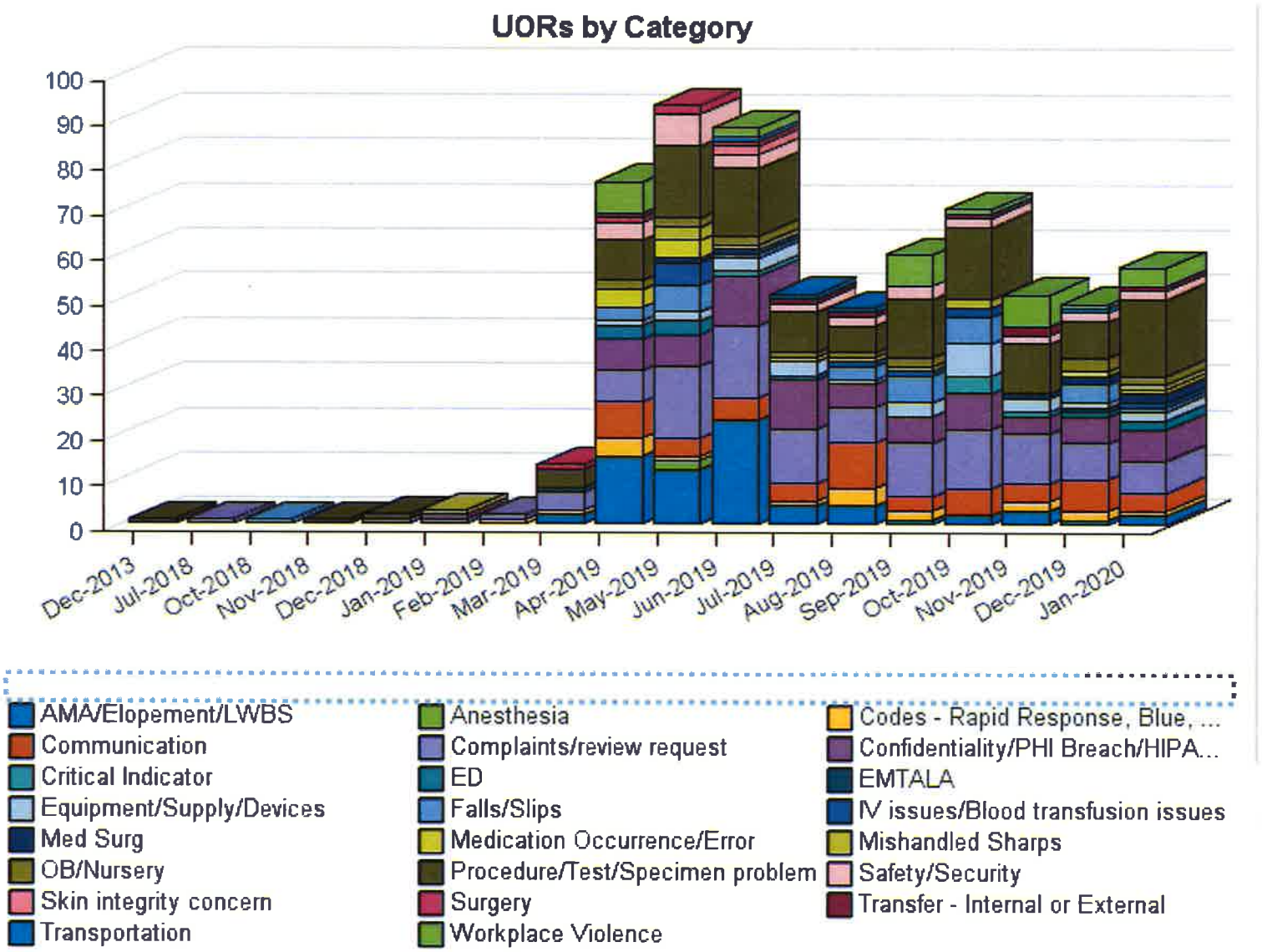
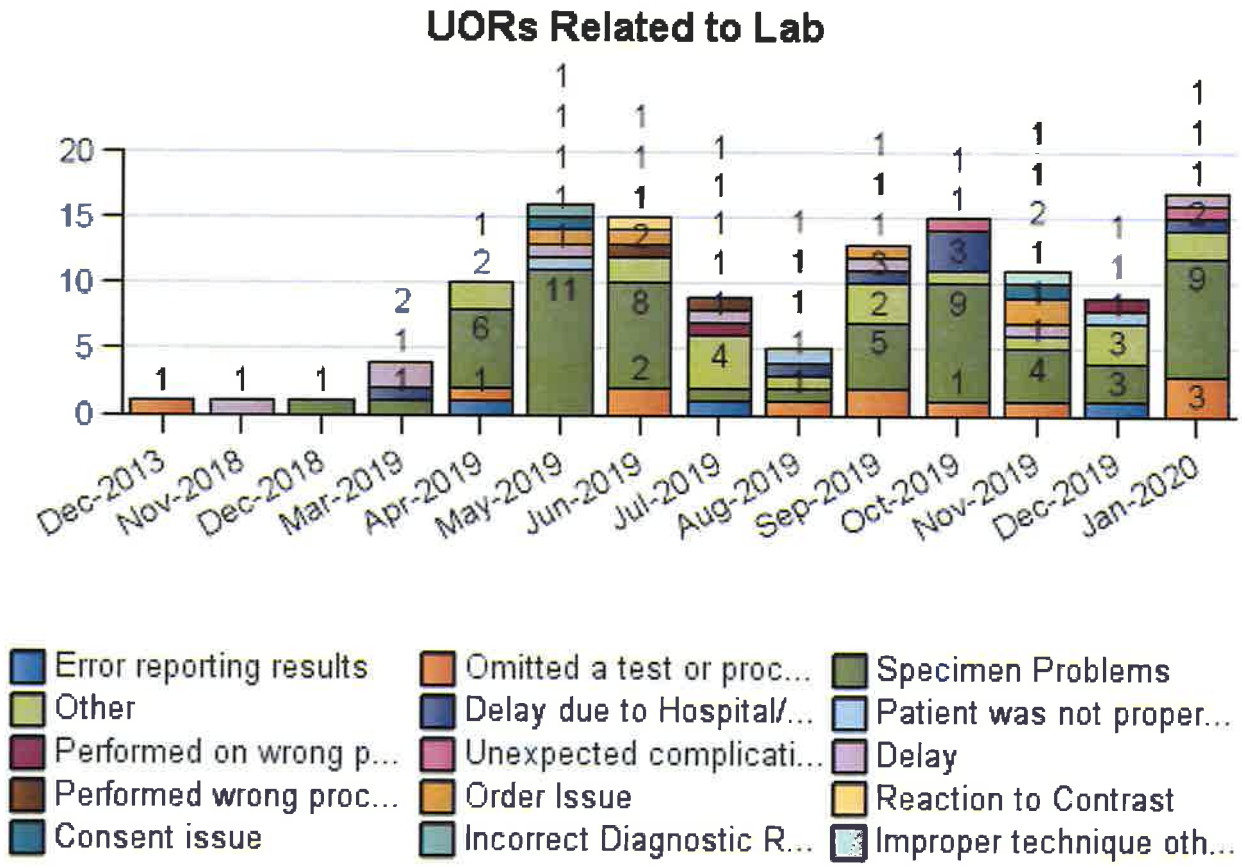


Chart data on following page

Unusual Occurrence Trends

	Dec-2013	Jul-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Total
AMA/Elopement/LWBS								2	15	12	23	4	4	1	2	3	1	2	69
Anesthesia										2									2
Codes - Rapid Response, Blue, Deescalation							1	1	4	1		1	4	2		2	2	1	19
Communication									8	4	5	4	10	3	6	4	7	4	55
Complaints/review request		1			1	1	1	4	7	16	16	12	8	12	13	11	8	7	118
Confidentiality/PHI Breach/HIPAA violation						1			7	7	11	11	5	6	8	4	6	7	73
Critical Indicator											1				4	1			6
ED									3	3		1					1	2	10
EMTALA																	1		1
Equipment/Supply/Devices									1	2	3	3	1	3	7	3	1	2	26
Falls/Slips			1						3	6	1		3	6	6		4	1	31
IV issues/Blood transfusion issues								1		5			1	1	2			1	11
Med Surg										1	1					1	2	2	7
Medication Occurrence/Error									4	4							1	1	10
Mishandled Sharps						1				3	1	1	1	1	2			1	11
OB/Nursery									2	2	2	1	1	2			3	2	15
Procedure/Test/Specimen problem	1			1	1			4	9	16	15	9	6	13	16	11	8	17	127
Safety/Security									4	7	3	2	2	3	2	2	2	2	29
Skin integrity concern											2								2
Surgery								1	1	2	1								5
Transfer - Internal or External									1			1	1		1	2		1	7
Transportation											1	1	1				1		4
Workplace Violence									7		2			7	1	7	1	4	29
Total	**1**	**1**	**1**	**1**	**2**	**3**	**2**	**13**	**76**	**93**	**88**	**51**	**48**	**60**	**70**	**51**	**49**	**57**	**667**

Unusual Occurrence Trends



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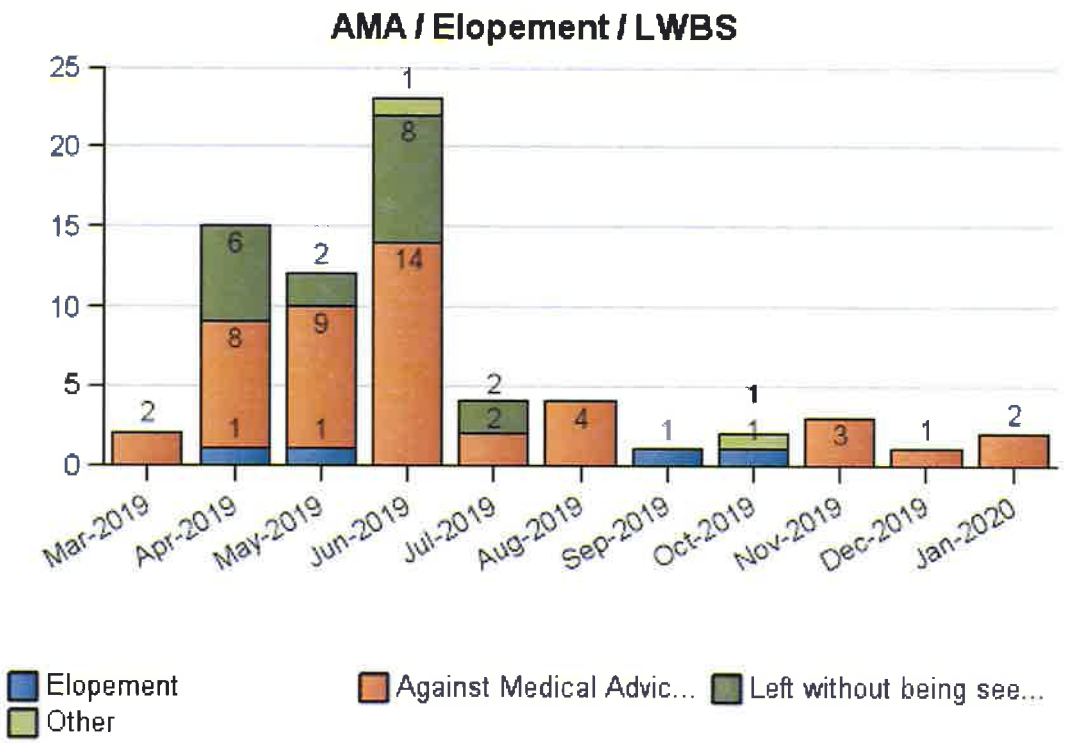
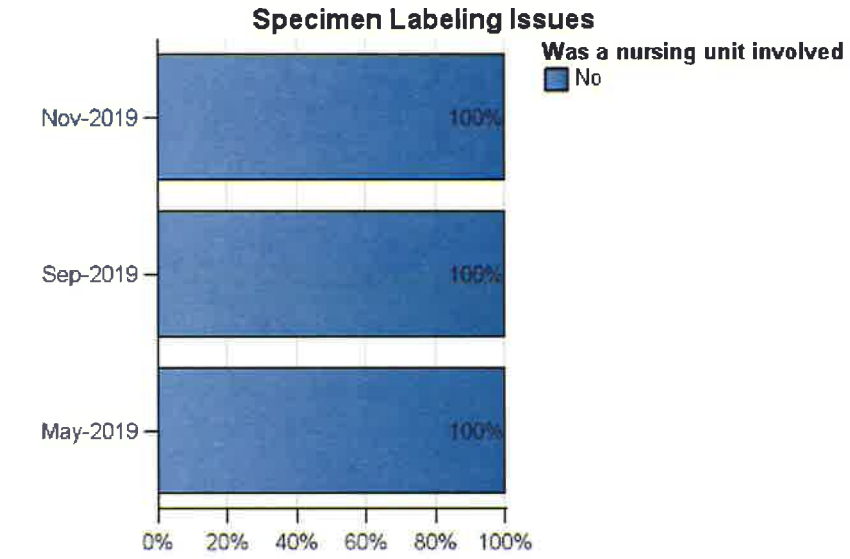
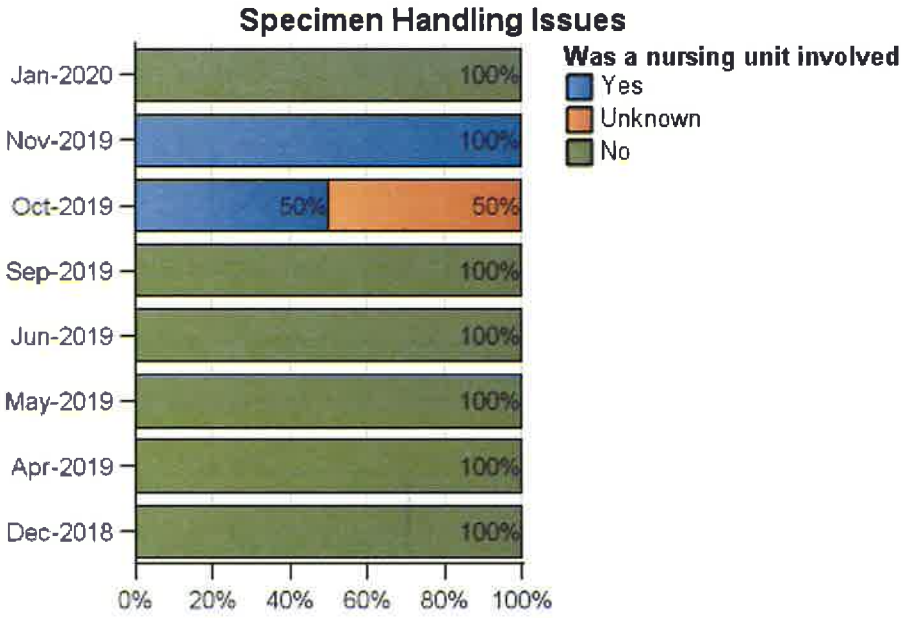


AMA is no longer a critical indicator for the ED, which explains the drop in reports following the June 2019 decision by Medical Staff.

Unusual Occurrence Trends





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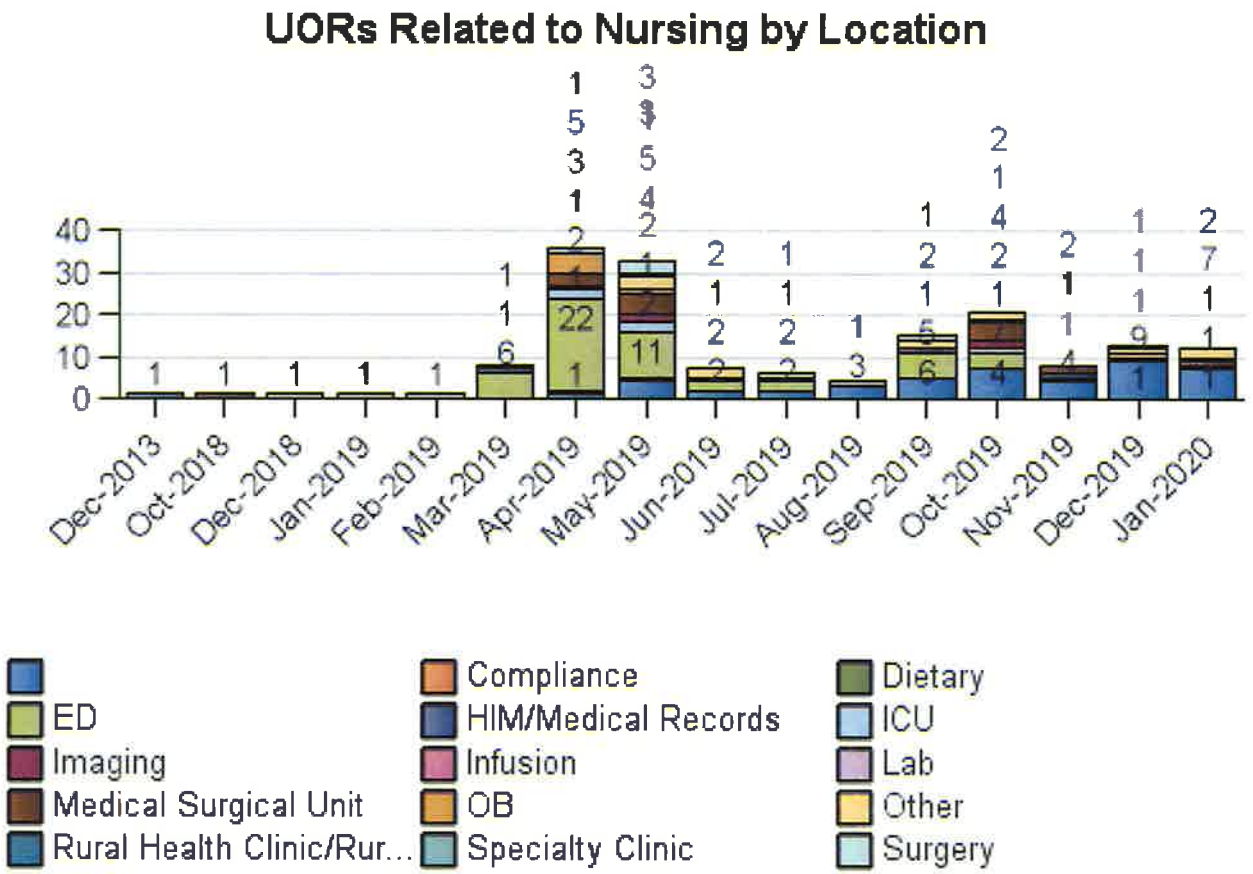
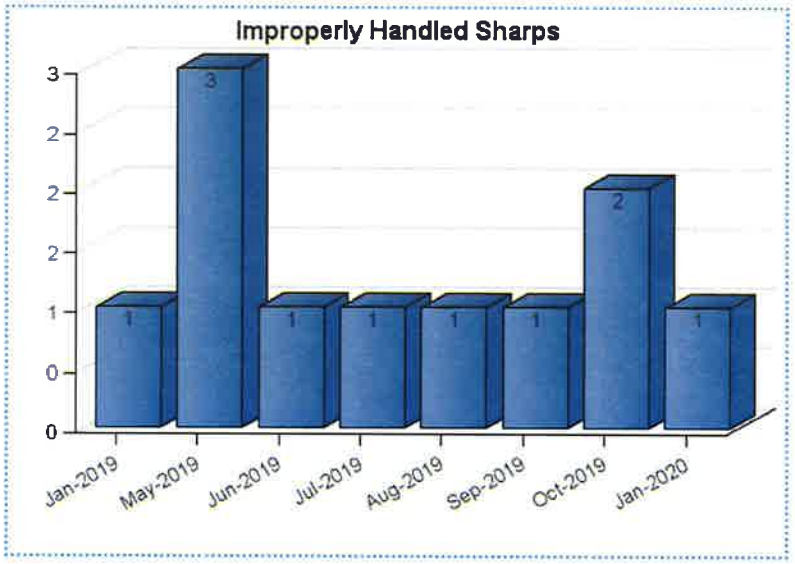
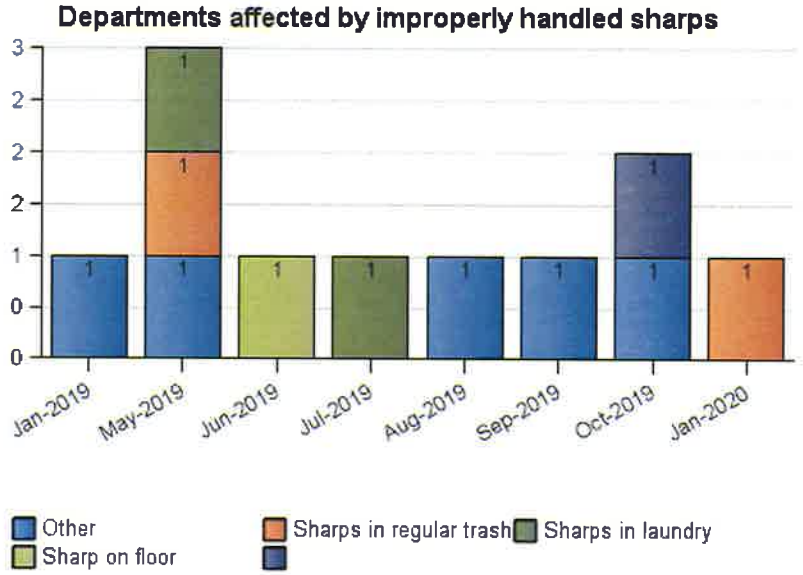


Working on labeling issues.

Unusual Occurrence Trends





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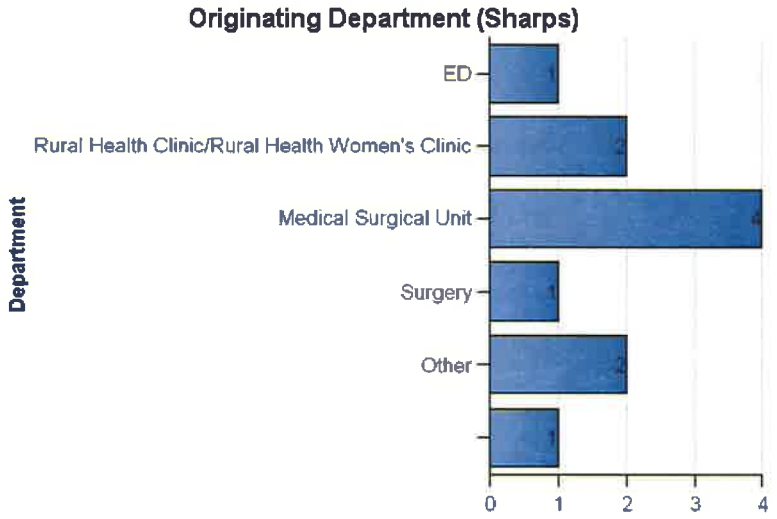

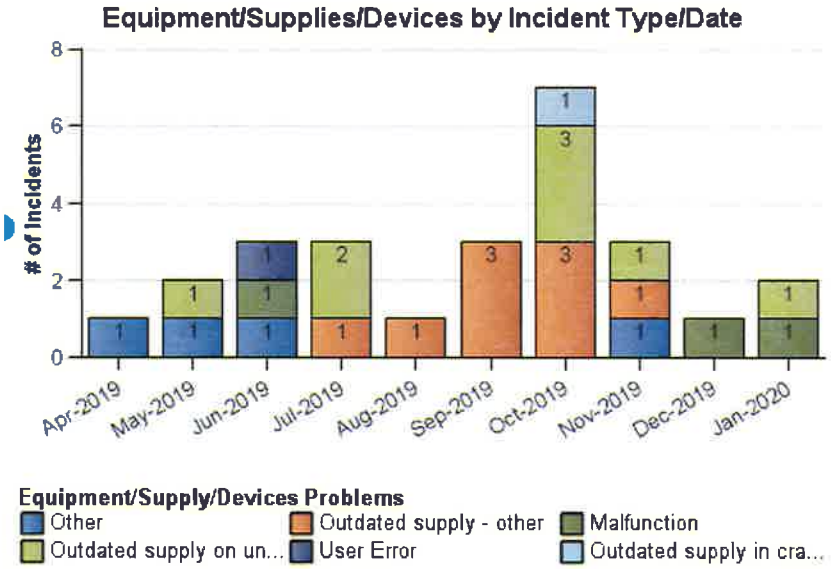

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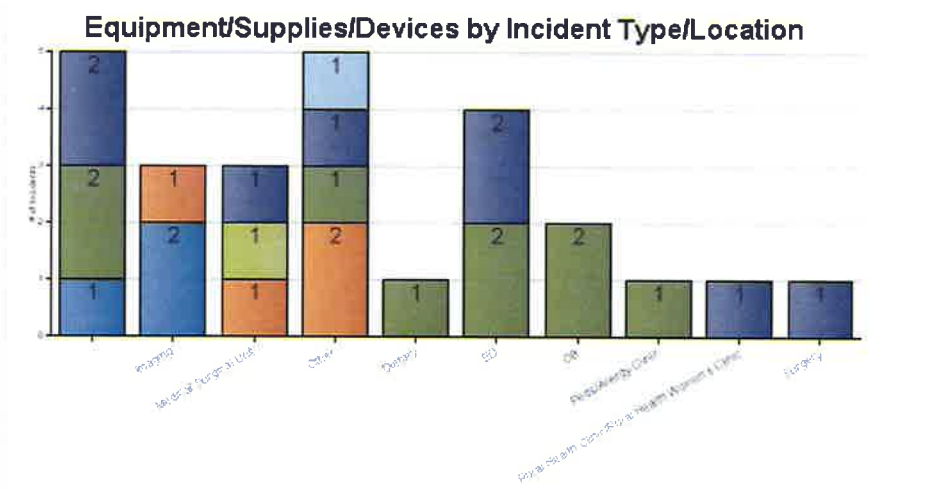

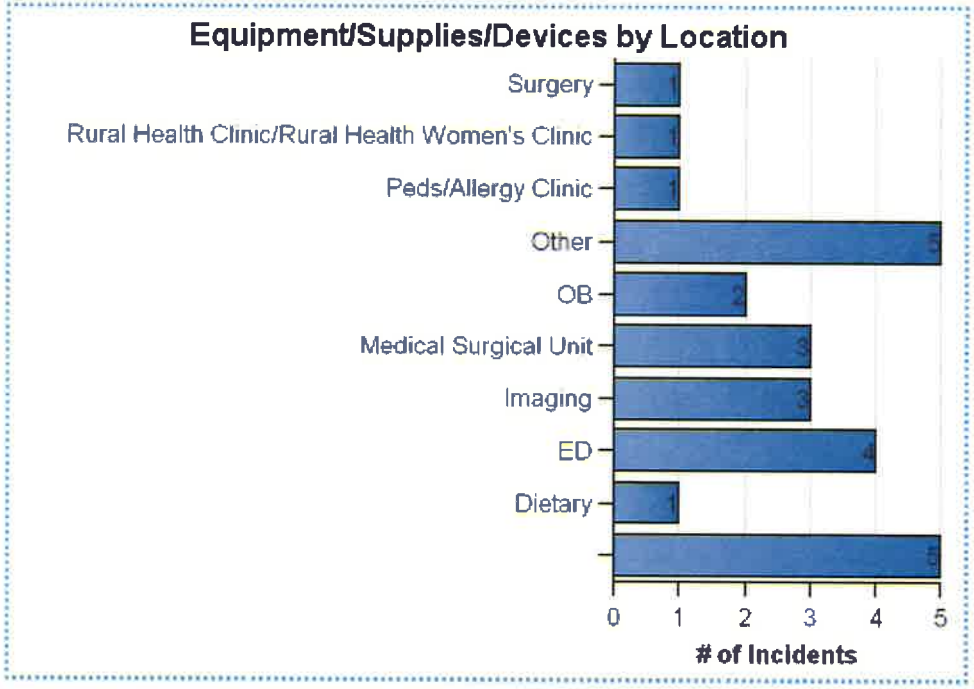

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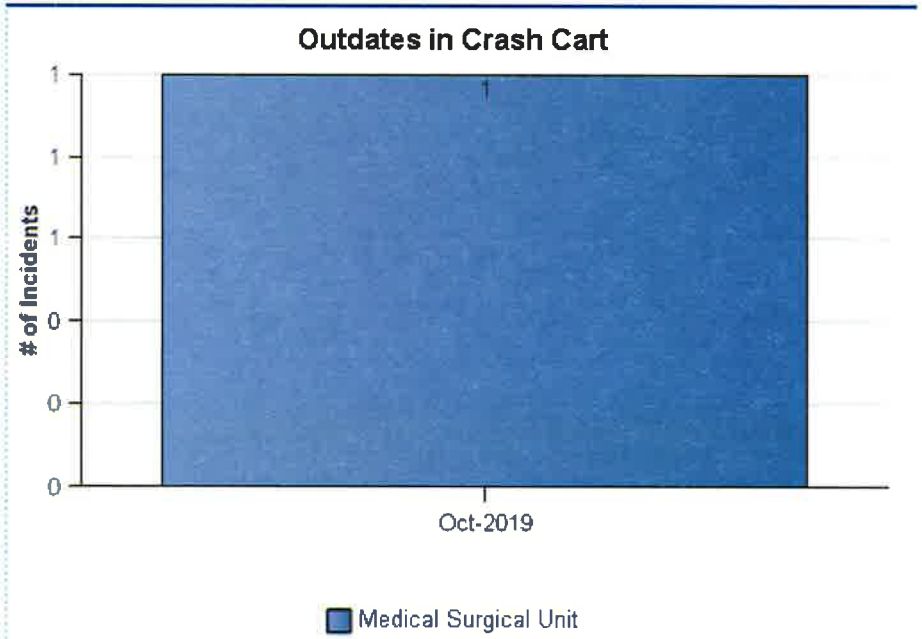
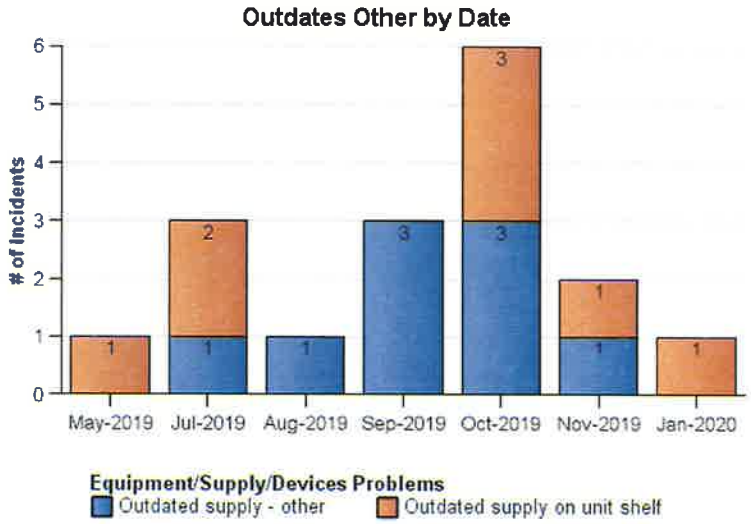
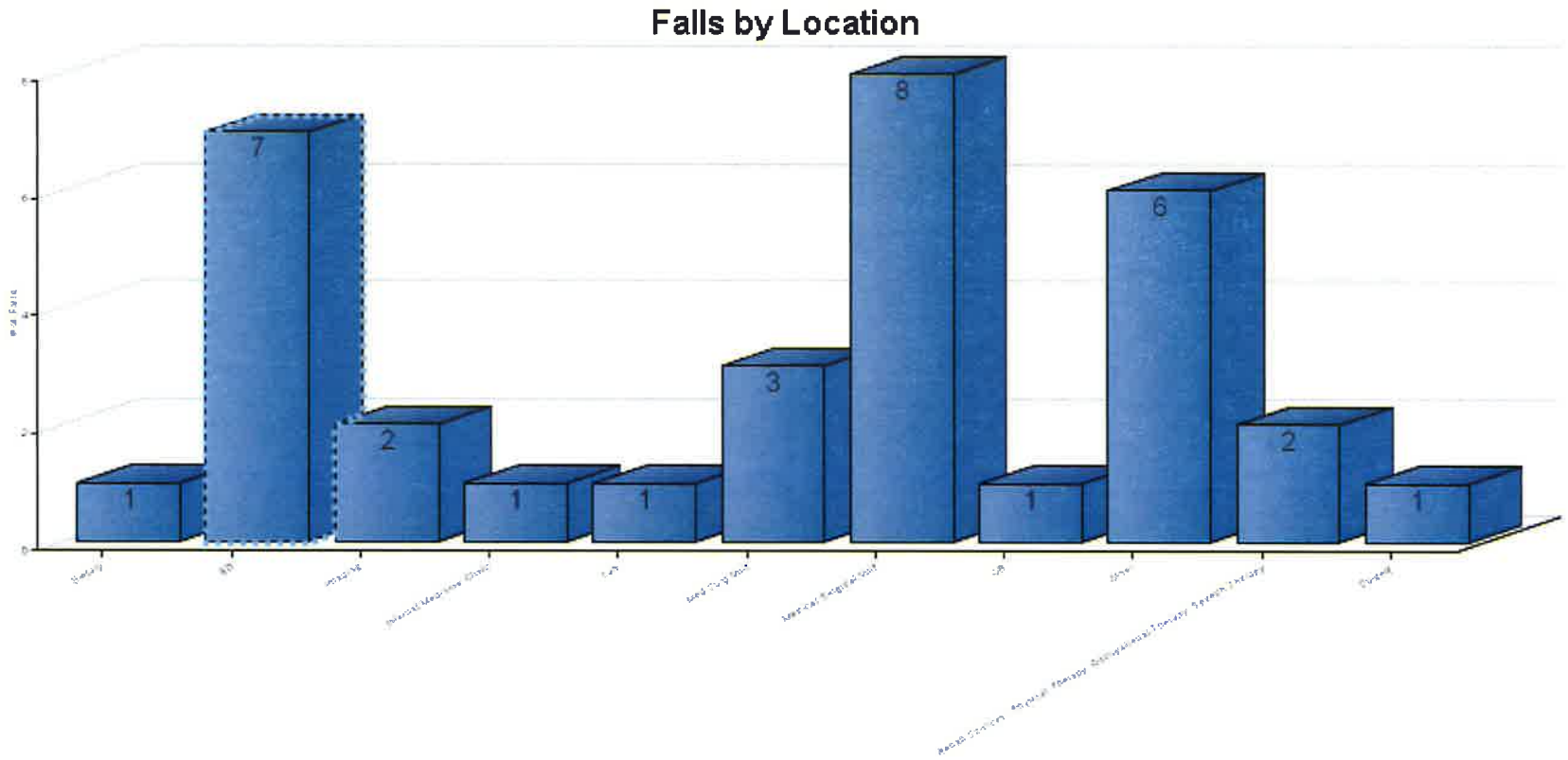




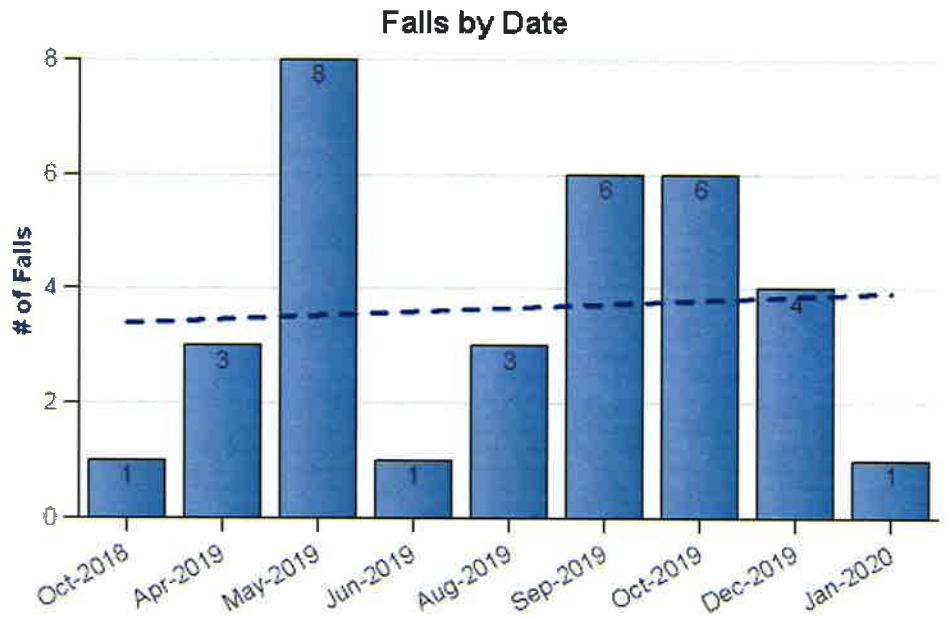
Unusual Occurrence Trends

# of Falls	Falls/Slips	Total
Dietary	1	1
ED	7	7
Imaging	2	2
Internal Medicine Clinic	1	1
Lab	1	1
Med Surg Unit	3	3
Medical Surgical Unit	8	8
OB	1	1
Other	6	6
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	2	2
Surgery	1	1
Total	33	33

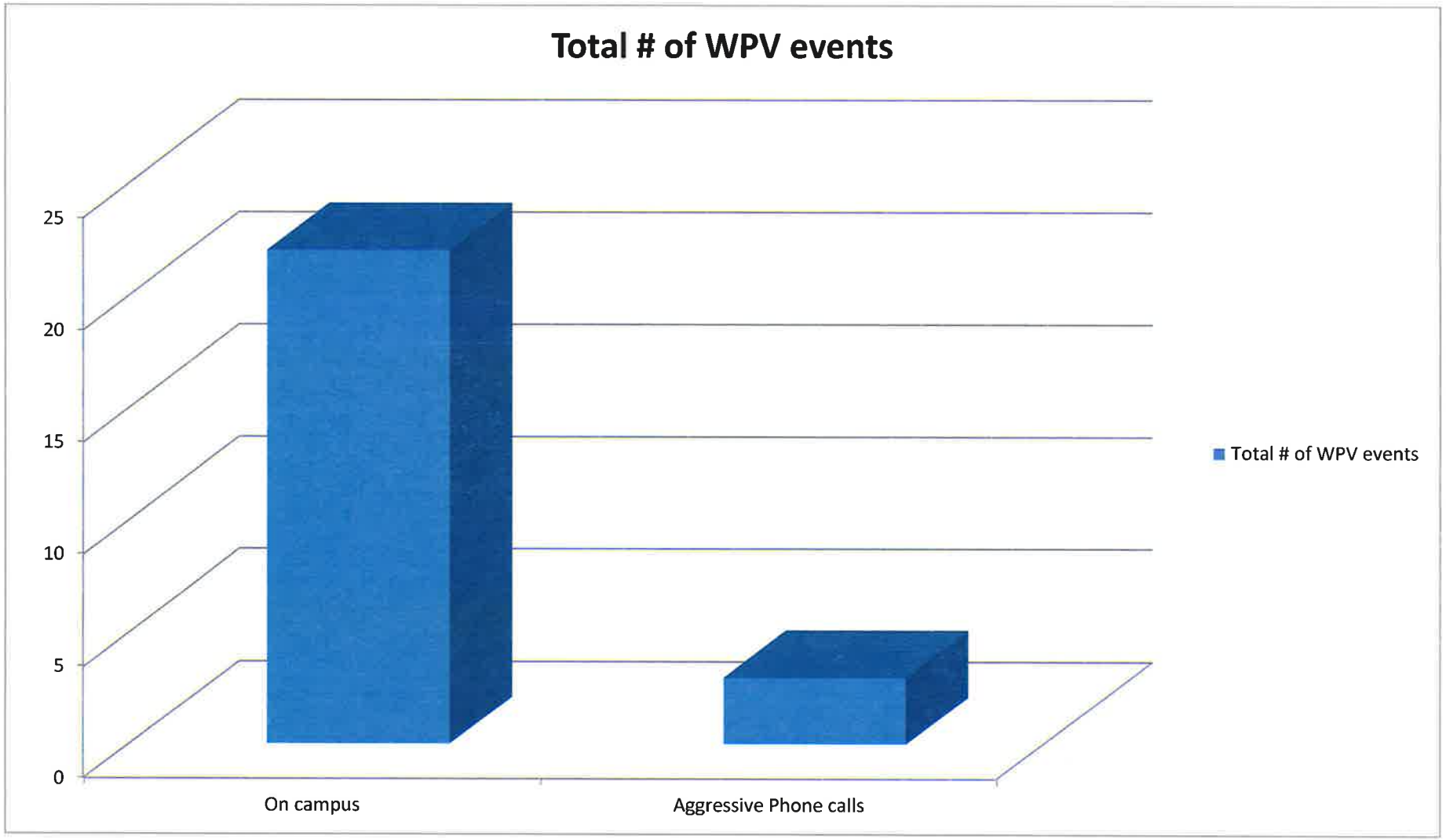
Unusual Occurrence Trends



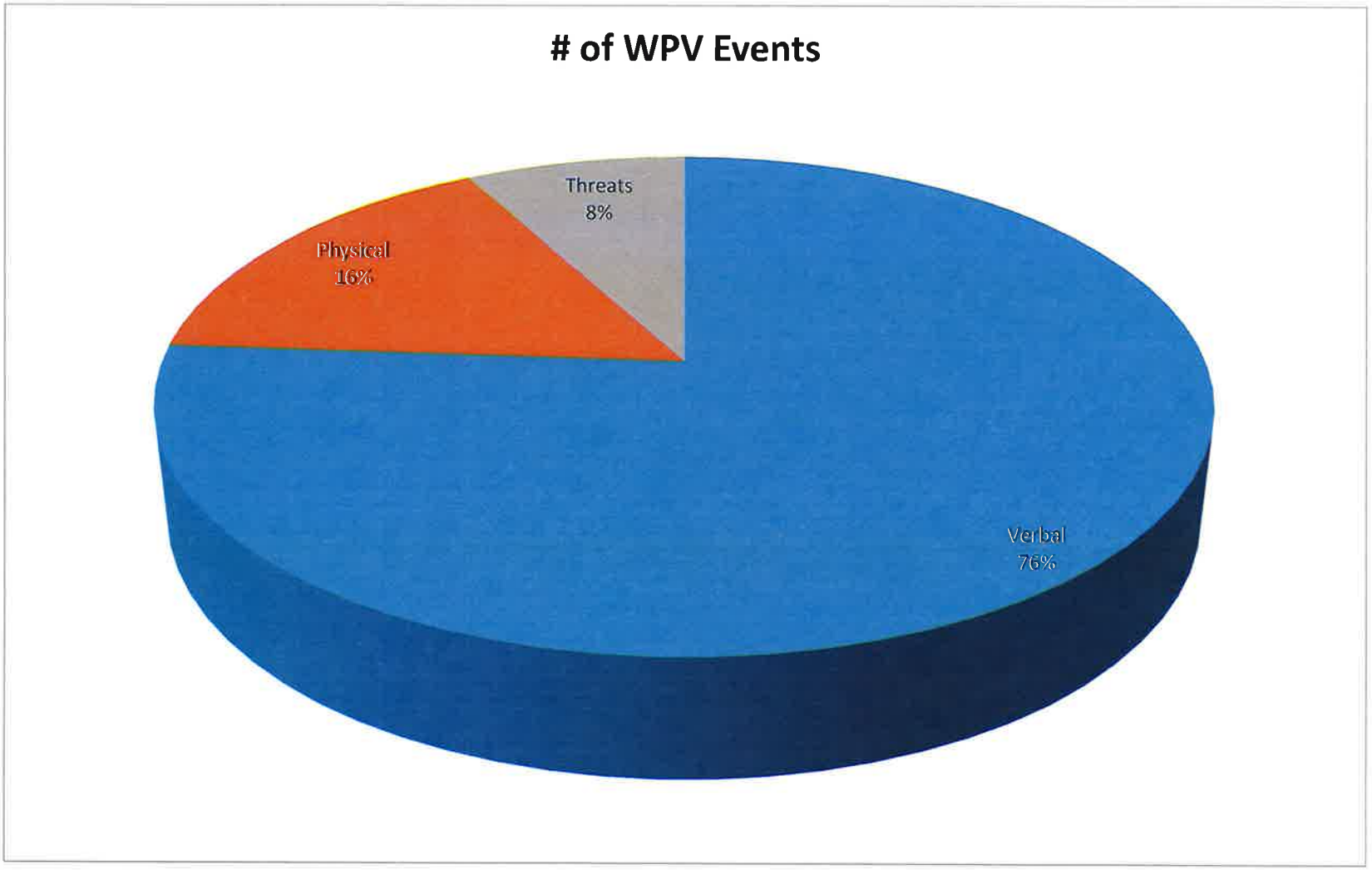
Unusual Occurrence Trends



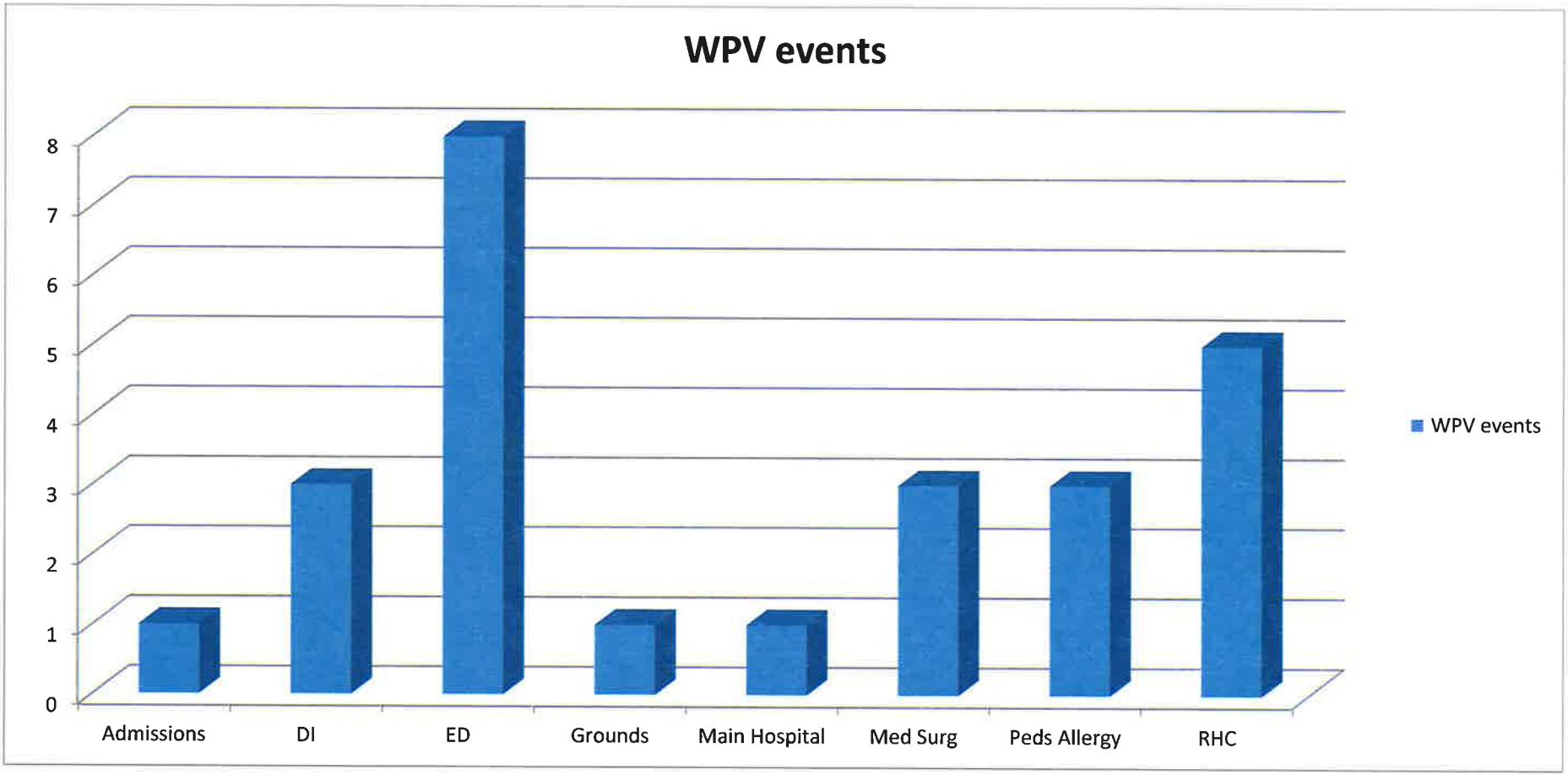
# of Falls	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Ice/weather related	Other	Stretcher/Table	Total
Not Identified	3	3			2	1	3	1	**13**
Confused	1	1	1						**3**
Oriented	6	1	1	2			6	1	**17**
Total	**10**	**5**	**2**	**2**	**2**	**1**	**9**	**2**	**33**



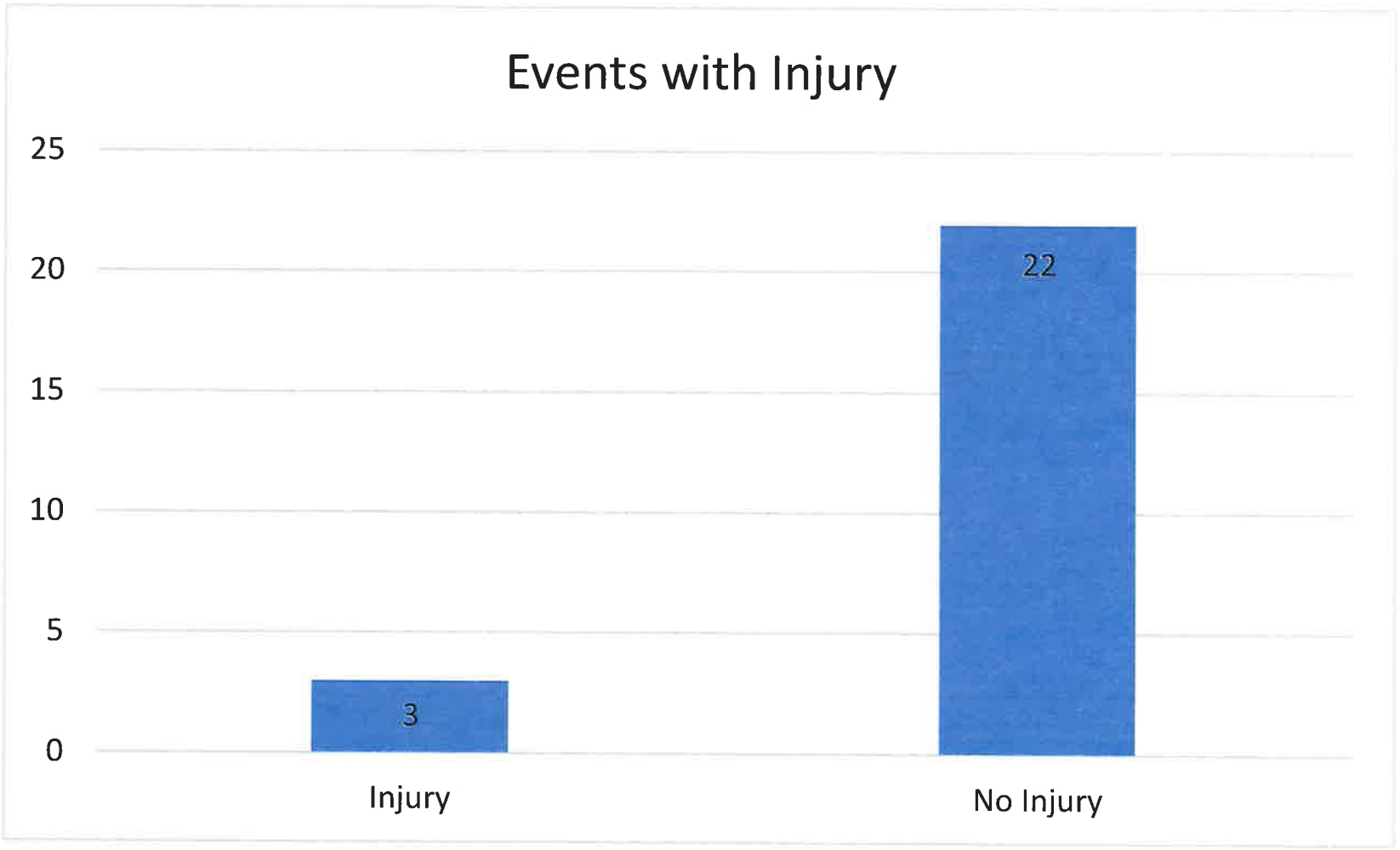
Location type	Total # of WPV events
On campus	22
Aggressive Phone calls	3
	25



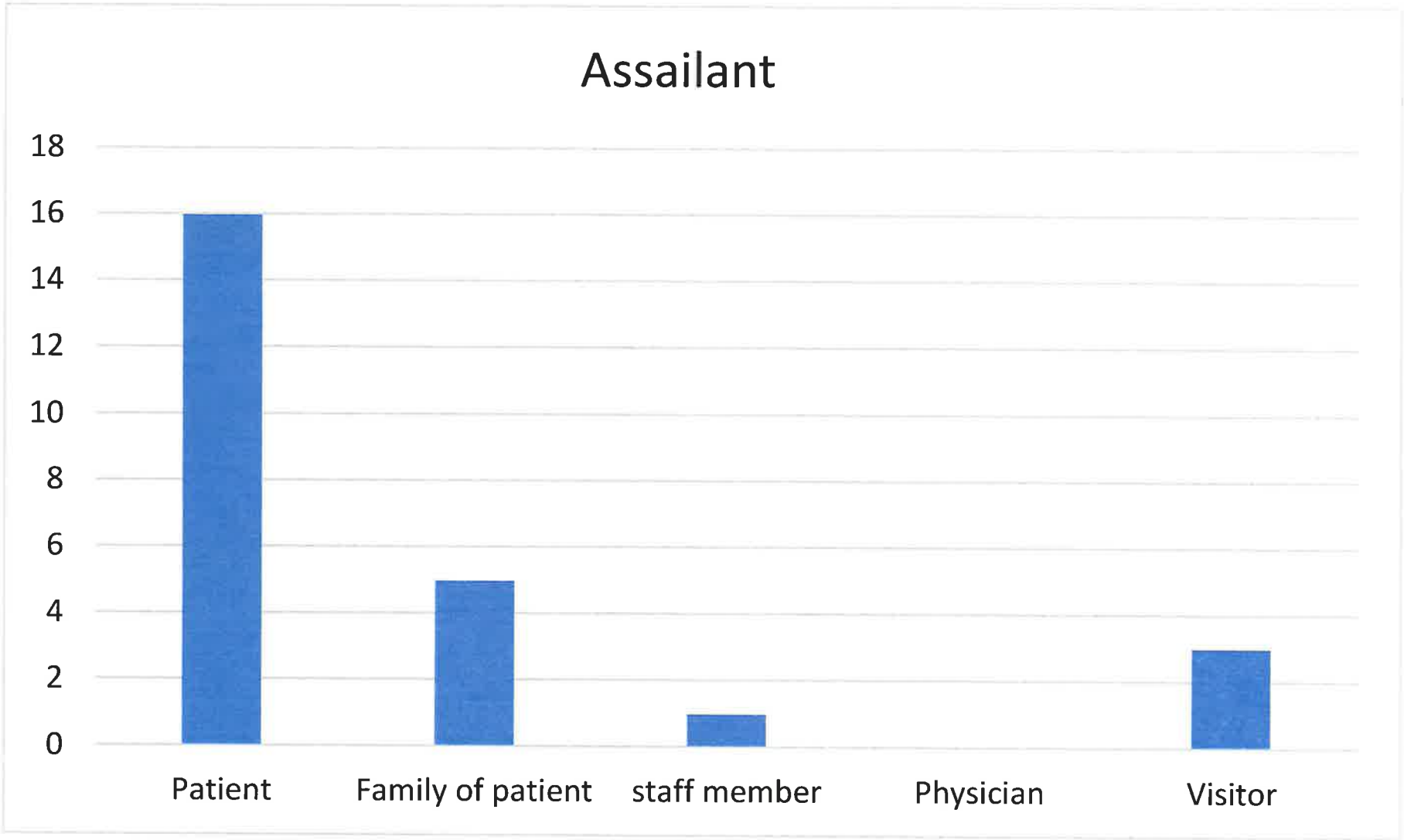
Type of Violence	# of WPV Events
Verbal	19
Physical	4
Threats	2



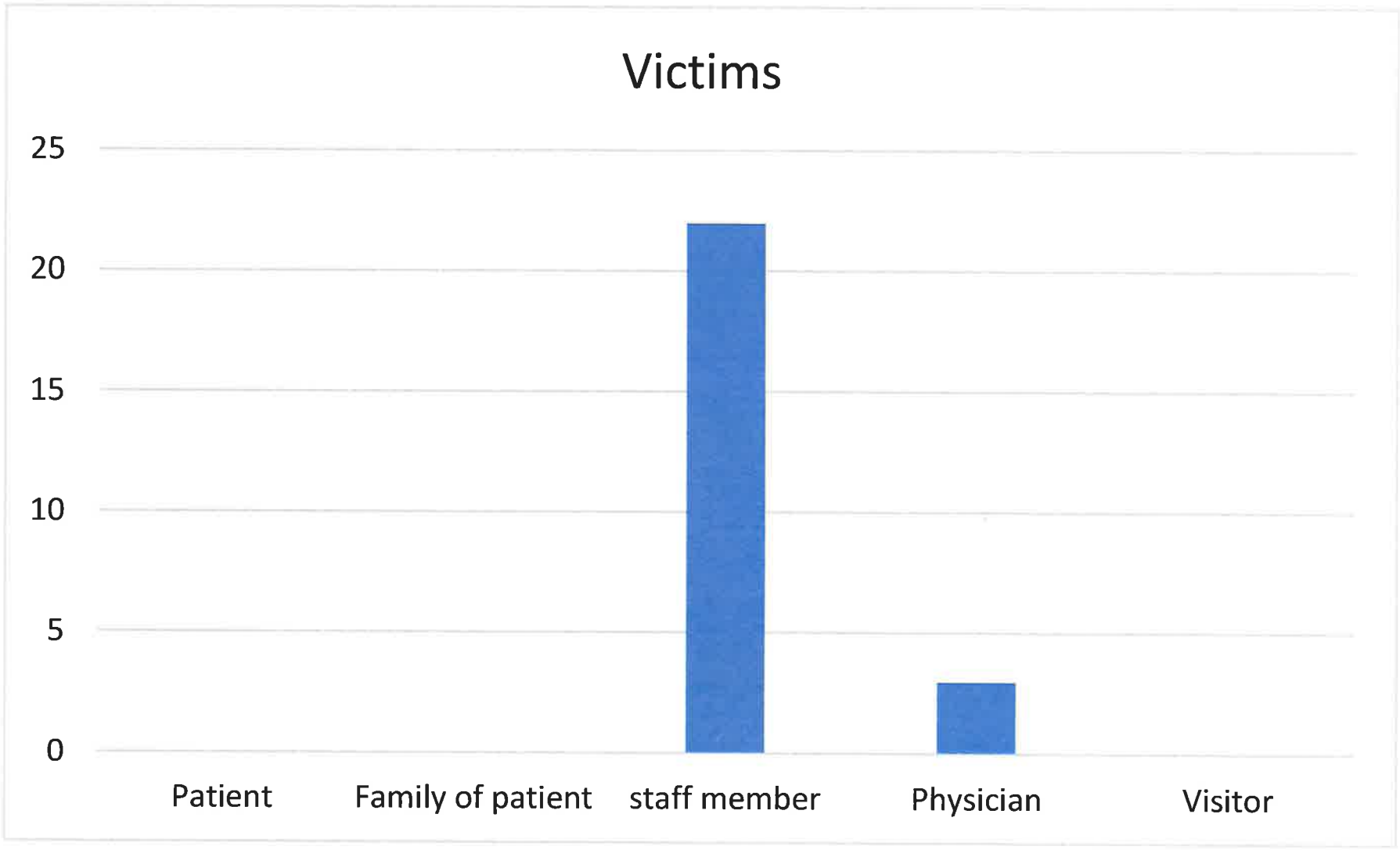
Location	WPV events
Admissions	1
DI	3
ED	8
Grounds	1
Main Hospital	1
Med Surg	3
Peds Allergy	3
RHC	5



Events w/Injury	Number
Injury	3
No Injury	22



Assailant	# events
Patient	16
Family of patient	5
staff member	1
Physician	
Visitor	3



Victim	# events
Patient	
Family of patient	
staff member	22
Physician	3
Visitor	

Security present	Hours
Sunday	18:00-03:30
Monday	18:00-03:30
Tuesday	18:00-03:30
Wednesday	18:00-03:30
Thursday	18:00-03:30
Friday	12:00-0400
Saturday	12:00-0400

WPV events by Month	# of events
Apr-19	4
May-19	0
Jun-19	2
Jul-19	1
Aug-19	2
Sep-19	6
Oct-19	2
Nov-19	6
Dec-19	2
Jan-20	

Day of week	# events (not including phone calls)
Sunday	2
Monday	3
Tuesday	3
Wednesday	4
Thursday	3
Friday	5
Saturday	1

WPV event by time of day	Sun		Mon		Tues		Wed		Thurs		Fri		Sat	
NOT INC PHONE CALLS	SECURITY PRESENT	EVENT LOC	SECURITY PRESENT	EVENT LOC	SECURITY PRESENT	EVENT LOC	SECURITY PRESENT	EVENT LOC	SECURITY PRESENT	EVENT LOC	SECURITY PRESENT	EVENT LOC	SECURITY PRESENT	EVENT LOC
00:00-01:00														
01:01-02:00														
02:01-03:00														
03:01-04:00														
04:01-05:00														
05:01-06:00														
06:01-07:00														
07:01-08:00														
08:01-09:00														
09:01-10:00										RHC		RHC		
10:01-11:00								ADMIS		RHC		ED		
11:01-12:00														MS
12:01-13:00										ED				
13:01-14:00				ED								DI		
14:01-15:00		DI		DI		ED								
15:01-16:00												ED		
16:01-17:00		MS						PHONE						
17:01-18:00						ED								
18:01-19:00								S						
19:01-20:00				ED										
20:01-21:00														
21:01-22:00														
22:01-23:00												ED		

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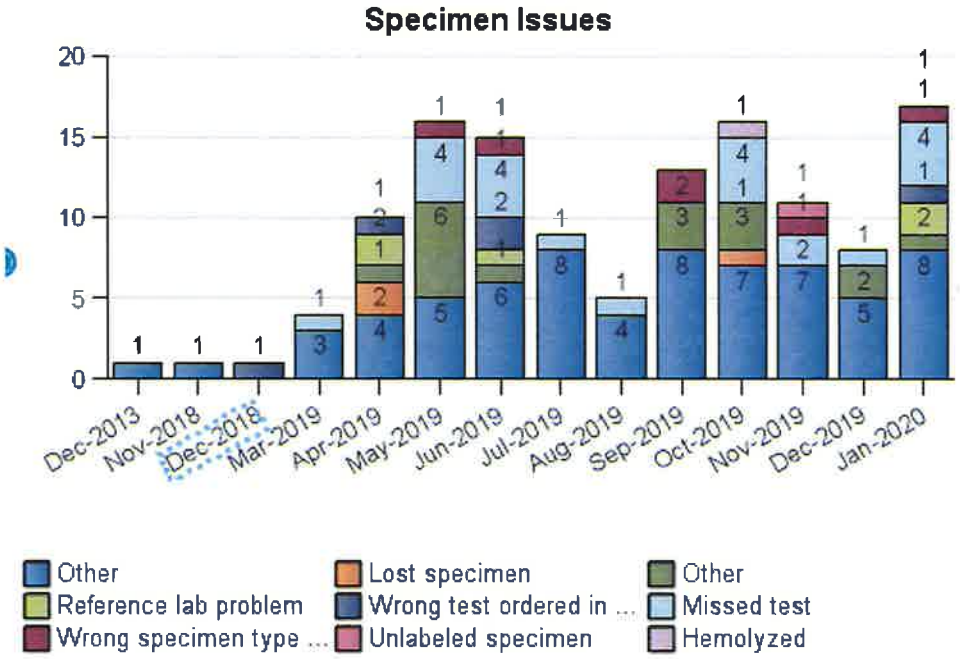

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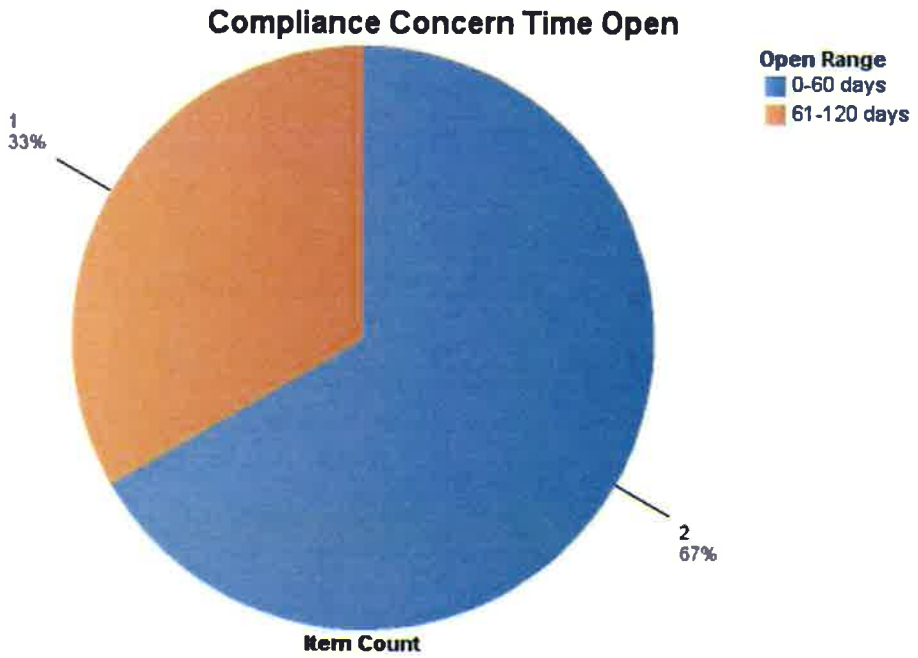

Compliance Concern Id		2019				2020		Total
		Jul	Sep	Nov	Total	Jan	Total	
			1		1			1
	Total		1		1			1
Billing				1	1	1	1	2
	Total			1	1	1	1	2
Compliance			1		1			1
	Total		1		1			1
HIPAA Security		1			1			1
	Total	1			1			1
Total		1	2	1	4	1	1	5

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E239	1. Developed new policy "Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners"	One day per month, for three months, all scheduled infusion patients' ordering provider(s) will be verified to be on the list of providers with a "documented Referral Arrangement " by a designated workforce member.	1 day/mon X 3 months; when at 100% 1 day/quarter x 3 addl quarters.	7/18/2018	DON Perioperative services to have oversight of data and report to Compliance. Compliance to report to Board of Directors (BOD) no less than annually	Monthly x 3, Quarterly x 3	Additional training provided			100%	100%	100%			100%							100%	100%	100%	Complete
	2. NIHD enters into a documented Referral Arrangement for Non-Staff Ordering Practitioners.			9/1/2018																					Complete
	3. Provided education and training to Infusion nursing staff via in-person and email.			9/1/2018																					Complete
E 242	Draft policy "Pediatric and Newborn Consultation Requirements" and obtain approval at perinatal/pediatrics medical staff committee on 10/12/2018, full approval anticipated on 11/21/2018. Education has been provided to the Medical Staff via committee process (see attached minutes).	All pediatric admissions are retrospectively reviewed by the Chief of Pediatrics on a monthly basis.	Monthly	11/23/2019	Audit data will be collected and tracked by the Medical Staff Office Manager and presented to the Chief of Pediatrics for review and presentation to the Medical Executive Committee quarterly. Once reviewed by Medical Executive Committee, aggregate data will be presented to the Board of Directors, no less than annually.	Monthly x 2 6 month OPPE periods or one year							100%		100%	100%	100%							1	Monitoring is current
E 276	Provided education and training to workforce regarding "Code Amber," "Code Amber" practice drills conducted on day and night shift.	Code Amber knowledge question added to Environment of Care monthly audit. Monthly data will be collected for trending by department for additional targeted training. Data tracking will occur until no wrong answers for 3 consecutive months, or 12 months. If goal not met, review and update plan of correction.	Monthly	10/12/2019	EOC trending, Operations?	100% correct answers for 3 consecutive months or a total of 12 months (reassess if no 3 consec month period)							<100%	<100%				100	100	100					Completed
E280	All contract RNs will particpate in skills days specific to their routinely assigned unit(s) during orientation.	Nursing administration and education will monitor 100% of contract RN orientation documentation for completion of competency validation routine assigned units. If 100% compliant, monitor 50% of contract RN orientation documentation for completion of competency validation routine assigned units for the following 2 months. If at 100%, sustainability goal will have been met. If not, review and update plan of correction		10/1/2019	CNO will have oversight of competency validation process for contracted RNs. Data will be reported to Nurse	3 months	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	100%	100%	100%	100%					Completed
	All contract RNs competency binders will contain documentation of completion of competency validations and skills validations for any unit to which they may be routinely assigned. Per policy,																								
	Competency orientation plans and supporting documents for contract RNs are reviewed by nursing administration or designee prior to independent assignments.																								

Enlarged print follows on next page

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E239	1. Developed new policy "Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners"	One day per month, for three months, all scheduled infusion patients' ordering provider(s) will be verified to be on the list of providers with a "documented Referral Arrangement " by a designated workforce member.	1 day/mon X 3 months; when at 100% 1 day/quarter x 3 addl quarters.	7/18/2018	DON Perioperative services to have oversight of data and report to Compliance. Compliance to report to Board of Directors (BOD) no less than annually
	2. NIHD enters into a documented Referral Arrangement for Non-Staff Ordering Practitioners.			9/1/2018	
	3. Provided education and training to Infusion nursing staff via in-person and email.			9/1/2018	
E 242	Draft policy "Pediatric and Newborn Consultation Requirements" and obtain approval at perinatal/pediatrics medical staff committee on 10/12/2018, full approval anticipated on 11/21/2018. Education has been provided to the Medical Staff via committee process (see attached minutes).	All pediatric admissions are retrospectively reviewed by the Chief of Pediatrics on a monthly basis.	Monthly	11/23/2019	Audit data will be collected and tracked by the Medical Staff Office Manager and presented to the Chief of Pediatrics for review and presentation to the Medical Executive Committee quarterly. Once reviewed by Medical Executive Committee, aggregate data will be presented to the Board of Directors, no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 276	Provided education and training to workforce regarding "Code Amber." "Code Amber" practice drills conducted on day and night shift.	Code Amber knowledge question added to Environment of Care monthly audit. Monthly data will be collected for trending by department for additional targeted training. Data tracking will occur until no wrong answers for 3 consecutive months, or 12 months. If goal not met, review and update plan of correction.	Monthly	10/12/2019	EOC trending, Operations?
E280	All contract RNs will particpate in skills days specific to their routinely assigned unit(s) during orientation.	Nursing administration and education will monitor 100% of contract RN orientation documentation for completion of competency validation routine assigned units. If 100% compliant, monitor 50% of contract RN orientation documentation for completion of competency validation routine assigned units for the following 2 months. If at 100%, sustainability goal will have been met. If not, review and update plan of correction		10/1/2019	CNO will have oversight of competency validation process for contracted RNs. Data will be reported to Nurse
	All contract RNs competency binders will contain documentation of completion of competency validations and skills validations for any unit to which they may be routinely assigned. Per policy,				
	Competency orientation plans and supporting documents for contract RNs are reviewed by nursing administration or designee prior to independent assignments.				

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 475	1b. Policy "Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)" completed.	1. Pharmacist-in-charge will monitor cleaning log once a month for 3 months and then once a quarter for 2 additional quarters for 100% complete ceiling cleaning. If goal not met, review and update plan of correction.			The Infection Preventionist has oversight responsibility. Data monitoring will be sent to the Infection Prevention Medical Staff Committee, quarterly, for review. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	once a month X 3 months, then once/quarter for 2 additional quarters for 100% completion					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	Completed
	Training completed for the pharmacy department on the updated draft policy while awaiting approval process. Just-in-time training will be completed by the Clinical Engineering and Compliance as needed.	2. Pharmacist-in-charge has oversight of this process. Compliance to review log reports for daily checks of temperature monitoring software, monthly for three months.			Aggregate data reported to the Pharmacy and Therapeutics Medical Staff Committee quarterly. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	3 months			100%	100%	100%														Completed
E 479	1a. Posting of Signage: Sign posted in ED at past location of the Malignant Hyperthermia Cart directing staff to the new location in PACU. 1b. Email Notification of RN Staff: Current RN staff will be sent an email with reminder of current location of the Malignant Hyperthermia Cart location.	1. Added knowledge question to RN rounding form, Nursing Leadership is rounding regularly and asking a minimum of 5 RNs (17% of the workforce monthly) per week as to the location of the Malignant Hyperthermia Cart.	When 3 months of RN Rounding form documentation results in 100% knowledge of the location of the Malignant Hyperthermia Cart we will consider the knowledge of cart location to be known by the nursing team.		Data will be tracked and trended by the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	3 months					75%	73%	62.50%		100%		100%	100%	100%						Completed
E480	Immediately verified the medications belonging in the crash cart and added the list to the policy.	All policies are reviewed by appropriate committees, leadership, and Board of Directors no less than once every three years. This review will ensure sustainability of this change. No additional monitoring needed.	No additional monitoring	10/17/2018	No additional monitoring	None	complete																		Completed
E485	Staff were educated at Sept 2018 MS/ICU staff meeting. Staff were educated about use of appropriate sedation scales and titration orders.	100% of ICU patient charts will be audited for titratable sedative dosing per order, and the appropriate use of RASS sedation scales. This will be completed by the unit management and just in time training will be completed if a deficient practice is found.	3 months at 100% compliance is reached	10/15/2018	Audit data will be collected and tracked by the Nursing Administration Office and presented to the Chief Nursing Officer. Once reviewed aggregate data will be submitted to the Compliance department for presentation to the Board of Directors, no less than annually.	If goal not met in one year, review education and training, and update plan of correction.						100%	100%	100%									Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 475	1b. Policy "Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)" completed.	1. Pharmacist-in-charge will monitor cleaning log once a month for 3 months and then once a quarter for 2 additional quarters for 100% complete ceiling cleaning. If goal not met, review and update plan of correction.			The Infection Preventionist has oversight responsibility. Data monitoring will be sent to the Infection Prevention Medical Staff Committee, quarterly, for review. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.
	Training completed for the pharmacy department on the updated draft policy while awaiting approval process. Just-in-time training will be completed by the Clinical Engineering and Compliance as needed.	2. Pharmacist-in-charge has oversight of this process. Compliance to review log reports for daily checks of temperature monitoring software, monthly for three months.			Aggregate data reported to the Pharmacy and Therapeutics Medical Staff Committee quarterly. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 479	1a. Posting of Signage: Sign posted in ED at past location of the Malignant Hyperthermia Cart directing staff to the new location in PACU. 1b. Email Notification of RN Staff: Current RN staff will be sent an email with reminder of current location of the Malignant Hyperthermia Cart location.	1. Added knowledge question to RN rounding form, Nursing Leadership is rounding regularly and asking a minimum of 5 RNs (17% of the workforce monthly) per week as to the location of the Malignant Hyperthermia Cart.	When 3 months of RN Rounding form documentation results in 100% knowledge of the location of the Malignant Hyperthermia Cart we will consider the knowledge of cart location to be known by the nursing team.		Data will be tracked and trended by the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.
E480	Immediately verified the medications belonging in the crash cart and added the list to the policy.	All policies are reviewed by appropriate committees, leadership, and Board of Directors no less than once every three years. This review will ensure sustainability of this change. No additional monitoring needed.	No additional monitoring	10/17/2018	No additional monitoring

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E485	Staff were educated at Sept 2018 MS/ICU staff meeting. Staff were educated about use of appropriate sedation scales and titration orders.	100% of ICU patient charts will be audited for titratable sedative dosing per order, and the appropriate use of RASS sedation scales. This will be completed by the unit management and just in time training will be completed if a deficient practice is found.	3 months at 100% compliance is reached	10/15/2018	Audit data will be collected and tracked by the Nursing Administration Office and presented to the Chief Nursing Officer. Once reviewed aggregate data will be submitted to the Compliance department for presentation to the Board of Directors, no less than annually.

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 503	1. Clove oil was removed from the Dental Box in the ED. 2. Dental Box content list has been updated. 3. Emergency Medicine Providers' group determined clove oil will no longer be used in the facility dental box 4. Education provided to ED workforce.	Dental box located in the ED will be audited once per month until 3 consecutive months of no Clove Oil. Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil.	3 months at 100% compliance is reached	7/20/2018 10/11/2018 10/8/2018 9/25/2018	Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil. This data will be reported to the Compliance Dept. and the Board of Directors no less than annually.	Until 3 consecutive months of no Clove oil in the ED Dental box.		100%	100%	100%	100%													Completed
E 511	1. Pharmacist in charge has directed pharmacy staff to remove AddVantage system supplies from all facility Omnicells. Pharmacy will switch to Baxter MiniBag Plus system, which comes in single use per overwrap package. Pharmacy staff has been educated on this change via email.	No additional monitoring is required.	None	7/20/2018	Pharmacist-in-charge is responsible for oversight of this change.	None	complete																		Completed
	2. Medication storage will be in accordance with manufacturer's specifications based on the FDA approved information in the package insert.	No additional monitoring is required.	None	10/12/2018	Pharmacist-in-charge is responsible for oversight of this change.	None	complete																		Completed
E 1363	Spreadsheets for tracking all supplies in the crash cart had been developed by the Cardiopulmonary department. The spreadsheet was updated to include month/day/year. Additional training was provided to the Cardiopulmonary Department to review the expiry dates monthly and replace all supplies prior to expiration.	If during monthly checks, an expired supply is found, a Quality Review/Unusual Occurrence report will be completed by the staff member. Compliance will review and trend UOR/QRRs for outdated supplies in crash cart. Time: Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters. Success is less than or equal to 1 UOR during the monitoring period. THis data will be reported to the Resuscitation Medical Staff Committee quarterly and to the Board of Directors no less than annually.	monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	10/12/2018	Resuscitation Medical Staff Committee	Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters.			100.0%	100.0%	100.0%	100.0%	<100% 1 UOR	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Completed
E 2115	Staff identified by the CDPH inspectors, and all other NIHD workforce, were within the timeframe identified by the Inyo County Health Officer, however, NIHD did not notify CDPH of this letter until the inspection. Inspectors instructed CNO to include the letter from the Inyo County Health Officer with the response to the licensing inspection.	No additional monitoring is required.		7/20/2018	Chief Nurse	None	complete																		Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 503	1. Clove oil was removed from the Dental Box in the ED.	Dental box located in the ED will be audited once per month until 3 consecutive months of no Clove Oil. Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil.	3 months at 100% compliance is reached	7/20/2018	Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil. This data will be reported to the Compliance Dept. and the Board of Directors no less than annually.
	2. Dental Box content list has been updated.			10/11/2018	
	3. Emergency Medicine Providers' group determined clove oil will no longer be used in the facility dental box			10/8/2018	
	4. Education provided to ED workforce.			9/25/2018	
E 511	1. Pharmacist in charge has directed pharmacy staff to remove AddVantage system supplies from all facility Omnicells. Pharmacy will switch to Baxter MiniBag Plus system, which comes in single use per overwrap package. Pharmacy staff has been educated on this change via email.	No additional monitoring is required.	None	7/20/2018	Pharmacist-in-charge is responsible for oversight of this change.
	2. Medication storage will be in accordance with manufacturer's specifications based on the FDA approved information in the package insert.	No additional monitoring is required.	None	10/12/2018	Pharmacist-in-charge is responsible for oversight of this change.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 1363	Spreadsheets for tracking all supplies in the crash cart had been developed by the Cardiopulmonary department. The spreadsheet was updated to include month/day/year. Additional training was provided to the Cardiopulmonary Department to review the expiry dates monthly and replace all supplies prior to expiration.	If during monthly checks, an expired supply is found, a Quality Review/Unusual Occurrence report will be completed by the staff member. Compliance will review and trend UOR/QRRs for outdated supplies in crash cart. Time: Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters. Success is less than or equal to 1 UOR during the monitoring period. THis data will be reported to the Resuscitation Medical Staff Committee quarterly and to the Board of Directors no less than annually.	monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	10/12/2018	Resuscitation Medical Staff Committee
E 2115	Staff identified by the CDPH inspectors, and all other NIHD workforce, were within the timeframe identified by the Inyo County Health Officer, however, NIHD did not notify CDPH of this letter until the inspection. Inspectors instructed CNO to include the letter from the Inyo County Health Officer with the response to the licensing inspection.	No additional monitoring is required.		7/20/2018	Chief Nurse

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 2150	1. Staff education that IV infusion tubing in the outpatient infusion department shall be discarded once disconnected from the patient.	1. PACU management will monitor daily for sterilely capped, patient labeled, re-used tubing in the infusion department for two months. If zero are found, no additional monitoring required.	Daily x 2 months	7/20/2018	This information will be reported to Nursing Executive Committe until two consecutive months of zero found goal is met. Compliance will report to the Board of Directors.	2 months with 100% compliance		100%	100%																Completed
	2. "Point of care -Accu-Chek Blood Glucose Testing" policy was reviewed and no changes regarding disinfection of the unit were required in the policy. Training and education have been provided to the NIHD staff who utilize the glucometer. Review of wet time procedures at department meetings and hospital orientation has occurred. Just-in time training is provided during rounding of unit managers and nursing leadership.	2. "Wet time" knowledge question added to Environment of Care monthly audits and Nursing Unit Rounding questions. Anyone getting the Wet-time answer wrong will receive "just-in-time" training. Monthly data will be collected for trending by department for additional targeted training.	When 3 months of RN Rounding form documentation results in 98% correct answers, we will consider the undestanding of "wet-times" to be known by the nursing team.	7/20/2018-ongoing	Data will be compiled and sent to the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually	Data tracking will occur until no wrong answers for 3 consecutive months. If goal not met, review and update plan of correction.				43.8%	85.7%	75.0%	92.30%		92.3%	70.0%	100.0%	100.0%	80.0%					Monitoring is current
	3. Paper towel and soap dispenser installed near sink in supply room in the Infusion department.			9/21/2018			complete																		Completed
	4. Additional dual tip protectors were ordered to ensure all sterilized hinged instruments are more clearly in an open position and cannot move to the locked position inadvertently after sterilization. Additional education and training to ensure all staff are knowledgeable that hinged instruments must be in an open position. All staff memebers in the Central Sterile Processing will participate in the auditing of sterilized instrument packets.	Audit processed peel packs weekly: 20 / week for September and October 2018 with 100% compliance.	If at 100% Compliance, no additional monitoring requirements.	10/15/2018	DON of perioperative services	No ongoing monitoring requirements.		100%	100%	100%	100%	100%			100%			100%							Completed
	5. Each area in the 3 ORs and Sterile Processing, Infusion, and PACU is assigned to a staff member who goes through and checks each item for dates. The person checking must initial the form once the check has been completed. Expired supplies will be removed. An unusual occurrence report will be completed for any expired supply found	Oversight of the Monthly outdate review is overseen by the DON of perioperative services.Compliance will trend UORs for outdated supplies.	Monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	8/1/2018	submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	Review and trend UORs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%	100%		Completed
	6. Signs were placed on patient allocated refrigeration units with "For Patient Use Only" signs. Provide in-service with nursing managers to audit patient refridgeration units.	6. Nursing Managers are monitoring patient designated refrigeration units once a week for three months, and then once per quarter for three quarters to ensure no non-patient food and beverage is stored in patient designated areas.	Once per week X 3 months, Once per quarter X 3 quarters	7/25/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	Once per week X 3 months, Once per quarter X 3 quarters			75%	100%	100%		100%			100%			100%			100%	100%	100%	Completed
	7. Discard all multiple use Hormel Thick and Easy Thickener throughout NIH campus. Purchase single serving packets of Hormel Thick and Easy Thickener Powder. Provided in-service on corrective action inventory procedures with dietary staff.	Monitor invoices and unit checks once a month for three months to ensure no multi use Hormel Thick and Easy thickener is on NIH campus to ensure compliance, last purchased date of multiple use Hormel Thick and Easy Thickener to not exceed 04/27/2018.	Monitor invoices once per month for three months, if no purchases, continue to monitor once per quarter for three quarters	7/20/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	once per month x 3 months, once per quarter x 3 quarters				100%	100%	100%	100%			100%			100%			100%	100%	100%	Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
	1. Staff education that IV infusion tubing in the outpatient infusion department shall be discarded once disconnected from the patient.	1. PACU management will monitor daily for sterilely capped, patient labeled, re-used tubing in the infusion department for two months. If zero are found, no additional monitoring required.	Daily x 2 months	7/20/2018	This information will be reported to Nursing Executive Committe until two consecutive months of zero found goal is met. Compliance will report to the Board of Directors.
	2. "Point of care -Accu-Chek Blood Glucose Testing" policy was reviewed and no changes regarding disinfection of the unit were required in the policy. Training and education have been provided to the NIHD staff who utilize the glucometer. Review of wet time procedures at department meetings and hospital orientation has occurred. Just-in time training is provided during rounding of unit managers and nursing leadership.	2. "Wet time" knowledge question added to Environment of Care monthly audits and Nursing Unit Rounding questions. Anyone getting the Wet-time answer wrong will receive "just-in-time" training. Monthly data will be collected for trending by department for additional targeted training.	When 3 months of RN Rounding form documentation results in 98% correct answers, we will consider the undestanding of "wet-times" to be known by the nursing team.	7/20/2018-ongoing	Data will be compiled and sent to the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually
	3. Paper towel and soap dispenser installed near sink in supply room in the Infusion department.			9/21/2018	

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 2150	4. Additional dual tip protectors were ordered to ensure all sterilized hinged instruments are more clearly in an open position and cannot move to the locked position inadvertently after sterilization. Additional education and training to ensure all staff are knowledgeable that hinged instruments must be in an open position. All staff memebers in the Central Sterile Processing will participate in the auditing of sterilized instrument packets.	Audit processed peel packs weekly: 20 / week for September and October 2018 with 100% compliance.	If at 100% Compliance, no additional monitoring requirements.	10/15/2018	DON of perioperative services
	5. Each area in the 3 ORs and Sterile Processing, Infusion, and PACU is assigned to a staff member who goes through and checks each item for dates. The person checking must initial the form once the check has been completed. Expired supplies will be removed. An unusual occurrence report will be completed for any expired supply found	Oversight of the Monthly outdate review is overseen by the DON of perioperative services.Compliance will trend UORs for outdated supplies.	Monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	8/1/2018	submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
	6. Signs were placed on patient allocated refrigeration units with "For Patient Use Only" signs. Provide in-service with nursing managers to audit patient refridgeration units.	6. Nursing Managers are monitoring patient designated refrigeration units once a week for three months, and then once per quarter for three quarters to ensure no non-patient food and beverage is stored in patient designated areas.	Once per week X 3 months, Once per quarter X 3 quarters	7/25/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.
	7. Discard all multiple use Hormel Thick and Easy Thickener throughout NIH campus. Purchase single serving packets of Hormel Thick and Easy Thickener Powder. Provided in-service on corrective action inventory procedures with dietary staff.	Monitor invoices and unit checks once a month for three months to ensure no multi use Hormel Thick and Easy thickener is on NIH campus to ensure compliance, last purchased date of multiple use Hormel Thick and Easy Thickener to not exceed 04/27/2018.	Monitor invoices once per month for three months, if no purchases, continue to monitor once per quarter for three quarters	7/20/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 2151	1. Created fit testing project team. 2.Team reviewed Aerosolized Transmissable Disease plan, which delineates job roles that require fit testing. 3. Developed tracking and reminder system for annual testing. 4. Developed process such that all new hires are tested before or within 3 weeks of hire.	A statistically significant sample of employees requiring fit-testing will have an audit of the fit test record to ensure compliance with the policy.	Auditing will occur monthly for 3 months or until 97% or greater compliance rate is achieved. Additional auditing will occur quarterly for 3 quarters with the sustainability goal of 97% or greater compliance rate is achieved.	11/1/2018	The Infection Preventionist is responsible for oversight. This data will be reported to the Infection Control Medical Staff Committee and Medical Executive Committee, quarterly. This data will be reported to the Board of Directors no less than annually.	I									88.0%		98.7%	98.0%	99.7%				99.7%	Completed
E 2354	1. Staff trained to look at the stickers and see if they are in compliance. **If out of date: Item to be pulled out of service**. Email to Engineering to request service. UOR completed. During transition year, staff will know that no piece of equipment is in date for greater than 1 year after inspection. 2. All equipment that can hold a PM sticker will be labeled with inspection date and expiration date to let clinical staff when a device is due for service. EOC rounds will ensure equipment is current for inspections as well as EOC reporting to the safety committee.	Unusual Occurrence Reports (UOR) will be utilized to document outdated PM Service tags, which indicate need for service, when found by the end user.	Quarterly review of the UORs will be expected to show 90% compliance of Non-High Risk Medical Equipment, and 100% complaince of High Risk Medical Equipment.	10/19/2018	Compliance Officer will provide oversight for this process. Compliance will report data to the Director of IT Services and the Board of Directors no less than annually.	After 3 concurrent Quarters of review at 90% and 100%, respectively, the audit will be complete														100% 100%	100% 100%	100% 100%		Completed

Results did not meet goals | Results met goals | Monitoring is ongoing and current.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 2151	1. Created fit testing project team. 2.Team reviewed Aerosolized Transmissable Disease plan, which delineates job roles that require fit testing. 3. Developed tracking and reminder system for annual testing. 4. Developed process such that all new hires are tested before or within 3 weeks of hire.	A statistically significant sample of employees requiring fit-testing will have an audit of the fit test record to ensure compliance with the policy.	Auditing will occur monthly for 3 months or until 97% or greater compliance rate is achieved. Additional auditing will occur quarterly for 3 quarters with the sustainability goal of 97% or greater compliance rate is achieved.	11/1/2018	The Infection Preventionist is responsible for oversight. This data will be reported to the Infection Control Medical Staff Committee and Medical Executive Committee, quarterly. This data will be reported to the Board of Directors no less than annually.
E 2354	1. Staff trained to look at the stickers and see if they are in compliance. **If out of date: Item to be pulled out of service**. Email to Engineering to request service. UOR completed. During transition year, staff will know that no piece of equipment is in date for greater than 1 year after inspection. 2. All equipment that can hold a PM sticker will be labeled with inspection date and expiration date to let clinical staff when a device is due for service. EOC rounds will ensure equipment is current for inspections as well as EOC reporting to the safety committee.	Unusual Occurrence Reports (UOR) will be utilized to document outdated PM Service tags, which indicate need for service, when found by the end user.	Quarterly review of the UORs will be expected to show 90% compliance of Non-High Risk Medical Equipment, and 100% complaince of High Risk Medical Equipment.	10/19/2018	Compliance Officer will provide oversight for this process. Compliance will report data to the Director of IT Services and the Board of Directors no less than annually.

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

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

TO: NIHD Board of Directors
FROM: William Timbers, MD, Chief of Medical Staff
DATE: March 3, 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 Appointments (*action items*)
    1. Casey Graves, MD (*emergency medicine*) – Provisional Active Staff

B. Policies and Procedures (*action items*)
    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*

C. 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)*

D. Physician recruitment update (*information item*)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cleaning and Disinfecting of Transesophageal Echo (TEE) Probe using Glutaraldehyde Use Station (GUS) Disinfection Soak Station	
Scope: Cardiopulmonary	Manual:
Source: Cardiopulmonary manager	Effective Date:

PURPOSE:
To assure all guidelines and standards for proper cleaning of the Transesophageal Echo (TEE) probe, using the Glutaraldehyde Use Station (GUS) Station, are met prior to probe use and to provide guidance for the safe use, testing and disposal of High level disinfectant (HLD).

POLICY:
The TEE probe is to be disinfected immediately after each use to protect patients and personnel from a variety of pathogens, according to manufacturer's recommendations**.**

PROCEDURE:
1. The manufacture's procedure for the HLD shall be followed and the expiration date will be printed across the container where HLD is stored. CIDEX OPA (ortho-Phthalaldehyde) solution expires 75 days after the manufacturer's container is opened.
2. Solution in the tube in the GUS station must be replaced every 14 days. The container should be labeled "fill" date and "change" date.
3. Personal Protective Equipment(PPE)
    a) Gown
    b) Full Face shield
    c) Gloves
4. Remove the probe cover and immediately clean the flexible shaft with Enzymatic Detergent Solution and Sponge, wipe or mild soap.
5. Rinse the probe thoroughly with running water and dry with Lint-Free Dry Wipes.
6. Visually inspect probe to look for holes, tears, or damage, and make sure it is clean. If damaged, contact probe manufacturer.
7. Perform an electrical leak test with leak tester per manufacturer's recommendation. Log pass/fail results. Dry with Lint-Free Dry Wipe.
8. High-Level Disinfection (HLD) of TEE Probe:
9. Make sure that GUS Disinfection Soak Station is ON before opening door and removing caps. Confirm that the red light in the power switch goes on. Use an approved HLD. **It is recommended that you leave the system running at all, times when you have the lid off the high-level disinfectant tube**.
10. Take temperature using Infrared Thermometer. OPA disinfectants, such as CIDEX OPA, recommend a minimum of 68˚F.
11. Immediately prior to use of the high-level disinfectant, the CIDEX OPA solution must be tested with CIDEX OPA Solution test strips to ensure that the Minimum Effective Concentration (MEC) of orhto-phthalaldehyde is present.(See CIDEX OPA Solution Test Strip section of procedure.) Verification shall be logged on CIDEX OPA Solution Record Log sheet.
12. Gently place probe into the HLD curved container only to the end of the flexible shaft. Insert the electrical cord into the grip clip by depressing the blue tab. The electrical connector may be placed on the soft foam pad on top of the GUS station.
13. Use Count down Timer to calculate soak time. The probe **must remain in the high-level disinfectant solution for a minimum of 12 minutes.** Excessive soaking of the probe (e.g. longer than an hour) during HLD and/or not rinsing three times with a fresh quantity

of water each time may result in residual CIDEX OPA solution remaining on the device, the use of which may cause staining, irritation or chemical burns of the mouth, throat, esophagus and stomach.

14. Prior to removing the TEE probe, place a damp paper towel or sterile cloth in your gloved hand. Nitrile gloves are the preferred gloves for working with high-level disinfectants.
15. After disinfection, push the blue tab back, and slowly remove the probe by gripping it firmly, draw it through your glove until you reach the flexible end part of the probe. Carefully place probe into the "initial rinse" container in the GUS station to avoid off gassing and drips
16. Following removal from "initial rinse" container, thoroughly rinse the TEE probe by immersing it completely in a large volume (e.g. 2 gallons) of water. Keep the device totally immersed for a minimum of 1 minute in duration. Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Repeat the procedure TWO additional times, for a total of Three RINSES, with large volumes of fresh water to remove CIDEX OPA solution residues. After rinsing with water, carefully dry probe using Lint-Free Dry Wipe.
17. Store TEE Probe per The Joint Commission's Recommendation:
    a) Hang probes vertically in a Storage System in order to maintain a clean, dry environment.
18. Disinfectant Disposal: Neutralization is required.
    a) For CIDEX OPA: While the GUS is ON, slowly pour a bottle of Glute-Out® Neutralizer (NG-QT) into HLD container. After 5 minutes, the disinfectant is neutralized. Secure container cap and go to sink to dispose with running water.
    b) Wash and rinse container thoroughly to remove any residual neutralizer.
19. Filling the High-Level Disinfectant (HLD) Containers:
    a) Refill HLD at the GUS station while it is ON. Pour HLD into the HLD container up to the maximum fill level established.
20. GUS Daily Cleaning:
    a) Make sure the cap on the HLD container is on securely, then turn GUS station OFF and disconnect power cord.
    b) Use a mild, non-abrasive detergent on a soft cloth to wipe down any drips and dry thoroughly.
    c) Wash and refill the rinse water container. Rinse water may be used for up to 24 hours, then must be changed. Plug GUS power cord back in and turn ON.
21. GUS Filter Replacement: Change Filter every 6 months in keeping with manufacturer instructions for use

<u>CIDEX OPA SOLUTION TEST STRIP QUALITY CONTROL AND USAGE</u>

1. The test strips must be contained in the original bottle with the lid closed tightly after each use.
2. Quality control shall be performed on the test strips when a new bottle is opened and every two weeks until expiration of strips.

Title: Cleaning and Disinfecting of Transesophageal Echo (TEE) Probe using Glutaraldehyde Use Station (GUS) Disinfection Soak Station	
Scope: Cardiopulmonary	Manual:
Source: Cardiopulmonary manager	Effective Date:

3. Test strip quality control procedure:
    a) To prepare positive and negative control solutions for testing, first verify that the labeled expiration date for the solution is appropriate. This solution may be used as a positive control. To prepare a negative control, dilute one part of full strength solution with one part water. Label each control solution appropriately.
    b) Following the directions for strip use, submerge three test strips in each of the above freshly prepared solutions for one second each. Remove. The three strips dipped in the full strength positive control solution should exhibit a complete purple color on the indicating pad at 90 seconds. The three strips dipped in the diluted negative control should either remain completely blue or exhibit an incomplete color change to purple when read at 90 seconds. Refer to the color chart on the test strip bottle for interpretation of results.
    c) Quality control on the testing strips shall be performed on each newly opened bottle of CIDEX OPA Solution Test strips, and repeated every two weeks.
    d) If the results of test strip quality control indicate, the strip is not functioning, repeat. If the quality control fails again, open a new bottle of strips. Test newly opened bottle. If strip quality control fails on multiple bottles of strips, return strips to Manager, documenting lot number, for contact with manufacturer for investigation of lot #.
4. Completely submerge the indicating pad on the end of the test strip for one second in the CIDEX OPA solution within the disinfecting tube, and then remove. Do not swirl the test strip as it may remove the reagent.
5. Read the test strip 90 seconds after removal from the CIDEX OPA. Effective concentration will show as purple on the indicating pad. If any blue appears on the indicating pad (apart from the top line) the CIDEX OPA is below acceptable strength and requires replacement prior to high-level disinfecting the TEE probe.
6. Dispose of the used test strip in the waste bin.

EMERGENCY AND FIRST AID PROCEDURE FOR SPILL OF CIDEX OPA.

EYES: flush thoroughly with water for 15 minutes and get medical attention immediately.

SKIN: Wash contaminated areas thoroughly with soap and water. Remove contaminated clothing and wash before re-use. Seek medical attention if irritation develops or persists.

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

INGESTION: do not induce vomiting. Rinse mouth followed by drinking a large quantity of water.

Title: Cleaning and Disinfecting of Transesophageal Echo (TEE) Probe using Glutaraldehyde Use Station (GUS) Disinfection Soak Station	
Scope: Cardiopulmonary	Manual:
Source: Cardiopulmonary manager	Effective Date:

To **neutralize the OPA spill**,

- A **glycine powder** should be sprinkled on the spill to neutralize the OPA
- The spilled disinfectant should be mopped into a plastic container
- The spill area should be mopped down with soap and water and then rinsed with large quantities of water
- The neutralized OPA should be poured down the drain followed by water

REFERENCES:

1. Civco (2017) Civco GUS Model G14TC-3 Disinfection Soak Station for Transesophageal Ultrasound Probes, Operator's Manual.
2. Safety Data Sheet (2010).
3. ANSI/AAMI ST58:(2013) Chemical sterilization and high-level disinfection in health care facilities.
4. Johnson and Johnson Company(2006-2010) CIDEX OPA ortho-Phthalaldehyde Solution INSTRUCTIONS FOR USE. Advanced Sterilization Products. Advanced Sterilization Products.
5. CIVCO TEE Probe Disinfection Checklist (2018).
6. Johnson and Johnson Company (2004) CIDEX OPA Solution Test Strips Instructions for Use, Advanced Sterilization Products. Advanced Sterilization Products.
7. Philips. (2019)Care and Cleaning of Ultrasound Systems and Transducers. Koninklijke Philips N.V.
8. Civco (2017) Spill Kits for OPA, Glutaraldehyde, Hydrogen Peroxide & Peracetic Acid
9. https://clinical.civco.com/blog/spill-kits-for-opa-glutaraldehyde-hydrogen-peroxide-peracetic-acid/

CROSS REFERENCE P&P:

1. ~~Cleaning/Sterilization or~~ High Level Disinfection of Equipment
2. Lippincott procedures, Transesophageal echocardiography, assisting

Approval	**Date**
CCOC	02/24/2020
Infection Control Committee	02/24/2020
Medical Executive Committee	03/03/2020
Board of Directors	
Last Board of Directors Review	

Developed: 2/2020 as
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Misoprostol for Cervical Ripening*	
Scope: Departmental	Manual: Perinatal – Medication (MED)
Source: Perinatal Nurse Manager	Effective Date: 7/2009

PURPOSE:
Misoprostol can be used for cervical ripening or labor induction in the third trimester of pregnancy.

POLICY:
Patients undergoing cervical ripening or labor induction with Misoprostol should undergo fetal heart rate monitoring and uterine activity monitoring in a hospital setting in the perinatal unit.

CONTRAINDICATIONS:
1. Placenta previa, abruptio placenta or unexplained vaginal bleeding
2. Asthma, glaucoma, or cardiac, renal or hepatic disease
3. Previous Cesarean Section or major uterine surgery
4. Patients on Pitocin. (Pitocin should not be started until at least 4 hours after the last dose of Misoprostol. If the patient was on Pitocin, you should wait at least 30 minutes prior to using Misoprostol.)
5. Contraindications for placing Misoprostol:
   a. Two or more painful contractions in 10 minutes.
   b. Bishop score greater than or equal to 8.
   c. Cervical exam greater than or equal to 3cm.
   d. Patient in active labor, tachysystole is present, or fetal monitor strip is category III.

PROCEDURE:
1. Obtain informed consent and place on the chart. The Physician or Certified Nurse Midwife (CNM) ~~Physicians~~ will discuss the risks and benefits including possible side effects of the medication prior to administration of the medication. This may be done in the office but documentation will be on the NIH record.
2. Nursing should complete a full nursing assessment including vital signs prior to this procedure.
3. Complete a 30 minute Electronic Fetal Monitor (EFM) baseline strip.
4. Patients will remain on EFM for 2 hours after the initial dose. At least a 20-minute strip every hour while utilizing Misoprostol.
5. If at any time the EFM changes to a category III strip, the Physician or CNM ~~MD~~ will be notified and continuous monitoring will resume. Fetal Intrauterine Resuscitation should begin.
6. Medication administration:
   a. The Physician or CNM ~~Physician (MD) or Certified Nurse Midwife (CNM)~~ will order the dosing. Insertion may be by the ~~MD~~Physician, CNM or Perinatal RN.
   b. NPO for the first dose for 1-2 hours
   c. Intravenous of LR, rate per ~~MD~~Physician or CNM
   d. Have the patient empty their bladder prior to each dose.
   e. Insert dose (per Provider order sheet) into the posterior fornix of the vagina. Do not use lubricating jelly. You may use normal saline or sterile water.
   f. Maintain patient in bed, supine with a lateral tilt for 2 hours post administration.
   g. The dose may be repeated according to Physician or CNM ~~MD/CNM~~ order.
   h. Vital signs should be monitored including BP and pulse every hour, temperature and respirations every 4 hours.

Title: Misoprostol for Cervical Ripening*	
Scope: Departmental	Manual: Perinatal – Medication (MED)
Source: Perinatal Nurse Manager	Effective Date: 7/2009

7. Intrauterine Resuscitation for Uterine tachysystole with indeterminate/abnormal fetal heart rate pattern:
    a. Remove remaining Misoprostol by vaginal exam, if possible. May use saline flush.
    b. Assist patient to lateral position.
    c. Give 500cc fluid bolus of LR. Must obtain order prior to administration.
    d. Give O2 at 10L via nonrebreather facemask.
    e. Have Terbutaline 0.25mg SQ readily available for administration. Must obtain order prior to administration.
    f. Notify Physician or CNM.~~MD/CNM.~~
    g. Document all measures implemented.

DOCUMENTATION:

1. Assessment
2. Interventions and responses
3. Medications times and dose
4. Patient education and care plan

Approval	**Date**
CCOC	1/27/2020
Pharmacy and Therapeutics Committee	2/20/2020
Perinatal/Pediatrics Committee	2/4/2020
Medical Executive Committee	3/3/2020
Board of Directors	
Last Board of Director Review	

Initiated: 7/2009
Revised: 7/2011jk, 8/2016 SG, 1/2020ss
Reviewed: 7/2011jk, 8/2016 SG

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Naloxone (Narcan) Distribution	
Scope: NIHD and NIA Clinics	Manual: RHC/ClinicsNursing Administration
Source: Care Coordination Nurse Manager	Effective Date:

PURPOSE:

Northern Inyo Health Care District (NIHD) volunteers/staff/peers (excluding non-clinic RN staff) who are trained in overdose prevention education, pursuant to the Standing Order to dispense naloxone issued by the prescribing ~~physician~~practitioner, will register and train opioid overdose responders to administer naloxone to individuals experiencing an opioid overdose. Naloxone is an opioid antagonist, which is used to reverse the effects of an opioid overdose.

POLICY:

NIHD is an organization that provides harm reduction education, safe drug consumption supplies and disposal services, and health and social service referrals to individuals. NIHD aims to engage, empower and increase access to essential services for Inyo County's underserved and hard to reach populations. Core direct services include comprehensive harm reduction services (education and supplies), overdose prevention education and naloxone distribution and hygiene supply distribution. Referrals for substance use disorder treatment, primary care services, Hepatitis C treatment, benefits enrollment, and Social Service assistance are also offered to participants.

NIHD Recovery Support Navigator (RSN): An NIHD employee who is responsible for coordinating the Overdose Prevention and Naloxone Distribution Program, including training Overdose Prevention Educators and monitoring naloxone inventory. The RSN is educated to conduct Opioid Overdose Responder trainings. Overdose Prevention Educators can be peers, volunteers, staff, or anyone else working with the program who is in a position to reach people who use drugs and other potential bystanders.

Prescribing ~~Physician~~Practitioner: A ~~physician~~practitioner licensed the State of California and who holds a valid DEA license who is issuing the standing order to dispense naloxone and is supporting the purchase of naloxone for NIHD. *See Attached Standing Order*

Opioid Overdose Responder: A person who participates in an overdose response training with a NIHD Overdose Prevention Educator.

Responsibilities of Prescribing ~~Physician~~Practitioner:

1. When indicated, ~~T~~the naloxone will be ordered by NIHD, under the license of the Prescribing ~~Physician~~Practitioner. The Prescribing ~~Physician~~Practitioner will provide their license and DEA number to pharmaceutical companies/distributors that NIHD (Medication Assisted Treatment (MAT) program purchases naloxone from. The naloxone will be shipped to NIHD, stored there, and distributed ~~at~~ with a syringe exchange program.

Title: Naloxone (Narcan) Distribution	
Scope: NIHD and NIA Clinics	Manual: RHC/ClinicsNursing Administration
Source: Care Coordination Nurse Manager	Effective Date:

2. The Prescribing ~~Physician~~Practitioner shall be responsible for writing all necessary standing orders for the distribution, possession and administration of the naloxone for the successful implementation of this program.

3. The Prescribing ~~Physician~~Practitioner will advise the NIHD MAT program related to any medical questions that may arise. The Prescribing ~~Physician~~Practitioner will not provide direct clinical care.

Training of NIHD MAT Overdose Prevention Educators:

All Overdose Prevention Educators who will be distributing naloxone will receive training by the RSN Overdose Prevention Coordinator in the following:

At a minimum, the training curriculum shall address:

- Risk factors for opioid overdose
- Prevention strategies
- Recognizing overdose
- Signs of an overdose
- Calling 911
- Rescue breathing
- Administering naloxone
- Completion of proper documentation
- Proper storage of naloxone
- Post-overdose care
- Refill procedure

Quality Assurance:

- All NIHD MAT Overdose Prevention Educators will attend a mandatory training with a RSN Overdose Prevention Coordinator that cover the above topics before distributing naloxone.
- The RSN will observe all NIHD MAT Educators providing an overdose prevention education training and will provide feedback if needed.
- Any clinical issues related to the dispensing of naloxone and other adverse events reported by participants will be referred immediately to the Prescribing ~~Physician~~Practitioner.

Training of the Opioid Overdose Responders (people who use drugs/other layperson bystanders):

1. NIHD MAT Overdose Prevention Educators shall be responsible for training Responders using the training curriculum.

Title: Naloxone (Narcan) Distribution	
Scope: NIHD and NIA Clinics	Manual: RHC/ClinicsNursing Administration
Source: Care Coordination Nurse Manager	Effective Date:

2. Trainings may be conducted in a variety of settings, including on the street or in a more conventional private indoor setting. The trainings may be in small groups or conducted one-on-one. The duration of the training shall depend on the number of responders in the class and their familiarity with naloxone administration and overdose. 1:1 training can be as short as 5-10 minutes, and group trainings should not exceed one hour.
3. Responders shall be given a naloxone kit during 1:1 training or at the end of the group training.

Distribution of Naloxone Kits:

1. The contents of the naloxone kits shall be assembled in accordance with the Prescribing ~~Physician~~Practitioner's standing order. The RSN may distribute multiple forms of naloxone depending on cost and availability.
2. Naloxone kit refills shall be made available to anyone who has previously completed the training.
3. Registered Nurses are outside of their scope of practice should they ~~distribute~~ dispense any medication, including Naloxone, EXCEPT when the RN is employed and working in the clinic setting and has a medical provider order to dispense.

Data Collection and Record Keeping:

1. NIHD MAT program and the RSN will complete data collection requirements as outlined by funders.

Safe Storage of Naloxone Supplies and Program Records:

1. The RSN Overdose Prevention Coordinator shall ensure that all naloxone kits are securely stored at each program site at room temperature (59-77F degrees, with exposure up to 104F without product failure) and protected from light.
2. The naloxone inventory shall be regularly assessed to ensure that it is not expired or close to expiration.

REFERENCES:

1. California Code, Civil Code - CIV § 1714.22

CROSS REFERENCE P&P:

1.

Approval	**Date**
CCOC	1/27/2020
Pharmacy & Therapeutics	2/20/2020
Medical Executive Committee	3/3/2020

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Naloxone (Narcan) Distribution	
Scope: NIHD and NIA Clinics	Manual: RHC/ClinicsNursing Administration
Source: Care Coordination Nurse Manager	Effective Date:

Board of Directors	
Last Board of Directors Review	

Developed: 8/2019dd
Reviewed:
Revised: 1/2020ta
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Pitocin Administration*~~Oxytocin (Pitocin) Administration	
Scope: Perinatal Services / Surgical/PACU	Manual: CPM - Medication (MED)
Source: Manager of Perinatal Department	Effective Date: 1/18/17

PURPOSE:
To provide guidelines for administration of Pitocin (Oxytocin) for induction, augmentation of labor, or postpartum administration to Perinatal Unit RNs

I. INDUCTION/AUGMENTATION ~~PITOCIN~~OXYTOCIN POLICY:

1. A qualified Perinatal Unit RN may initiate a ~~Pitocin~~Oxytocin infusion for induction or augmentation of labor when ordered by the attending ~~physician~~practitioner.
2. The ~~physician~~practitioner must be within 15 minutes of the hospital and available immediately by phone.
3. A category I baseline fetal monitoring strip must be obtained prior to the beginning of the induction or augmentation of labor. Induction or augmentation may be appropriate and occur with a Category II strip by specific Provider order.
4. Patients must be on continuous fetal monitoring while on ~~Pitocin~~Oxytocin unless otherwise specified by Provider order.
5. If internal monitoring is requested refer to "Internal Fetal Monitoring" policy.
6. ~~Pitocin~~Oxytocin is required to be double checked with another RN, according to high alert medication policy, prior to connecting the ~~Pitocin~~Oxytocin to the patient.
7. The nurse must inform the ~~physician~~practitioner if any of the following occur:
    a. Abnormal FHR (Fetal Heart Rate)
    b. Uterine tetany
    c. Uterine Hypertonus: When using an IUPC (intrauterine pressure catheter) and uterine baseline is >20mmHg or contractions do not return to baseline.
    d. Tachysystole: A series of single contractions lasting 2 minutes or more, a contraction frequency of more than 5 in 10 minutes averaged over a 30 minute period, or contractions of normal duration occurring within 1 minute of each other.
    e. Inability to adequately monitor the patient
    f. Maternal sequelae:
        - increased BP
        - increased temperature
        - excessive bleeding
    g. Signs and symptoms of water intoxication, (e.g., Drowsiness, Listlessness, Headache, Confusion, Shortness of Breath, Edema, Decreased BP, Urinary Output <30ml/hr, Anuria)
    h. Failure to progress
    i. If at any time the nurse feels it is not safe to start or continue the induction or augmentation.
8. ~~Pitocin~~Oxytocin must be administered through appropriate pump tubing on an IV pump.
9. The ~~MD~~ practitioner will order the rate for IV maintenance fluids.

PRECAUTIONS:

1. Contraindications for use of ~~Pitocin~~Oxytocin include: CPD, fetal malpresentations, prolapsed cord, macrosomia, placenta previa or abruption, prior cesarean section, Category III strip, or active genital herpes.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Pitocin Administration*~~Oxytocin (Pitocin) Administration	
Scope: Perinatal Services / Surgical/PACU	Manual: CPM - Medication (MED)
Source: Manager of Perinatal Department	Effective Date: 1/18/17

PROCEDURE:

1. Prior to starting ~~Pitocin~~Oxytocin, the risks and benefits of the medication must be discussed with the patient, and written consent obtained.
2. Prior to starting ~~Pitocin~~Oxytocin, obtain and assess maternal vital signs, obtain a 30-minute baseline fetal monitor strip, and complete a vaginal exam to confirm presentation and dilation, except in patients with Premature Rupture of Membranes (PROM).
3. Place an 18-gauge (preferred) or 20-guage catheter IV.
4. Using appropriate pump IV Tubing and on the IV pump, start a primary IV with a 1000L bag of LR or solution ordered by ~~physician~~practitioner and infuse as ordered.
5. Obtain a pre-mix bag of ~~Pitocin~~Oxytocin 30 units in 0.9% NaCL 500mL and ensure IV ~~Pitocin~~Oxytocin Rate Label is on the bag, as well as the high-alert medication sticker.
6. IV ~~Pitocin~~Oxytocin stickers are required in 3 places prior to beginning administration. The IV pump, on the ~~Pitocin~~Oxytocin tubing at the patient hub attachment port, and in the middle of the IV tubing.
7. Using separate appropriate pump IV tubing and a second IV pump, connect the ~~Pitocin~~Oxytocin piggyback to the primary IV tubing using the port nearest the patient's catheter site.
8. The ~~Pitocin~~Oxytocin infusion rate will be ordered by the ~~physician~~practitioner. The concentration is 1 milliunit (mU) per minute = 1 ml per hour.
9. The starting rate of ~~Pitocin~~Oxytocin and interval for rate change will be specifically ordered by the ~~physician~~practitioner and titrated by the Perinatal Unit RN assessing fetal response and uterine activity/labor progress.
10. Nursing assessments and documentation must be charted as specified under the Oxytocin induction order set, or more often if the patient's condition requires more frequent intervention.
11. For Tachysystole or Tetanic Uterine Contractions:
    a. Discontinue Oxytocin infusion for uterine tachysystole unrelieved by intervention. Give Terbutaline as ordered after uterine resuscitation measures have failed and you have notified the physician~~MD~~/CNM.
12. Intrauterine Fetal Resuscitation per ~~MD~~ physician or CNM order:
    b. Discontinue Oxytocin
    c. Assist patient to lateral position.
    d. Give 500cc fluid bolus of LR.
    e. Give O2 at 10L via nonrebreather face mask.
    f. Have Terbutaline 0.25mg SQ readily available for administration.
    g. Notify ~~MD~~physician/CNM.
    h. Document all measures implemented.

DOCUMENTATION:

1. Frequency of assessments should always take into consideration maternal-fetal condition and at times will need to occur more often if the maternal-fetal clinical needs change.
2. Maternal vital signs:
    a. Temperature q4 hours with intact membranes
    b. Temperature q2 hours with ruptured membranes
    c. Temperature q1 hr with ≥100°F
    d. Temperature q30 minutes ≥101°F
    e. Pulse and respirations q1 hour
    f. BP q10-15 minutes with each rate change

g. BP q30 minutes when ~~Pitocin~~Oxytocin rate is stable

3. Fetal Heart Rate, Variability, and Uterine Activity:
   a. Record with each rate change
   b. First stage: FHR q15 minutes at a minimum
   c. Second stage: FHR q5 minutes
4. Observe for, document, and notify ~~physician~~practitioner of the occurrence of the following potential side effects:
   a. Maternal hypotension
   b. Maternal tachycardia
   c. Nausea and vomiting
   d. Water Intoxication (e.g., Drowsiness, Listlessness, Headache, Confusion, Shortness of Breath, Edema, Decreased BP, Urinary Output <30ml/hr, Anuria)
   e. Uterine Tetany: Contractions that plateau and do not return to baseline within two contraction cycles or five minutes or one such contraction which lasts longer than three min.
   f. Tachysystole: A series of single contractions lasting 2 minutes or more, a contraction frequency of more than 5 minutes averaged over a 30 minute period, or contractions of normal duration occurring within 1 minute of each other
   g. Uterine Hypertonus: When using an IUPC and uterine baseline is >20mmHg or contractions do not return to baseline
   h. Fetal Tachycardia: FHR ≥ 160 bpm for 10 minutes or longer
   i. Fetal Bradycardia: FHR ≤110 bpm for 10 minutes or longer
   j. Late decelerations
   k. Prolonged or recurrent variable decelerations
   l. Rapid labor progression
   m. Failure to progress: Lack of labor progression with demonstration of > 2 hours of an adequate contraction pattern
   n. Category III strip
   o. Nursing interventions and any provided treatments, including the results
   p. Time of occurrence
   q. Time of ~~physician~~practitioner notification

II. POSTPARTUM ~~PITOCIN~~OXYTOCIN POLICY:

1. A qualified RN may initiate postpartum ~~Pitocin~~Oxytocin, after delivery of the baby, as ordered by ~~physician~~practitioner.
2. The pre-mixed ~~Pitocin~~Oxytocin will not be connected to the patient (or rate changed to postpartum rate) until it is double checked with a second RN, or a verbal timeout is performed and documented in the MAR if second RN is not immediately available to witness administration on the MAR.
3. The pre-mixed ~~Pitocin~~Oxytocin will be started as ordered for standard postpartum ~~Pitocin~~Oxytocin administration, unless otherwise ordered by ~~physician~~practitioner.

PROCEDURE:

1. A qualified RN may obtain the pre-mixed ~~Pitocin~~Oxytocin, prime the tubing, ensure proper labeling of each port program the IV pump (if patient is not currently on ~~Pitocin~~Oxytocin for augmentation/induction), but will not connect ~~Pitocin~~Oxytocin to the patient.
2. RN will program the ~~Pitocin~~Oxytocin pump in anticipation for delivery:
   a. Prime the tubing with the pre-mixed ~~Pitocin~~Oxytocin 30 mU in 0.9% NaCL 500 ml.

Title: ~~Pitocin Administration*~~Oxytocin (Pitocin) Administration	
Scope: Perinatal Services / Surgical/PACU	Manual: CPM - Medication (MED)
Source: Manager of Perinatal Department	Effective Date: 1/18/17

b. Program pump to run at 200 ml/hr with a VTBI (volume to be infused) of 333 ml to give the patient a total of 20 mU of ~~Pitocin~~Oxytocin as standard postpartum ~~Pitocin~~Oxytocin ordered by ~~physician~~practitioner.

3. After patient has delivered the baby, confirm the dose of ~~Pitocin~~Oxytocin with another RN, or if another RN is not immediately available, perform a verbal timeout with ~~physician~~practitioner. Document in the MAR.
4. According to the postpartum ~~Pitocin~~Oxytocin ~~physician~~practitioner ~~standing~~ orders, the LR is to be running concurrently at 400 ml/hr on the second IV pump.

Committee Approval	**Date**
CCOC	1/27/2020
Perinatal/Pediatrics Committee	2/4/2020
Pharmacy/Therapeutics Committee	2/20/2020
Medical Executive Committee	3/3/2020
Board of Directors	
Last Board of Directors Review	

Developed: 11/97
Reviewed:
Revised: 07/06: 08/10: 9/12jk: 4/2014jk; 8/2016 SG, 1/2020ss

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

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:

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.

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:

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
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:

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).

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:

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:

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

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
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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.

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

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:
Supersedes:
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
Revised:
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

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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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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

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
Revised:
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

Developed: 2/3/2016, PD
Reviewed:06/20/2018
Revised:
Supersedes:
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
Medical Executive Committee	3/1/2016
Board of Directors	3/16/16
Last Board of Directors Review	6/20/2018

Developed: 2/4/2016, PD
Reviewed: 6/20/2018
Revised:
Supersedes:
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 5:15 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 Kelli Davis MBA, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, BSN, Chief Nursing Officer
ABSENT	Kevin S. Flanigan MD, MBA, Chief Executive Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner stated at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of 3 minutes each. No comments were heard.
ADJOURNMENT TO CLOSED SESSION	Ms. Turner announced the meeting would adjourn to Closed Session to allow the District Board of Directors to discuss: a. Public Employee Performance Evaluation/Discipline/Dismissal/ Release (*Government Code Sections 54954.5 and 54957(b*), title: Chief Executive Officer.
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 6:02 pm the meeting returned to Open Session. Ms. Turner reported the Board took no reportable action.
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner again stated at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of 3 minutes each. Comments were heard from Ms. Gayla Wolf.
PRIMER ON SUSTAINABLE BUILDING PRINCIPLES FOR RHC CONSTRUCTION PROJECT	Northern Inyo Healthcare District (NIHD) Rural Health Clinic Medical Director Stacey Brown MD, introduced Mr. Tate Walker with OPN Architects to provide an overview of sustainability practices for building projects. The intent of sustainable projects is to create a building tailored to meet the occupant's needs while allowing for ecology, wellness, and an environment that promotes maximum employee productivity and well-being. Elements of sustainable building design include: - Design for integration - Design for community - Design for ecology, water, and energy - Design for wellness - Design for economy and resources - Design for change Doctor Brown reviewed the 9 foundations of a healthy building, and discussed healthy building principles including adequate ventilation; air

quality; thermal health; moisture; safety and security; lighting and views; noise levels, and water quality. Open dialog on the subject of sustainable building principles took place, and questions were asked and answered. The importance of designing with patient flow in mind was also noted, as was the need to make sure that this building project proceeds in a timely manner in order to comply with Opportunity Zone project guidelines. It was additionally noted that the cost of building with sustainability in mind typically adds only 0 to 3 percent to the cost of a building project.

ADJOURNMENT TO CLOSED SESSION

Ms. Turner thanked Mr. Walker and Doctor Brown for facilitating a robust discussion on this topic. At 7:51 pm she announced the meeting would return to Closed Session to allow the District Board of Directors to continue discussion of:

a. Public Employee Performance Evaluation/Discipline/Dismissal/ Release (*Government Code Sections 54954.5 and 54957(b*) title: Chief Executive Officer.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:49 pm the meeting returned to Open Session. Ms. Turner reported the Board took unanimous action to authorize outside labor counsel to contract with outside investigators regarding District finances and operations.

Ms. Turner also reported the Board took unanimous action to place Chief Executive Officer Kevin S. Flanigan MD, MBA on paid Administrative Leave pending completion of that investigation.

Ms. Turner additionally stated the Board took unanimous action to appoint NIHD Chief Operating Officer Kelli Davis to act as Interim Chief Executive Officer of the District effective immediately and until completion of the investigation into District finances and operations.

Ms. Turner again asked if any member of the public wished to comment on any items listed on the Notice for this meeting. No comments were heard.

ADJOURNMENT

The meeting adjourned at 8:50 pm.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

CALL TO ORDER	The meeting was called to order at 6:00 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 Will Timbers MD, Chief of Staff Kelli Davis MBA, Interim Chief Executive Officer John Tremble, Chief Financial Officer Tracy Aspel RN, BSN, Chief Nursing Officer
ABSENT	Kevin S. Flanigan, MD, MBA, Chief Executive Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda. No comments were heard.
PIONEER HOME HEALTH QUARTERLY REPORT	Pioneer Home Health (PHH) Director Pat West provided a quarterly report on the operations of Pioneer Home Health. She provided a history of the development of the organization from 1990 to present, and an overview of Northern Inyo Healthcare District's (NIHD's) financial support of PHH beginning in 2018. Ms. West noted that Pioneer's patient census has tripled since partnering with NIHD, and additionally stated that she will retire as Director of PHH effective as of March 1, 2020. Ms. Ruby Allen will assume the role of Director of Pioneer Home Health.
NIHD CARE SHUTTLE PRESENTATION	NIHD Rural Health Clinic Transportation Coordinator Oscar Esparza provided a presentation on patient services provided by the District's Care Shuttle program. The shuttle is for non-emergency patient transportation to and from medical appoints, and to and from Northern Inyo Hospital. It provides door-to-door transportation services and is staffed by volunteer drivers. The Care Shuttle program utilizes 3 vehicles, 2 of which are wheelchair accessible, and the service operates 7 days a week. Care Shuttle services will soon expand to include medical courier services, and grant funding for the startup of a mobile clinic is being looked into. Mr. Esparza noted that the Care Shuttle program is always looking for additional volunteer drivers, and he also stated that the program receives financial support from the NIHD Foundation.
FISCAL YEAR BUDGET FOR 2019/2020	NIHD Chief Financial Officer John Tremble presented a proposed operating budget for the 2019/2020 fiscal year, calling attention to the

following:

- The District has had significant issues with its' new general ledger product, and as a result the budget being presented represents a carry forward of the District's 2018/2019 budget
- Operational changes between the current and the prior fiscal year include expansion of services including Same Day Service at the NIHD Rural Health Clinic; urology services start-up for 8 days a month; and an increase of outpatient revenues to 73% of gross patient revenue
- Mr. Tremble also reviewed the following elements of the proposed operating budget: patient volumes and services; employee salaries expense and FTE's; supplies and purchased services; capital; net revenues; continuation of discounts and charity care policies; intergovernmental transfer revenues; and 2019/2020 personnel recruitment requests
- 2020 budget challenges including electronic health record costs; an increase in base wages without growth in service revenue; and the cost of the building separation and pharmacy construction projects

Mr. Tremble also stated that the District's bottom line net income for the current fiscal year is expected to be a positive $500,000. It was moved by Robert Sharp, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the proposed 2019/2020 operating budget as presented.

PIONEER MEDICAL ASSOCIATES LEASE

NIHD Compliance Officer Patty Dickson reported that the District is making progress toward renewing its office space lease with Pioneer Medical Associates for the property located at 152 Pioneer Lane, Bishop. Following establishment of a new lease, the District will resume discussion of the possible purchase of the Kamei and Hathaway interest in Pioneer Medical Associates.

DISTRICT BOARD RESOLUTION 20-02

Chief Financial Officer John Tremble called attention to proposed District Board Resolution 20-02, which re-states a previous Board resolution and adds authority for all Chief Officers to invest the cash reserves and operations funds of the Hospital District in legal forms of investment as specified in Government Code section 53635. It was moved by Ms. Kilpatrick, seconded by Jody Veenker, and unanimously passed to approve District Board Resolution 20-02 as presented.

UPDATE ON NIHD LEGAL SERVICES RFP

Ms. Turner reported that interviews for District legal services providers will be conducted next week. An update on NIHD's Legal Services RFP process will be placed on the agenda for the March regular meeting.

GOVERNANCE CONSULTANT UPDATE

Ms. Turner additionally reported that Jim Rice with Gallagher Associates will travel to Bishop to provide two half-day Governance trainings for members of the District Board on March 20 and March 21, 2020.

RHC BUILDING UPDATE

Interim Chief Executive Officer Kelli Davis and Vice Chief of Staff Stacey Brown, MD reported that the NIHD RHC Building project is moving forward and that a special meeting on the topic of sustainable building projects recently took place. District Administration, Mr. Sam Walker, and legal counsel for both parties have met and progress has been made toward establishing contracts for the Opportunity Zone construction project. An initial project team meeting will be held later this week, and potential construction project managers are being considered for the project. All parties involved are encouraged that the project is moving forward in a positive direction, and it was acknowledged that the success of the project is a priority for the Healthcare District.

COMPLIANCE DEPARTMENT QUARTERLY REPORT

Compliance Officer Patty Dickson provided a quarterly Compliance Department Report as of February 2020, which included a review of Breaches; Issues and Inquiries; audits; Conflicts of Interest questionnaires; CPRA requests; and California Department of Public Health and Joint Commission reporting. It was noted that the Compliance report requires District Board approval, so it will be placed on the agenda for the March regular meeting as an action item.

RURAL HEALTH CLINIC ANNUAL REPORT

Ms. Turner stated that presentation of the NIHD Rural Clinic annual report will be tabled to the March regular meeting of the District Board.

ADJOURNMENT TO CLOSED SESSION

At 7:18 pm Ms. Turner announced that the meeting would adjourn to Closed Session to allow the Board of Directors to discuss items listed on the Closed Session portion of the agenda. Following return to Open Session, the meeting will continue as indicated on the agenda.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:55 pm the meeting returned to Open Session. Ms. Turner reported that the Board took no reportable action.

CHIEF OF STAFF REPORT

Chief of Staff William Timbers, MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following District-wide Policies and Procedures:

POLICY AND PROCEDURE APPROVALS

1. *Practitioner Re-Entry Policy*
2. *MetaNeb Policy*
3. *Standards of Care in the Perioperative Unit*
4. *Heparin Dosing Protocol*

It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve Policies and Procedures 1 through 4 as presented.

MEDICAL STAFF APPOINTMENTS

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

1. Joe Miller, MD (*urology*) – Provisional Consulting Staff

2. Louis Rivera, MD (*surgical oncology*) – Provisional Consulting Staff
3. Andrew Tang, MD (*internal medicine/hospitalist*) – Locums/Temporary Staff

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

TELEMEDICINE STAFF APPOINTMENT

Doctor Timbers also requested approval of the following Telemedicine Staff appointment, credentialing by proxy:

1. Muhammad Alim, MD (*pulmonology, Adventist Health Bakersfield*) – Telemedicine Staff

It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and unanimously passed to approve the Telemedicine Staff appointment of Muhammad Alim, MD as requested.

TEMPORARY PRIVILEGES

Doctor Timbers additionally reported the Medical Executive Committee recommends approval of Temporary Privileges for 120 days for the following:

1. Ruhong Ma, DO (*internal medicine/hospitalist*) – Locum tenens/Temporary Staff

It was moved by Ms. Kilpatrick, seconded by Topah Spoonhunter, and unanimously passed to approve the Temporary Privileges of Ruhong Ma, DO, as requested.

ADDITIONAL PRIVILEGES IN SURGERY

Doctor Timbers also reported the Medical Executive Committee recommends approval of additional privileges in surgery for the following:

1. Jon Bowersox, MD (*general surgery*) – addition of privileges in EGD and colonoscopy
2. Jeannie Pflum, DO (*obstetrics and gynecology*) – addition of outpatient core privileges in obstetrics and gynecology

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve both additions of privileges in surgery as requested.

ADDITIONAL PRIVILEGES IN MAMMOGRAPHY

Doctor Timbers additionally requested approval of additional privileges in Mammography for the following:

1. Farres Ahmed, MD (*radiology*)
2. John Erogul, MD (*radiology*)
3. Carly Harvey, MD (*radiology*)
4. Jaren Kasper, MD (*radiology*)
5. Stephen Loos, MD (*radiology*)
6. Edmund Pillsbury, MD (*radiology*)
7. Kinsey Pillsbury, MD (*radiology*)

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve all seven additional privileges in Mammography as requested.

MEDICAL STAFF ADVANCEMENT

Doctor Timbers also reported the Medical Executive Committee recommends approval of the following Medical Staff advancement:

1. Samantha Jeppsen, MD (*emergency medicine*) – recommendation for advancement from Provisional Active Staff to Active Staff

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve the Medical Staff advancement of Samantha Jeppsen, MD as requested.

APPROVAL OF ANNUAL REVIEWS

Doctor Timbers additionally requested approval of the following Annual Reviews:

1. Critical Indicators
    i. Emergency Medicine
    ii. Anesthesia
    iii. Surgery

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve all three Critical Indicators as requested.

CHIEF MEDICAL OFFICER JOB DESCRIPTION

Doctor Timbers also called attention to a proposed Chief Medical Officer (CMO) Job Description based on input received from the NIHD Medical Staff general membership. He additionally stated it is the opinion of the NIHD Medical Staff that this is a good job description for the CMO position, however they are not recommending the CMO as an addition to the Chief Officers Executive Suite unless it is the Board of Directors desire to take that action. The proposed job description is the result of many months of consideration, collaboration, and effort on the part of the NIHD Medical Staff. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the Chief Medical Officer job description, with thanks being given to the physicians for their many hours of dedication to this task.

PHYSICIAN RECRUITMENT UPDATE

Doctor Timbers additionally stated that NIHD is actively recruiting a general surgeon who is currently completing a fellowship. It is hoped that the doctor will come on site for a visit in the near future.

CONSENT AGENDA

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

- Approval of minutes of the January 15, 2020 regular meeting
- Approval of minutes of the January 8, 2020 special meeting
- Approval of minutes of the January 21, 2020 special meeting
- Financial and Statistical reports as of December 2019
- Policy and Procedure annual approvals

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve all five Consent Agenda items as presented.

BOARD MEMBER REPORTS

Ms. Turner asked if any members of the Board of Directors wished to comment on any items of interest. Director Kilpatrick informed those present that the NIHD Foundation dinner has been scheduled for May 2, 2020. Ms. Veenker reported that she and Ms. Kilpatrick recently met to

begin planning for Board outreach to the NIHD Medical Staff, and to plan future events for the two groups. No other comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 9:05 pm Ms. Turner reported the meeting would adjourn to Closed Session to allow the Board of Directors to/for:

A. Discussion of a real estate negotiation regarding price, 152 Pioneer Lane, Bishop, California, agency negotiators Kevin S. Flanigan MD, MBA and Pioneer Medical Associates Partners (*pursuant to Government Code Section 54956.8*).
B. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2*)).
C. Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
D. 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 9:18 pm the meeting returned to Open Session. Ms. Turner reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 9:19 pm.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

Type	Title
	Admission Procedure to the Acute Sub Acute Department*
	Chart Check Guidelines
	Discharge Planning for Homeless Patients
	Emergency Medication and Code Blue Crash Cart Policy
	Emergency Medication Trays Policy
	FUNCTIONAL RISK ASSESSMENT CRITERIA FOR THERAPY REFERRAL*
	ICU Acuities
	Interfacility Transfer Guidelines
	Intubation Tray Adult/Pediatric
	Intubation Tray Infant
	Iron Dextran (Imferon) Administration
	IVIG (Intravenous Immune Globulin)
	Latex Precautions
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
	Medication Reconciliation
	Myocardial Perfusion Stress Test: Nuclear
	Neupogen / Procrit Administration
	NPO Guidelines
	Nursing Care of Outpatient Interventional Radiology Patient

Page 2 of 3 (44 items) « < 1 **2** 3 > »

Type	Title
	Nutritional IV
	OmniCell Automated Dispensing Unit (ADU)
	Ordering Dietary Supplements
	ORTHOPEDIC HARDWARE
	PAPR Respirator Inspection Record
	Patient Nutritional Care
	Patient Warmer (Warm Air Hyperthermia System)
	Physician Certification Form
	Physician Request for Consult
	Poison and Drug Overdose Information
	Portacath Vascular Access System
	Potassium Intravenous Administration
	Radiation Policy for Management of Patients with Excessive Exposure
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Removal of Placenta from Hospital per Patient's Request
	Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
	Resuscitation Quality Improvement (RQI)
	Saline Lock For Blood Draw
	Scope of Service Acute/Subacute*
	SUBMISSION OF BIOPSY (TISSUE) SPECIMENS (NOT FLUID)

Page 3 of 3 (44 items) « < 1 2 **3** > »

Type	Title
	Surgical Drains Care of
	Warfarin Monitoring Protocol
	Warming Cabinet for Blankets/Solutions
	Wound Vac - Vacuum Assisted Closure System ATS

Nursing Administration:

Page 1 of 2 (30 items) « < 1 2 > »

Type	Title
	Athena Designated Field Documentation
	Bed Bug Infestation and Management
	Blood Product Replacement During Obstetric Hemorrhage
	Discharge Planning for Homeless Patients
	Emergency Medication Trays Policy
	Entries in the Medical Record
	Guide to Release of Patient Information to the Media
	Guidelines for Employee Transportation of Patients
	Guidelines for Licensed Nurses Nursing Students Giving Medications
	Kronos Timekeeping System
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Legal Blood Alcohol Intake Form Completion of the
	Linen Laundry Processes AB 2679
	Med Occurrence/Med Errors Scoring and QI Form
	Medication Occurrence Report
	Medication Reconciliation
	Nursing Care of Outpatient Interventional Radiology Patient
	Nursing Department Dress Code
	Nursing Instructor Policy
	OmniCell Automated Dispensing Unit (ADU)

Page 2 of 2 (30 items) « < 1 2 > »

Type	Title
	Patient Visitation Rights
	Plan for the Provision of Nursing Care
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Release of Patient Information to News Media and Patient's Right to Confidentiality
	Removal of Placenta from Hospital per Patient's Request
	Responsibilities of Nursing Students and Hospital Staff
	Resuscitation Quality Improvement (RQI)
	Safe Injection Practices
	Temperature Monitoring of Storage Devices and Units
	Withholding Resuscitative Measures

Page 1 of 1 (1 items) « < 1 > »

Type	Title
	Admission, Discharge, Transfer of Patients: Continuum of Care

Social Services:

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*

Page 1 of 1 (8 items) « < 1 > »

Type	Title
	American Heart Association Training Center Faculty and Course Instructor Roles and Training*
	American Heart Association Training Center Policies and Procedures*
	American Heart Association Training Center QAPI*
	Community Skills Session; Reservation, No Show or Cancellation Policy*
	Ensuring Compliance with Continuing Education Guidelines at NIH*
	Nursing Education Department Plan
	Nursing Instructor Policy
	Staff Development Dispute Resolution Policy

Employee Health:

Page 1 of 1 (3 items) « < 1 > »

Type	Title
	Employee Access to His or Her Own Protected Health Information*
	Employee Health Access of Patient Personal Medical Record
	Scope of Service - Employee Health*

PACU/Infusion:

Page 1 of 3 (53 items) « < 1 2 3 > »

Type	Title
	Steris Gravity / Prevacuum Sterilizer (Autoclave)
	Delayed Blood Bank Banding of Patients
	DI Lead Apron/ Protective Equipment Policy*
	Diagnostic Imaging - Premedication for Radiographic Contrast Sensitivity*
	Emergency Medication and Code Blue Crash Cart Policy
	Emergency Medication Trays Policy
	Environmental and Infection Control PACU
	Fire / Safety PACU
	Intubation Tray Adult/Pediatric
	Intubation Tray Infant
	IVIG (Intravenous Immune Globulin)
	Laryngeal Mask Airway Removal
	Laser Safety
	Latex Precautions
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
	Medication Reconciliation
	NPO Guidelines
	Nursing Care Guidelines in PACU
	Nursing Care of Outpatient Interventional Radiology Patient

Page 2 of 3 (53 items) « < 1 **2** 3 > »

Type	Title
	Nursing Management of the Patient Receiving Local Anesthesia for Procedures
	OmniCell Automated Dispensing Unit (ADU)
	OPD/PACU Discharge Instructions
	Orientation and Cross Training to OPD/PACU
	PACU Discharge Criteria
	PACU Equipment
	Patient Warmer (Warm Air Hyperthermia System)
	Pediatric Standards of Care in the OPD/PACU
	Performance Improvement Program Anesthesia Service
	Point of Care Testing (Blood Glucose, Urine Dipsticks) OPD/PACU
	Post Operative Follow-up Phone Calls
	Post Operative Patient Care In The ICU
	Postoperative Teaching
	Postpartum Patient Care in the PACU
	Potassium Intravenous Administration
	Preoperative Instruction Sheet
	Preoperative Interview
	Preoperative Medication Guidelines
	Propofol Use In Critical Care Areas
	Recommendation for Prophylaxis After Occupational Exposure to HIV

Page 3 of 3 (53 items) « < 1 2 **3** > »

Type	Title
	Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
	Responsibility of Service Perioperative
	Saline Lock For Blood Draw
	Scope of Perioperative Nursing Practice
	Staffing Plan OP/PACU*
	Standards of Care in the Outpatient Infusion Unit
	Standards of Care in the Perioperative Unit
	Surgical Drains Care of
	Surgical Procedures
	Temperature Monitoring of Storage Devices and Units
	Universal Protocol
	Warming Cabinet for Blankets/Solutions
	Wound Vac - Vacuum Assisted Closure System ATS

Page 1 of 2 (34 items) « < 1 2 > »

Type	Title
	Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners
	Delayed Blood Bank Banding of Patients
	Emergency Medication Trays Policy
	Fire Safety in the OP Infusion Unit
	Iron Dextran (Imferon) Administration
	IVIG (Intravenous Immune Globulin)
	Latex Precautions
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
	Medication Reconciliation
	Myocardial Perfusion Stress Test: Nuclear
	Neupogen / Procrit Administration
	Nursing Care of Outpatient Interventional Radiology Patient
	Nursing Management of the Patient Receiving Local Anesthesia for Procedures
	OmniCell Automated Dispensing Unit (ADU)
	OPD/PACU Discharge Instructions
	Operative Consents
	Orientation and Cross Training to OPD/PACU
	Outpatient Department Medication and Solution Policy
	Pediatric Standards of Care in the OPD/PACU

Page 2 of 2 (34 items) « < 1 2 > »

Type	Title
	PHARMACIST INTERVENTION FOR IRON REPLACEMENT
	Point of Care Testing (Blood Glucose, Urine Dipsticks) OPD/PACU
	Portacath Vascular Access System
	Potassium Intravenous Administration
	Rapid Fluid/Blood Infuser
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Resuscitation Quality Improvement (RQI)
	Saline Lock For Blood Draw
	Scope of Services, Infusion Center*
	Secretin Test
	Staffing Plan OP/PACU*
	Standards of Care OPD
	Temperature Monitoring of Storage Devices and Units
	Wound Vac - Vacuum Assisted Closure System ATS

OR:

Page 1 of 5 (81 items) « ‹ 1 2 3 4 5 › »

Type	Title
	Accessibility & Labeling of Piped Med Gas System EC.02.05.09 EP11
	Areas Designated for Administration of General Anesthesia EC.02.05.01 EP25-27
	Bone Graft Tissue Bank*
	Chemotherapeutic Agents in the OR
	Death in the Operating Room
	Draping for Surgical Procedures
	Electrosurgical Cautery
	Emergency Medication Trays Policy
	Emergency Supplies in Surgery
	Eye Wash Stations in the Perioperative and Sterile Processing Units
	FIRE SAFETY - FIRE HAZARDS DURING SURGICAL PROCEDURES EC02.03.01 EP 11-12
	Fire Safety in Surgery
	Handling of Infants/Fetus/Stillborns and Genetic Workup
	Immediate Use Sterilization Procedure (IUS)
	Implantation of Medical Devices
	Intraoperative Nursing Care for the Pediatric Patient
	Laser Safety
	Latex Precautions
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement

Page 2 of 5 (81 items) « < 1 **2** 3 4 5 > »

Type	Title
	Lithotripsy
	Management of Gas Storage Locations EC.02.05.09 EP1-6
	Manufacturer's Information on Hardware/Equipment
	Medical Device Tracking
	Medical Students in the OR
	Medication Reconciliation
	Microbiological Specimen Handling
	NPO Guidelines
	Nursing Management of the Patient Receiving Local Anesthesia for Procedures
	Observation in the Operating Room
	Obtaining Blood Bank Samples from Patients in Surgery
	Operating Room Sanitation
	Operating Rooms EC.02.05.01 EP20
	Operative Consents
	OR Electrical Safety
	ORTHOPEDIC HARDWARE
	Pathology Specimens
	Pathology Specimens In The Operating Room*
	Patient Warmer (Warm Air Hyperthermia System)
	Pentax Emergency Bedside Intubating Laryngoscope

Page 3 of 5 (81 items) « < 1 2 **3** 4 5 > »

Type	Title
	Performance Improvement Program Anesthesia Service
	Performance Improvement Program Surgical Service Physicians
	Perioperative Scope of Practice
	Pneumatic Tourniquet
	Positioning of the Surgical Patient
	Potassium Intravenous Administration
	Preoperative Instruction Sheet
	Preoperative Interview
	Preoperative Medication Guidelines
	Principles of Asepsis in the Operating Room
	Quality Assessment / Improvement Indicators Surgical Anesthesia Service
	Radiation Policy for Management of Patients with Excessive Exposure
	Radiation Protection in the OR
	Rapid Fluid/Blood Infuser
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Records and Reports Surgery
	Removal of Placenta from Hospital per Patient's Request
	Responsibility of Service Perioperative
	Restocking and Maintenance of Anesthesia Equipment
	RN First Assistant, RNFA

Page 4 of 5 (81 items) « < 1 2 3 4 5 > »

Type	Title
	Saline Lock For Blood Draw
	Scope of Perioperative Nursing Practice
	Shoulder Arthroscopy 3 Point Distraction System*
	Staffing Plan in the Operating Room*
	Standardized Protocol – Physician Assistant in the Operating Room
	Steris System 1E Processor
	Storage Requirements for Sterile and Clean Items
	SUBMISSION OF BIOPSY (TISSUE) SPECIMENS (NOT FLUID)
	Surgeries Requiring an Assistant*
	Surgery Charges*
	Surgery Emergency Generator Power
	Surgery Equipment and Routine Supplies
	Surgery Medication and Solution Policy
	Surgery Tissue / Bone Graft "Look Back" Policy*
	Surgical Hand Hygiene and Hand Scrub
	Surgical Procedures
	Temperature Monitoring of Storage Devices and Units
	Transfer of Evidence
	Vaginal Delivery in the OR
	Warming Cabinet for Blankets/Solutions

Page 5 of 5 (81 items) « < 1 2 3 4 5 > »

Type	Title
	Wound Vac - Vacuum Assisted Closure System ATS

Sterile Processing:

Page 1 of 2 (36 items) « ‹ 1 2 › »

Type	Title
	Basic Principles of Sterilization
	Biological Monitoring System for Steam Sterilizers
	Cleaning & Sterilization of NeuroTherm Probes
	Cleaning / Sterilization or High Level Disinfection of Equipment
	Cleaning and Care of Surgical Instruments
	Emergency Medication Trays Policy
	Eye Wash Stations in the Perioperative and Sterile Processing Units
	Heat Sealer
	Immediate Use Sterilization Procedure (IUS)
	Infection Control Sterile Processing Policy
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Loaner Instruments Care
	Manufacturer's Information on Hardware/Equipment
	Manufacturer's Recall Sterile Processing
	Medication Reconciliation
	Quick Rinse
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Reprocessing Single Use Items
	Selection and Use of Packaging Systems
	Special Procedure Trays

Page 2 of 2 (36 items) « ‹ 1 2 › »

Type	Title
	Sterile Processing Disaster Plan
	Sterile Processing Philosophy
	Sterile Processing Objectives and Functions
	Sterile Processing Staffing of Unit
	Sterile Processing Standards of Practice
	Sterilization Recall Policy*
	Sterilization Challenge Pack (Verify Assert)
	Sterilization of CMI Vacuum Pump
	Sterilizing of Orthopedic Implants
	Steris System 1E Processor
	Steris Vision Single Chamber Washer Disinfector
	Steris V-Pro 1 Low Temperature Sterilizer System
	Storage Requirements for Sterile and Clean Items
	Supplies After Hours Sterile Processing
	Temperature Monitoring of Storage Devices and Units
	Wrapping and Dating of Supplies and Instruments

Environmental Services Policies

For BOD Review March, 2020

- C.Difficile Spore Killer cleaning agent
- Cleaning Procedure: Patient Room Daily and at Discharge
- Cleaning Procedures: Contact and Enteric Isolation Rooms at Discharge
- Cleaning Procedures: Clinical Support Areas: Clinical Support & Ancillary Service Areas
- Cleaning Procedures: Clinical Support Areas: Dietary Department
- Cleaning Procedures: Clinical Support Areas: Pharmacy
- Cleaning Procedures: Clinical Support Areas: Protocol For Clinical Laboratory
- Cleaning Procedures: Non Patient Care Equipment: Refrigerators
- Cleaning Procedures: Non-Clinical Areas: Conference/Meeting Rooms
- Cleaning Procedures: Non-Clinical Areas: Entrances
- Cleaning Procedures: Non-Clinical Areas: Hallways
- Cleaning Procedures: Non-Clinical Areas: Lobbies and Waiting Rooms
- Cleaning Procedures: Non-Clinical Areas: Offices
- Cleaning Procedures: Non-Clinical Areas: Public, Staff Restrooms
- Cleaning Procedures: Non-Clinical Areas: Storage Areas, Unlocked
- Cleaning Procedures: Non-Patient Care Equipment: Cubicle Curtains and Drapes
- Cleaning Procedures: Non-Patient Care Equipment: Furniture
- Cleaning Procedures: Non-Patient Care Equipment: Mini Blinds and Vertical Blinds
- Cleaning Procedures: Non-Patient Care Equipment: Various Non-Patient Care Items
- Cleaning Procedures: Nursing Units: Isolation Rooms
- Cleaning Procedures: Nursing Units: Nursing Stations
- Cleaning Procedures: Nursing Units: Patient Care Areas
- Cleaning Procedures: Nursing Units: Patient Restrooms
- Cleaning Procedures: Nursing Units: Patient Room Occupied
- Cleaning Procedures: Nursing Units: Soiled Utility Rooms
- Cleaning Procedures: Nursing Units: Special Procedure Rooms
- Cleaning Procedures: Nursing Units: Tub Room
- Cleaning Procedures: Patient Care Equipment: Bassinets
- Cleaning Procedures: Patient Care Equipment: Cribs
- Cleaning Procedures: Patient Care Equipment: Isolettes
- Cleaning Procedures: Patient Care Equipment: Video Terminal Monitors
- Cleaning Procedures: Room/Building Components: Baseboards
- Cleaning Procedures: Room/Building Components: Carpet Cleaning
- Cleaning Procedures: Room/Building Components: Ceilings
- Cleaning Procedures: Room/Building Components: Dust Mopping
- Cleaning Procedures: Room/Building Components: Floor Care
- Cleaning Procedures: Room/Building Components: Floor Care (Taski Method, Mop Method, Floor Polishing)
- Cleaning Procedures: Room/Building Components: Floor Finish Applications
- Cleaning Procedures: Room/Building Components: Floor Finish Stripping
- Cleaning Procedures: Room/Building Components: Intake Vents

Cleaning Procedures: Room/Building Components: Light Fixtures
Cleaning Procedures: Room/Building Components: Machine Buffing
Cleaning Procedures: Room/Building Components: Machine Scrubbing
Cleaning Procedures: Room/Building Components: Vacuuming
Cleaning Procedures: Room/Building Components: Walls
Cleaning Procedures: Room/Building Components: Wet Mopping
Cleaning Procedures: Room/Building Components: Windows
Cleaning Procedures: Specialized Areas: Central Supply
Cleaning Procedures: Specialized Areas: Nursery
Cleaning Procedures: Specialized Areas: Operating Rooms, Between Cases
Cleaning Procedures: Specialized Areas: Perinatal Unit
Cleaning Procedures: Specialized Areas: Surgical Suite (In-Depth)
Cleaning Procedures: Various Non-Patient Care Equipment
Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)
Compliance: Competency/Criteria Based on Job Description Form
Compliance: Documentation of Annual Competencies
Compliance: Miscellaneous Information
Emergency: Internal/External Disaster Plan
Environmental Disinfectant - Cleaning Solution
Environmental Services Cleaning Policy
Environmental Services Key Sets: All Areas
Environmental Services Key Sets: All Areas
Environmental Services Performance Improvement Plan
Environmental Services Quality Assurance Program
Equipment and Supplies: Care and Use of Daily Cleaning Supplies and Equipment
Equipment and Supplies: Care and Use of Equipment: General Guidelines
Equipment and Supplies: Care and Use of Floor Care Equipment
Equipment and Supplies: Care and Use of Upholstery Cleaning Equipment
Equipment and Supplies: Preventive Maintenance Program
Equipment and Supplies: Storage of Environmental Services Supplies and Equipment
General Administrative: Personnel Policies: Absenteeism and Lateness
General Administrative: Personnel Policies: Code of Ethics
General Administrative: Personnel Policies: Continuing Education
General Administrative: Personnel Policies: Dress Code
General Administrative: Personnel Policies: Environmental Services Organizational Chart
General Administrative: Personnel Policies: Functions of Environmental Services
General Administrative: Personnel Policies: General Safety
General Administrative: Personnel Policies: Hours of Service
General Administrative: Personnel Policies: In-Service Education
General Administrative: Personnel Policies: Philosphy

General Administrative: Personnel Policies: Scope of Service
General Administrative: Personnel Policies: Staff Meetings
General Administrative: Personnel Policies: Staffing Allocation
General Administrative: Personnel Policies: Statement of Accountability/Responsibility
Infection Control Measures For Environmental Services Staff
Infection Control: Care of Handwashing Products
Infection Control: Special Dress Requirements
Infectious/Bio-Hazardous Waste: Hazardous Substance Communication Program
Job Description: Environmental Services Staff
Job Description: Environmental Services Supervisor
Job Description: Relief Environmental Services Supervisor
Job Duties: 4LPA
Job Duties: 4RHC and 130SatRHC
Job Duties: Checklist For Cleaning Maintenance, Purchasing, Lab, ER Physician Room, Building #4, and RHC
Job Duties: Checklist For Daily Cleaning of ICU and Infusion Rooms
Job Duties: Checklist of PM/NOC Shift Custodian Cleaning Radiology Building
Job Duties: NOC Shift Custodian Cleaning
Job Duties: PM Shift
Orientation: Attachment I - Work Area Orientation
Orientation: Employee Orientation Program
Orientation: New Employee Orientation
Orientation: Orientation Completion Checklist
Orientation: Self Evaluation Employee Form
Personnel Policies: Environmental Services Goals
Pest control for North Inyo Hospital
Rotation Procedures For Patient Cubicle Curtains and Shower Curtains
Temperature Monitoring of Storage Devices and Units
Training: Interactive Training Videos List
Training: Skills Checklist Form

Laundry Policies

For BOD Review March, 2020

Rotation Procedures For Patient Cubicle Curtains and Shower Curtains

Chief Nursing Officer Board Report

March 2020

General Nursing Projects:

Quality Council: During Feb 2020 meeting, worked on the vision for the flow of quality process. Chart will be available after approval at the March meeting. Also developed a "Quality Project Worksheet". (Please see attached). The structure for NIHD Quality, as defined in the District QAPI Plan, is beginning to take shape.

Blood Transfusion Audits: These are being performed across all nursing units to follow compliance with policy and patient monitoring during transfusions. Multiple processes have been adjusted, including the update of the procedure, with steady improvement in data. Leadership of this collaborative effort has come from Catherine Baldwin, CLS.

Patient Early Mobility Project: Collaboration between physical therapy and nursing has led to work to mobilize our patients sooner post-operatively. Development of Specific teams occurred to target Cesarean section and total joint replacement patient's early mobilization. Medical Staff involvement is key in this continuing project development. Benefits to the patients include less post op complication and shorter hospital stays.

Fit Testing: In order to meet Occupational Safety and Health Administration (OSHA) standards and to keep our staff safe, fit testing with N95 (respirator) masks or PAPR devices is required annually. Sarah Rice, Nursing Administrative Assistant, sends employees reminders. Respiratory Care Practitioners perform the testing. Hospital employees are reaching 99% compliance.

Language Services: Jose Garcia, Manager-working on implementation of "Interpreter Intelligence" scheduling program to meet live interpreter needs for Limited English Proficiency Spanish patients. Staff training on use of the program should begin in the next 45 days.

Professional Practice Council: They have begun an "Early MRSA screening for pre-operative patients" project team. The goal is to prevent late surgery cancellations due to MRSA. The PPC team is working to set up criteria for screening our pre-op patients early for elective surgeries. Once in place, this will be a patient satisfaction improvement practice, as well as a safety initiative. This team is working with a physician champion, Dr. Richard Meredick.

Perioperative Services: Ann Wagoner, DON – continues to grow her new leader. Replacement of bubbling floor in sterile processing area is underway. This required one day of closing OR for elective cases. Partnership with maintenance allowed for this to happen seamlessly.

Surgery & Sterile Processing: Julie Allen is growing in her new role of Surgery Manager. She is working with her team to streamline inventory management, specifically orthopedic supplies. She has implemented daily staff huddles to increase communication.

PACU & Outpatient Infusion: Nicole Eddy, Manager – Staff has made adjustments during the closure of the infusion center, moving infusion patients to PACU and wound care patients to ICU. Volumes have been high during the past 6 weeks for outpatient area. Wound care continues under the medical direction of Dr. Leja. Kathryn Erickson, BSN, MBA, RN, is taking an advanced wound care course currently and is sharing pearls of wisdom with the team.

ED & Inpatient Services: Allison Partridge, DON – Completed the heparin process improvement with pharmacy. Will begin a similar project team collaboration on insulin administration process. Is actively involved in leadership of COVID-19 project team. Ticket-to-Ride – implementation of improved communication tool between DI and hospital nursing teams is in use currently.

ED: Gina Riesche, Nurse Manager and Jenny Bates, Assistant Nurse Manager- Jenny Bates, MSN, RN, is working with Sepsis project team to improve early sepsis recognition and treatment process based on best practice for the district. ED team has been active in the COVID-19 surge plan development.

ICU & Medical Surgical: Justin Nott, Manager– Assistant Nurse Manager role is currently vacant; Interviews are in process. Med/Surg has intentionally not refilled two RN vacancies. Auditing is in process to see how down staffing will affect the number of low census staff call-offs versus call-ins due to high census. Staff communication has occurred on the trial master staffing change.

OB: Nurse Manager role is currently vacant; interview team and process is being set up currently.– Continues to have quarterly drills for perinatal emergency readiness. Julie Tillemans, BSN, RN, is now filling clinical Staff Educator role.

Infection Control: Robin Christensen, Infection Preventionist – Leader role in the COVID-19 surge plan and infection prevention process. Participating in CDC/CDPH telephone updates multiple times per week. Remains a resource to staff on best practice for infection control. Colleen Moxley, BSN, RN, is beginning cross training to IC under Robin Christensen. Water management plan continues; NIHD recently removed all large bottled water stands due to bacteria presence. Sharp's Committee met in Feb., with product and process review to decrease incidences of employee exposures to blood/body fluids via sharps injuries.

Quality/Clinical Informatics: Robin Christensen, Manager – continued timely data reports as required by regulatory agencies are completed. Michelle Garcia was hired as the QA/PI analyst for the district.

Employee Health: Marcia Male, EH Specialist –to assure alignment with CDC guideline, review and revision of policies continues. Influenza vaccine administration rates remain excellent at 88% of district staff.

Submitted by,

Tracy Aspel, BSN, RN

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Quality Project Worksheet

Name of Project:	
Project Lead:	
Project Description	
Recommended key stakeholders:	
Additional committee involvement required ☐ Project Share ☐ Project Management ☐ Change Committee ☐ Safety Committee ☐ Other	
Educational plan	
Fiscal impact:	
Data Evaluation	
Estimated Timeline	
Priority Level	
Disposition	

Developed: 02/2020 Revised:

As the Interim CEO, effective February 13, 2020, much time has been spent on transitioning Dr. Flanigan's CEO calendar/schedule over for oversight, preparation and carrying out meetings, projects, events and more during his absence. Support from Sandy Blumberg, Executive Assistant, Administration, has been essential and effective.

Support from the Board of Director's, Chiefs, mid-level leaders, members of the medical staff and departmental team members has allowed for the forward movement on the following points of interest.

Points of Interest:

RHC Building Project – multiple meetings with Sam Walker, Robert Sharp, legal counsel for the District and legal counsel for Sam Walker. Focus is on legal document preparation, review and agreement to. We have narrowed the points of challenge down to 5 items. Both parties continue to work to ensure the intent of the project is clear, transparent and stands the test of time.
Regular meetings with the NIHD RHC Project team continue. Expansion of participants to include Scott Hooker (Facilities), Lynda Vance (Project Management) and Kelli Davis, (Interim CEO) has added to the knowledge base and collaboration.
Construction Management Design/Build interview and demo was set-up by Scott Hooker and well attended with Drs. Brown, Helvie and Meredick, Lynda Vance, Scott Hooker, Paul Connolly (Clinic Administrative Director, Kelli Davis and Louise Vargas (Colombo Construction) in attendance.

Pioneer Home Health Care – Pat West retired effective February 28. Standing weekly meetings with Pat West and Ruby Allen have continued. The PHHC 2020/21 budget has been approved by the PHHC Board of Director's. Discussion around the need and availability of Corporate Compliance Officer for PHHC is being had. Flexibility of NIHD's Compliance Officer as a shared resource has also been in review.

2/20/2020 Healthy Lifestyle Talk: "Going Beyond the Echoes of Your Heart" – James Fair, MD/Terry Tye, Echocardiographer. Community attendance was good; participation was active.

Labor Relations for Technical Group – 2/21/2020 negotiations were overseen by Attorney Irma Moisa and Alison Murray, HR Labor Relations Specialist. Ongoing progress is being made toward laying the groundwork for ongoing successful negotiations and the development of a memorandum of understanding. Review of what articles in the Nursing Labor Relations Memorandum of Understanding can and cannot be mirrored/shared by this 2nd group.

Electronic Health Record Search – At the guidance of the Steering Committee and "in the weeks" User Group, the vendors being considered has been narrowed down to 2 vendors: Allscripts and Cerner. This selection process continues to advocate for clear, transparent information review, sharing and encouragement for ALL staff to voice their ideas, thoughts, concerns and recommendations into the selection of the best productive for NIHD. A group meeting with over 100 staff/providers invited, was held on February 27th to include District employees, providers and leaders at one venue for deliberate discussion around the vendor product review of Allscripts and Cerner, encouragement of open discussion about pros/cons of both products, and how to ensure every voice is heard through the next

steps of the selection process. Timing is essential at this point but rushing people through the selection process without a clear line of navigation defined by all participants is not the goal. It was determined that a survey should be issues with clear questions that all will feel comfortable voicing their recommendation, concerns and comments.

Proclamation for March as "Colorectal Cancer Awareness Month" – the Bishop City Council and the Inyo County Board of Supervisors initiated proclamations supportive of the Eastern Sierra Cancer Alliances' focus on awareness and timely action in screening and preventing the spread of cancer. See attached highlights from Rosie Graves, NIHD Oncology Patient Navigator.

Bishop Student Athlete Program – Focus on injury prevention for student athletes including concussions. Jess Douglas, NIHD PT, Simone Mata, NIHD PT, Thad Harlow, NIHD Rehab Director, Dr. Helvie, Dr. R. Meredick, Paul Connolly and Kelli Davis, continue to work to develop training, screening, consistent protocols and collaborative partnerships with community sports program leaders, Bishop School District, student athletes and the parents of student athletes.

NIHD Marketing and Strategic Communications – Services and event highlights for the District are under continual review at the lead of Barb Laughon to ensure accurate, timely and motivational messaging is being delivered through all media types. The Wednesday and Friday KIBS radio interviews being done by Dr. Flanigan have now transitioned to rotating service line leaders. This will allow a variety of voices to reach out to our community with information about the services, education and special events at the District. To date, Denice Hynd, (Registered Dietitian), Rosie Graves, (Patient Oncology Navigator) and Lindsey Hughes, (Registered Dietitian – Diabetes Focus) have presented for interviews and delivery to our community by KIBS. Barb has developed a rotating schedule that will highlight services and information through interviews with our Directors and other leaders.
Event advertising continues with no change to date. Barb is ensuring that we maintain and improve any marketing strategies previously developed.

Employee Evaluations – to ensure proper evaluation of employees and their potential for capturing an increase in pay based on performance and wage scale, evaluations to be completed by the CEO have been reassigned to ensure no further delays.

Standing Weekly Meetings – Employees who report to the CEO and whom typically have standing meetings, continue to have their meetings with the Interim CEO to ensure consistent ongoing communications, support needs and resource reviews.

Medical Staff Meetings – Meetings have continued with NIHD medical staff to ensure their needs are being met and there is clear understanding of areas of focus, new and renewal contract negotiations, service line growth and more.

COVID19 (Corona Virus) Preventative Action Planning – Multiple lengthy meetings have been held with key stakeholders from the District, Inyo County, Mono County and CDPH (via teleconference) to define, determine and develop action plans for the District to ensure risk exposure and prevention methods are in place for staff, providers, patients, and community members. The decisions implemented are baseline methods defined by the Centers for Disease Control. The approach is to take a minimal approach that impacts the greatest risk prevention as a starting point; these measure include but are not limited to the

reduction in visitors, volunteers, vendors and non-patient traffic on campus, cancellation of meetings that are held at the District by local groups, cancellation of out-of-town travel to District paid education events for staff, education and increased community awareness about COVID19, education of employees about illness and need to stay home, increased patient screening at key points on campus, reduced access points for patients, employees, providers, visitors and others to increase screening opportunities, implementation of supply control measures and more.

Dr. Brown and Barb Laughon continue to interview for local media to ensure increased awareness and expectations for services due to COVID19 concerns.

Regular meetings for District and County stakeholders to review the fluidity of information and best practices.

Opening of an NIHD Incident Command to ensure daily information is reviewed and driving action planning.

Respectfully,

Kelli Davis, MBA
Interim CEO/COO
Northern Inyo Healthcare District

ESCA UPDATE 2019/2020

- 2019 – 40 new applicants and more than $50,000 given out in financial support
- Angel Mentorship started
- Blue Ribbon Event in March – Colorectal Cancer Awareness Month
- Community Pink Day was a success.
    - Ribbons decorated Main Streets from Lone Pine to Coleville.
    - Employers embraced the support with wearing pink and hanging ribbons.
    - Media showed their support – pictures were displayed in the newspapers that month and the radio stations spotlighted our community outreach
    - Community gave praise throughout the month; prior breast cancer survivors who expressed their gratitude in bringing about the awareness
    - Employer Donations
        - Special recognition to Bishop Elementary School with a last-minute fundraiser effort and raised $250
        - NIHD employees donated $2100
        - Bishop PD Wives $230 sell of pink patches
        - Eastern Sierra Community Bank raffled a basket $215
        - NHSRA $3200
- Employer Outreach
        - Toiyabe with a Wear Pink Day, Walk for Women with 51 participants, talks to their employees and community. Mammogram Days for employees and community members.
        - NIHD Moonlight Mammograms. New this year - Sunrise Mammograms. Both offering extended hour to get mammograms. No appointments necessary.
        - NIHDs Dr. Harness to employer talks such as Cal Trans, Inyo Mono Title, Toiyabe and NIHD.
        - SIHD – employee and community members utilizing CAREshuttle for mammogram days
        - Healthy Lifestyle Talks
        - Mammoth Hospital – 1st ever evening-extended hours for mammograms
- 19th Annual Breast Cancer Awareness 5K walk/run was a success
    - 232 registered – net profits $33,645
- 2020 Events
    - September 2020 – 20th Anniversary Celebration – planning underway and more to come!
    - Started the year off with expansion - Continued success and growth lead to the expansion to our board from 7 to 11, which includes: Pat Ramirez, Cheryl

Underhill, Rosie Graves, Michelle Garcia, Andrea Shallcross, Deb Christiansen, Sarah Fruendt, Cori Denault, Amy Stange, Kevin Carunchio & James Tyler

- 3rd Annual Blue Ribbon Walk & Run to be held on March 7th hosted at the Brown's Town Campground. This event is a 3K/5K/10K Colorectal Cancer Awareness event.
- June 7th which is National Cancer Survivorship Day, planning is underway for the 1st ever Cancer Survivorship Celebration event.
- October 17th – 20th annual Breast Cancer Awareness Fun 5K walk/run. Hoping it will be our biggest turnout ever.
- New this year and starting in April is a Cancer outreach calendar-offering Yoga, Qigong, cancer exercises, education and more!

- Toiyabe and NIHD are hoping to bring medical oncology to the community. We look forward to the next many years to come and many thanks again to the Eastern Sierra.

- Data on Inyo County higher incident rates are due to Lynch Syndrome. There is a family in the Owens Family with this inherited syndrome. Lynch syndrome, also known as hereditary non-polyposis colorectal cancer (HNPCC), is a type of inherited cancer syndrome associated with a genetic predisposition to different cancer types. This means people with Lynch syndrome have a higher risk of certain types of cancer (Lynch Syndrome, 2018)

PROCLAMATION DATA

DECLARING MARCH NATIONAL COLORECTAL AWARENESS MONTH

WHEREAS, Eastern Sierra Cancer Alliance (ESCA) is a grassroots organization founded in 2001, initially with the mission to support and provide resources to residents diagnosed with breast cancer; and

WHEREAS, the non-profit organization has expanded in both size and scope over the past 20 years to serve residents of Inyo and Mono counties diagnosed with all forms of cancer and,

WHEREAS, for almost two decades ESCA Board members have coordinated their efforts with countless, compassionate volunteers and community organizations in service to those with cancer diagnoses – friends, family members, neighbors; and

WHEREAS, this service includes providing resources and educating the community about different forms of cancer in an effort to increase community awareness of current practices and positive outcomes; and

WHEREAS, ESCA also provides financial and moral support for clients and families as they cope with their cancer diagnosis and costs of treatment; and

WHEREAS, ESCA continues to work diligently to maintain a respectful relationship with its clients and local governments, organizations and individuals with which it partners; and

WHEREAS, gaining the trust and commitment of various Inyo and Mono organizations, businesses, and healthcare agencies has allowed ESCA to continue its mission, improve programs and serve more than 400 clients since 2001 – many of whom have needed repeat assistance due to travel out of the area for oncology appointments and cancer treatments; and

WHEREAS, Colorectal cancer (cancer that starts in the colon or rectum) is the third most commonly diagnosed cancer and the second leading cause of cancer death in men and women combined in the United States; and

WHEREAS, since the mid-1980s, the colorectal cancer survival rate has been increasing, due in part to increased awareness and screening; and

WHEREAS, Wearing blue, which represents the eternal memory of those whose lives have been lost to colorectal cancer and the hope for a future free of disease; and

WHEREAS, March is national Colorectal Awareness Month; and

Whereas, Colorectal Cancer has a higher incidence in Eastern Sierra than the rest of the nation;

NOW THEREFORE BE IT RESOLVED THAT, (The Mono Board of Supervisors/Inyo Board of Supervisors/Bishop City Council) declare March 2020 Colorectal Awareness Month with the explicit intent of improving awareness of a cancer that is preventable, treatable and beatable!

References

Lynch Syndrome. (2018, August). Retrieved from Cancer.net: https://www.cancer.net/cancer-types/lynch-syndrome

While all areas continue to focus on day-to-day workflow and workforce needs, Athena & related system navigation, new electronic health record search, specialized department projects and budget preparation, additional highlights for include:

Staffing Update

The search for a Human Resources Director continues. We have received several applications and interviews will be starting shortly.

Our Interim Rehabilitative Services Director, Thad Harlow, who signed on in February, has settled in nicely and is making consistent strides with the Rehab team and District co-workers.

Points of Interest:

Cardio-Pulmonary

Transesophageal Echo (TEE) project implementation continues

MidMark EKG project development continues; training set to start March 31st.

Coordination with RHC to process smoking cessation orders through Athena underway.

Diagnostic Imaging

Completion of the transition of breast imaging interpretations to Tahoe Carson Radiology (TCR).

Customer service training for Diagnostic Imaging staff, RHC staff and Admission Services staff to be done on March 30th during (2) half day sessions.

Dietary/Nutrition Services

Weight loss challenge for employees – week 7. Program provides healthy eating options, exercise focus, partnerships with co-workers, food choices, recipes and more.

Denice was the first leader to be interviewed by Gary Young at KIBS; discussion centered on Hidden Sugars in the diet.

February 27 – NIHD Healthy Lifestyle Talk: "Identifying Hidden Sugars in Your Diet" with Denice Hynd, RD. Great turnout, active participation in hands on demonstrations.

Facilities

New work order management system for Maintenance is up and running. In February, there were 270 open work orders with 189 compliance related. 165 upcoming preventative work orders will need to be addressed.

Multiple office moves underway.

Continued focus on the Building Separation Project and upcoming Pharmacy Project.

Central Plant roof replacement is nearing completion.

Ortho Clinic remodel project is underway.

Human Resources:

The Human Resources Department has moved to the dining room hallway effective February 26th.

The department now has the following positions filled:

- HR Labor Relations Specialist
- HR Recruiting Generalist
- HR Benefits Generalist
- HR Clerk

The HR Director position remains open. 4 or more applications have been received. Interviews to start in the next 2 weeks.

Weekly teleconferences with MRG Consulting continues to ensure areas of the consultant report are being discussed and action plans are being developed. Don Turko and Charlie Wilson, HR Consultants, are providing resources for industry best practices with job descriptions for vacant roles and posting/recruiting/interviewing and hiring points.

Laboratory

January COO Report included information on the hardship the resignations of (2) Certified Laboratory Scientists, have had on the Lab. UPDATE: HR and Lab have successfully recruited 2 CLS's to fill the open positions.

Pharmacy

340B Program review and process improvement discussions underway

Chemotherapy order review and process improvement focus.

New procedure development for more efficient transfusion department turn-around

Security

(1) new Security Officer, Todd Clayborn, has started.

Safety –

The Safety Huddle meets Monday through Friday (except on holidays) at 8:00am. This group of leaders and designees report on departmental volumes for the day, organizational safety concerns that have occurred within the last 24 hours, are currently happening and/or are anticipated to occur within the next 24 hours and local/state/national happenings that the District should be aware of. In the months of January and February, there were 21 safety related concerns, ideas or events that were reported and worked through the Safety Huddle. These ranged from violent behavior risks, fall risks, unlocked doors, signage issues, parking & speeding, food recalls, system downtimes, equipment issues and so forth.

Violence Prevention Assessment Team (VPAT) meets on a monthly basis to review and discuss workplace violence (WPV) events that have occurred, (the cause, participants, resolution and risk prevention), District training, regulatory updates and policy. During the February 2020 VPAT Meeting, 4 events from November, December and January were reviewed.
An Ad Hoc VPAT Meeting was held on 2/13/2020, to discuss a weapon threat by a patient in the RHC. Action steps were developed to support staff and help manage the patient.

Monthly Operations' Team Meetings – February Focus Areas:

NORTHERN INYO HEALTHCARE DISTRICT
OPERATIONS TEAM MONTHLY MEETING
AGENDA

Name of Group: NIHD Operations Team	***Date of Meeting:*** January 21, 2020	***Time of Meeting:*** 2:00 – 3:00pm **Location:** AMR
Title of Meeting: Monthly Operations Team Meeting		
Meeting Called By: Kelli Davis, Chief Operating Officer	***Location:*** AMR	
Participants:		
Amy Stange, Larry Weber, Sarah Yerkes, Cori Stearns, Lindsey Hughes, Scott Hooker, Danny Webster, Lori Bengochia, Denice Hynd, Marjorie Routt, Frank Laiacona, Rich Miears	**Guest(s):** Mary Mae Kilpatrick	
Meeting Objectives(s): Communication, Collaboration & Education Amongst Operations' Team Members		

Pillar	***Agenda/Minutes***	
1. People	*"Vision comes alive when everyone sees where his or her contributions make a difference"- Ken Blanchard* • Welcome • ADP 101	Kelli Davis Lori Bengochia
2. Quality	• "A Very Particular Set of Skills" – Modern Healthcare	Information Item (Article)
3. Finance	• "Hospital Outpatient Visits See First Dip in 35 Year" – Modern Healthcare	Information Item (Article)
4. Growth	• Leadership – 21 Irrefutable Laws of Leadership – Book Club Update • 12 Keys to Good Management Relias Training • "How Humble Leadership Really Works" - HBR	Group Discussion Information Item (Assigned Relias Training due 2/28/20) Information Item (Article)
5. Round Table	• Upcoming Department Events/Changes - Success Stories - Projects - Challenge Areas/Need for Support - Staffing – Incoming/Departing	Group Discussion **"Improving our communities, one life at a time: One Team. One Goal. Your Health."**

Operations Team Book Club: As a team, we chose the book "The Busy Leader's Handbook: How to Lead People and Places that Thrive" by Quint Studer for our 2nd book review. We meet

weekly to discuss 1-3 chapters that we've read independently. Great discussion, insight and "ah ha" moments have come during our weekly time together.

"To all those people who each and every day strive to help others become the very best they can be. Never underestimate the difference you make". Quint Studer

This book consists of 3 sections and we are starting with:

1. Introduction
    a. Section 1 – **THE LEADER IN YOU: KEY SKILLS AND BEHAVIORS**
        - Strive to Be Self-Aware and Coachable
        - Invite Feedback from Others and Don't Take It Personally; Instead, Take Ownership
        - To Be a Good Leader, First Learn to Be a Good Follower
        - Quiet the Ego and Lead with Humility
        - Let Value Be Your Guide
        - Be a Good Communicator
        - Know How to Get Things Done: Hit the Brakes on the Ideas; Hit the Gas on the Execution
        - Get Intentional About Time Management
        - Grace Under Fire: How to Manage Yourself During Stressful, Busy Times

Overview: Organizational billed charges were poor in November and December with continued slowness in outpatient, OR cases and diagnostics. January saw a jump in OR cases and Infusion.

	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	13,020793	13,186,280

Gross Accounts Receivables in Athena continue to be high at $54,252,254; 118.1; Gross Days in AR. Remaining Gross Accounts Receivable in Paragon is $2,283,443 and Centricity is $338,834.

Salaries and Wages for Hospital operations were lower with high PTO use; although temporary labor expenses were over budget by $114,000 in the month of January due to open positions.

	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

Preliminary February 2020 Financial Results: Volumes slowed in the hospital and ended near budget.

A review has been started 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.

Submitted by John Tremble

Northern Inyo Healthcare District - Summary of Key Ratios & Debt Covenants

Unit of Measure	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:	$ 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	82.44	85.69	86.74	93.02	105.00	103.65	112.70	116.60
Athena Gross Accounts Receivable	$ 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	$ 459,223	$ 443,212	$ 437,962	$ 444,616	$ 430,894	$ 440,084	$ 432,425	$ 420,533
Gross Days in AR	118.14	114.19	117.67	114.20	113.17	110.81	102.92	101.99
Key Statistics								
Acute Census Days	218	247	203	203	211	191	240	2,803
Swing Bed Census Days	10	16	14	14	23	15	7	454
Observation Days	47	27	32	44	36	38	39	485
Total Inpatient Utilization	275	290	249	261	270	244	286	3,742
Average Daily Inpatient Census	8.87	9.35	8.02	8.43	8.71	7.87	9.23	10.25
Average Acute Daily Charge	$ 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)	45.07	38.53	36.75	40.88	35.91	41.27	41.54	38.29
Emergency Room Visits	826	703	726	767	641	868	889	9,153
Emergency Room Visits Per Day	26.6	23.4	24.2	24.7	21.4	28.0	28.7	25.1
Operating Room Inpatients	21	21	16	23	20	19	23	230
Operating Room Outpatient Cases	104	82	92	118	104	90	93	1,240
RHC Clinic Visits	2,989	2,546	2,423	2,377	2,439	2,377	2,675	29,446
NIA Clinic Visits	2,034	1,829	1,951	2,030	1,864	2,027	1,924	
Outpatient Hospital Visits	4,117	4,157	4,127					
Hospital Operations								**Fiscal 2019**
Inpatient Revenue	$ 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	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	570,019	536,445	506,364	541,363	458,568	593,322	465,433	6,784,060
Total Revenue	$ 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	$ 510,387	$ 436,326	$ 430,015	$ 462,868	$ 420,173	$ 467,294	$ 456,209	$ 420,533
% Change (Month over Month)	17.0%	1.5%	-7.1%	10.2%	-10.1%	2.4%	1.8%	
Salaries	$ 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	364,101	190,609	294,562	266,736	254,834	254,720	269,335	3,255,428
Total Salaries Expense	$ 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	$ 89,385	$ 85,817	$ 93,044	$ 90,442	$ 89,232	$ 89,777	$ 88,577	$ 79,324
% Change	4.2%	-7.8%	2.9%	1.4%	-0.6%	1.4%	2.8%	
Operating Expenses	$ 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	$ 132,882	$ 129,504	$ 139,956	$ 140,989	$ 144,344	$ 126,782	$ 130,701	$ 135,052
Capital Expenses	$ 574,402	$ 630,855	$ 604,834	$ 589,185	$ 590,014	$ 589,257	$ 560,212	$ 7,103,119
Capital Expenses Per Day	$ 18,529	$ 20,350	$ 20,161	$ 19,006	$ 19,667	$ 19,008	$ 18,071	$ 19,461
Total Expenses	$ 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	$ 240,797	$ 235,671	$ 253,162	$ 250,436	$ 253,244	$ 235,567	$ 237,349	$ 233,837
Gross Margin	$ 624,508	$ 358,996	$ 53,621	$ 724,122	$ (522,456)	$ 435,083	$ 522,819	$ 1,772,471
Gross Margin Per Adjusted Day	$ 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	2.19	2.29	2.21	2.20	2.26	2.19	2.12
Quick Ratio (Cash & Net AR/cl) >1.33	1.88	1.77	1.78	1.76	1.87	1.96	1.93	1.87
Days Cash on Hand > 75	82.44	85.69	86.74	93.02	105.00	103.65	112.70	116.60
Debt Service Coverage > 1.5	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	1.34	1.37	1.54	1.38	2.18	2.19	1.54

Northern Inyo Healthcare District
Income Statement
As of January 31, 2020

	Month To Date 1/31/2020	Month To Date 12/31/2019	Month To Date 11/30/2019	Year To Date 1/31/2020	Year To Date Budget	Year To Date 1/31/2019
Patient Services Revenue						
Inpatient Revenue	3,038,298	3,408,357	3,092,670	19,997,936	20,410,600	20,253,013
Outpatient Revenue	12,213,684	9,581,304	9,301,405	74,161,796	67,081,700	64,739,116
Clinic Revenue	570,019	536,445	506,364	3,671,512	4,200,000	3,705,578
Total Gross Patient Service Revenue	15,822,001	13,526,106	12,900,439	97,831,244	91,692,300	88,697,707
Deductions from Revenue	(8,421,383)	(6,606,120)	(6,002,790)	(48,610,394)	(46,092,383)	(45,892,330)
Other Patient Revenue	28,403	383	24,481	94,264	30,000	(10)
Total Net Patient Revenue	7,429,021	6,920,369	6,922,130	49,315,114	45,629,917	42,805,367
Income/Expense from Cost Reporting	0	(1)	23,576	47,131	700,000	3,458,922
Other Operating Revenue	660,183	744,442	702,760	5,278,871	8,120,000	5,877,104
Gross Operating Profit	8,089,204	7,664,810	7,648,466	54,641,116	54,449,917	52,141,393
Operating Expenses						
Repairs and Maintenance	-1,956	12,468	54,740	112,592	227,500	314,625
Leases and Rental Expenses	31,745	50,901	35,296	185,938	350,000	497,328
Salary & Wages	2,406,844	2,469,711	2,496,760	17,337,328	17,507,000	17,046,815
Benefits	1,697,593	1,504,288	1,735,509	11,468,704	11,860,000	11,419,979
Non-Benefit Expenses	23,001	24,068	23,703	116,570	98,000	101,921
Professional Fees	897,413	918,617	920,625	6,011,863	6,790,000	6,913,493
Supplies	898,459	775,256	776,097	5,790,301	6,066,667	6,143,952
Contract Services	344,948	317,220	838,576	4,092,122	2,800,000	2,938,865
Other Department Expenses	98,514	180,293	115,586	801,024	700,000	640,294
Hospital Insurance Expenses	36,143	37,488	36,593	224,606	210,000	248,119
Utilities	120,303	120,727	109,534	909,207	840,000	909,171
Depreciation and Amortization	346,649	374,459	373,787	2,494,218	2,450,000	2,367,085
Other Fees	337,290	287,208	(148,797)	1,072,585	1,050,000	695,116
Interest Expense - Operating	227,752	233,110	231,047	1,621,291	1,575,000	1,641,849
Total Operating Expenses	7,464,698	7,305,814	7,599,056	52,238,349	52,524,167	51,878,612
Total Net Operating Profit (Loss)	624,506	358,996	49,410	2,402,767	1,925,750	262,781
Non-Operating Revenue						
Tax Payer General Support	52,608	48,743	48,743	345,066	367,500	398,913
Bond/ Tax Payer Bond Support	157,115	137,596	137,595	982,690	1,002,400	1,005,458
Fin Chgs-Pt Ar - Int Incm-Payors	4	2	918	2,904	12,250	14,256
Interest Income	45,970	34,560	36,638	330,754	262,500	357,690
Interest on Patient Account	1,827	1,367	493	10,183	0	495
Total Other Income	257,524	222,268	224,387	1,671,597	1,644,650	1,776,812
Grant Revenue	0	25,000	0	61,468	1,760,000	2,035,716
Other Non-Operating Income	1,596	1,596	1,596	9,576	7,000	19,628
Net Medical Office Activity	(544,652)	(689,191)	(582,868)	(3,823,363)	(3,500,000)	(3,764,822)
340b Net Activity	56,245	26,783	55,535	337,613	189,000	155,030
Donations	50,000	0	19,713	113,773	9,100	3,300
Rental Income	4,882	5,460	4,881	34,748	34,748	15,994
Gain/Loss on Sale of Assets	0	0	(31,762)	(31,762)	0	0
Gain - Investments - Other Income	0	(1,697)	4,524	17,213	0	5,081
Net Non-Operating Revenue	(431,929)	(632,049)	(528,381)	(3,280,734)	(1,500,152)	(1,530,073)
Non-Operating Expenses	0	(45,000)	(50,000)	(225,000)	(175,000)	0
Total Net Non-Operating Profit	(174,405)	(454,781)	(353,994)	(1,834,137)	(1,675,152)	260,699
Total Net Income	450,101	(95,785)	(304,584)	568,630	250,598	639,352

Northern Inyo Healthcare District
Balance Sheet
As of January 31, 2020

Current Assets	
Cash and Short Term Investments	17,614,060.44
PMA Partnership	801,030.00
Accounts Receivable	56,703,440.84
Allowances against Receivables	(33,954,140.52)
Total NIA Accrued Allowances	(901,944.05)
Total Accounts Receivable, Net of Allowance	21,847,356.27
Other Receivables	8,193,244.77
Inventory	2,063,199.56
Prepaid Expenses	1,397,338.96
Total Current Assets	51,916,230.00
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	2,579,818.15
Total Assets Limited as to Use	18,308,638.57
Long Term Assets	
Long Term Investment	1,753,817.86
Fixed Assets, Net of Depreciation	
Fixed Assets	126,852,604.45
Accumulated Depreciation	(52,074,719.93)
Construction in Progress	2,438,014.21
Total Fixed Assets, Net of Depreciation	77,215,898.73
Total Long Term Assets	78,969,716.59
Total Assets	149,194,585.16
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	293,000.00
Accounts Payable	7,519,613.36
Accrued Payroll and Related	7,169,333.87
Accrued Interest and Sales Tax	239,808.73
Due to 3rd Party Payors	2,341,874.36
Due to Specific Purpose Funds	(25,097.72)
Other Deferred Credits - Pension	3,481,539.70
Total Current Liabilities	21,020,072.30
Long Term Liabilities	
Long Term Debt	39,253,947.15
Bond Premium	448,546.23
Accreted Interest	14,294,105.25
Other Non-Current Liability - Pension	32,705,323.00
Total Long Term Liabilities	86,701,921.63
Suspense Liabilities	(194,898.11)
Total Liabilities	107,527,095.82
Fund Balance	
Fund Balance	39,710,398.65
Temporarily Restricted	1,625,520.33
Net Income	568,630.36
Total Fund Balance	41,667,489.34
Liabilities + Fund Balance	149,194,585.16