Northern Inyo Healthcare District

Board Meetings

December 11, 2024 CQSRC Meeting

NOTICE

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS – CQSRC MEETING

December 11, 2024, at 4:00 pm

The CQSRC (Compliance, Quality, Safety, and Risk Committee) will meet in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via Zoom. Public comments can be made in person or via Zoom:

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)
https://us06web.zoom.us/j/85291705552
Meeting ID: 852 9170 5552

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 852 9170 5552

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1. Call to Order at 4:00 pm.
2. Public Comment: At this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The QSC&R committee is prohibited from generally discussing or taking action on items not included in this Notice.
3. New Business
   a) Meeting Minutes, September 18, 2024
   b) Charter updated – *Information Item*
4. Reports - *Information Item*
   a) Compliance Report
   b) Employee Health and Infection Control Report
   c) Quality Report
   d) Medical Staff Report
   e) Facilities Report
   f) Cybersecurity Report
5. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board Governance Committee meeting, please contact the administration at (760) 873-2838 at least 24 hours prior to the meeting.

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 4:00 pm.
PRESENT	Melissa Best-Baker, Chair Jean Turner, Vice Chair Ted Gardner, Secretary David McCoy Barrett, Treasurer via Zoom Mary Mae Kilpatrick, Member at Large Stephen DelRossi, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief of Human Resources Adam Hawkins, DO, Chief Medical Officer Alison Feinberg, Manager of Quality and Survey Readiness, Quality Assurance Bryan Harper, ITS Director Patty Dickson, Compliance Officer Robin Christensen, Manager Employee Health & Infection Control Scott Hooker, Director of Facilities and Property Management
ABSENT	Dianne Picken, Medical Staff Director
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
NEW BUSINESS	Chair Best-Baker called attention to the New Business
CHARTER DEVELOPMENT	CEO DelRossi expressed the need to develop a charter. A section from the Board of Directors bylaws was read aloud. *a) Members of this standing committee shall include a committee of the whole of the Board of Directors, the Chief Executive Officer, the Chief Medical Officer, the Chief of Staff, and others as requested. The Directors shall be the only members of the Committee with voting privileges.* *b) The function of the Compliance/Quality/Safety/Risk Committee (CQSRC) is to analyze data regarding compliance, safety, and quality of care, treatment, and services and establish priorities for performance improvement.* *c) The Compliance/Quality/Safety/Risk Committee (CQSRC) shall meet no less than quarterly.* CEO DelRossi expressed a need to define a purpose for the committee. A sample purpose statement was read aloud: *a) The purpose of the Compliance/Quality/Safety/Risk Committee (CQSRC) is to analyze data regarding compliance, safety, and quality*

of care, treatment, and services and establish priorities for performance improvement.

Request from committee members to continue working on clarifying the purpose statement. Some of the ideas included:

b) The committee will receive recommendations from the organization on priorities and status performance
c) The committee will present recommendations to the Board of Directors on priorities and ways to measure and improve performance
d) The Board of Directors will receive and approve or support those recommendations
e) The goal of the committee is to guide the Executive Team and Board of Directors in their decision-making
f) The goal is to oversee and ensure the highest standard of healthcare
g) The committee acts as an advisory body to the Board of Directors by identifying and vetting opportunities to improve compliance, quality, safety, and risk.

Ali, Bryan, Patty, Robin, and Scott will work on clarifying what they will present, and develop standing agenda items. They will present this information to the Executive Team and work together to create a clear purpose to propose to the committee at the next meeting.

Discussed the goals of the Board of Directors

a) the desire to have an opportunity for in-depth information to help guide their decisions
b) desire to have information as and before issues arise enabling them to provide direction

Examples of compliance responsibilities:

a) Regularly review significant risk exposures or potential compliance violations, including those relating to alleged violations of the Code of Conduct and the steps that have been taken to monitor, correct, and/or mitigate potential violations or risks.
b) Review the relevant departments of NIHD, the development of internal systems and controls to carry out standards, policies, and procedures relating to ethics, regulatory, and corporate compliance
c) Ensure that the NIHD is in good standing and compliance with all directives and regulations of all applicable regulatory bodies
d) Provide an objective and unbiased authority to evaluate and oversee NIHD in responding to any inquiries, complaints, investigations, litigation, or other actions involving the NIHD and/or the employees of NIHD

Discussed responsibilities of compliance. CEO DelRossi expressed a desire to include:

a) Quarterly reporting
b) Inform the Board of Directors of new rules and regulations

c) Detail the implementation of rules and regulations and mitigation of risks associated

Examples of safety responsibilities:

a) Review data security programs, including cyber security and procedures regarding disaster recovery and critical business continuity, and review programs and plans that management has established to monitor compliance with data security compliance programs and test preparedness

Discussed safety responsibilities. Committee members expressed a need to add to this area including facilities and patient safety.

Examples of quality of care, treatment, and services.

a) Provides oversight, monitoring, and assessment of key organizational processes, outcomes, and external reports; makes recommendations concerning physician credentialing and other oversight activities; and recommends appropriate Board policies
b) To directly oversee that quality assurance and improvement processes are in place and operating in the hospital.
c) To enhance quality across and throughout the patient care, technical, and operations. Encompasses all aspects of the interface and experience between patients, families, and the community.
d) Assure continual learning and skills development for risk surveillance, prevention, and continual improvement.

Committee members discussed a desire to develop this area of responsibility more and to include items about oversight.

Discussed how to include elements of risk in the purpose statement. Committee members expressed that risk is connected to the other areas listed. Committee members will work to define what elements of risk need to be included.

Discussed membership to the committee:

a) The CQSRC shall include a committee of the whole of the Board of Directors, the Chief Executive Officer, the Chief Medical Officer, the Chief of Staff, and others as requested. The Directors shall be the only members of the Committee with voting privileges.
b) The CQSRC may have one member from the community, subject to approval by the Board of Directors.

The committee suggested that membership should include:

c) Executive team
d) Alison Feinberg, Manager of Quality and Survey Readiness, Quality Assurance
e) Bryan Harper, ITS Director
f) Dianne Picken, Medical Staff Director
g) Patty Dickson, Compliance Officer
h) Robin Christensen, Manager of Employee Health & Infection Control

i) Scott Hooker, Director of Facilities and Property Management

Frequency of meetings

a) The CQSRC shall meet quarterly at a minimum unless there is a need for additional meetings. Meetings may be held at irregular intervals.

Public participation

a) All CQSRC meetings shall be announced and conducted according to the Brown Act. The general public, patients, their families and friends, Medical Staff, and District staff are always welcome to attend and provide input.

Frequency Review/revision

a) The CQSRC shall review the Charter biennially, or more often if required. If revisions are needed, they will be taken to the Board for action.

GOALS	These items will be developed in future meetings.
TIME-SENSITIVE CALENDAR	
WORK PLAN	
REPORTS	Compliance Quarterly Report will be reviewed in the regular board meeting on September 18, 2024 @ 5:30
ADJOURNMENT	Adjournment at 4:48 pm

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Ted Gardner
Northern Inyo Healthcare District Chair
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Compliance, Quality, Safety, and Risk Committee Charter		
Owner: Board Clerk and CFO Assistant	Department: Administration	
Scope:		
Date Last Modified: 12/03/2024	Last Review Date: No Review Date	Version: 1
Final Approval by:	Original Approval Date:	

From the Board of Directors Bylaws: Compliance/Quality/Safety/Risk Committee

1. Members of this standing committee shall include a committee of the whole of the Board of Directors, the Chief Executive Officer, the Chief Medical Officer, the Chief of Staff, and others as requested. The Directors shall be the only members of the Committee with voting privileges.
2. The function of the Compliance/Quality/Safety/Risk Committee (CQSRC) is to analyze data regarding compliance, safety, and quality of care, treatment, and services and establish priorities for performance improvement.
3. The Compliance/Quality/Safety/Risk Committee (CQSRC) shall meet no less than quarterly.

COMMITTEE PURPOSE

The purpose of the Compliance/Quality/Safety/Risk Committee (CQSRC) is to assist the Board in fulfilling its oversight responsibilities.

COMMITTEE RESPONSIBILITIES

1. Collect and review data analysis reports regarding compliance, safety, risk, and quality of care, treatment, and services.
2. Assist in reviewing and monitoring progress, addressing concerns and barriers, and establishing priorities for performance improvement.

COMMITTEE REPORTS

1. Compliance
    a. Review the design and implementation of comprehensive compliance training programs
    b. Review and provide oversight for navigation of regulatory requirements, facility risk mitigation, and ethical conduct.
    c. Review and provide oversight of processes to prevent and detect fraud, waste, and abuse.
    d. Review and provide oversight of policies, procedures, and training to prevent, detect, and mitigate damage from individually identifiable medical information breaches.
2. Quality of care, treatment, and service
    a. Quality Incentive Pool (QIP) Program
    b. Regulatory Reporting
    c. Healthcare-Associated Infections (HAI) Rates
        i. Surgical Site Infection
        ii. Device Infection (CVC, F/C, Vent)

review

iii. Clostridium Diff Infections
iv. MRSA and VRE Blood Stream Infections

d. Antibiotic Stewardship activities/goals
e. Internet Protocol (IP) Surveillance Activities Tracers
f. Credentialing and Privileging
g. Appointment and Reappointment
h. Peer Review, Ongoing Professional Practice Evaluation (OPPE), and Focused Professional Practice Evaluation (FPPE)

3. Safety
    a. Sharps and Safe Patient Injury Data (Employee Injuries)
    b. Occupational Health and Safety Compliance: Ensure compliance with California Division of Occupational Safety and Health (Cal/OSHA) standards, preventing workplace injuries, handling hazardous materials, and managing ergonomics.
    c. Workplace Violence Prevention: Address the growing concern of workplace violence in healthcare settings. California requires healthcare facilities to have a workplace violence prevention plan in place, so monitoring this is essential.
    d. Infection Control: Develop and monitor protocols for infection prevention and control, especially for preventing healthcare-associated infections (HAIs). California has stringent regulations in this area, so ensuring compliance is critical.
4. Risk
    a. Cyber Security

COMMITTEE MEMBERSHIP

1. The CQSRC shall include the Board of Directors, Executive Team, and others as requested. The Directors shall be the only members of the Committee with voting privileges.
2. The CQSRC may have one member from the community, subject to approval by the Board of Directors.

FREQUENCY OF MEETINGS

1. The CQSRC shall meet quarterly at a minimum unless there is a need for additional meetings. Meetings may be held at irregular intervals.

PUBLIC PARTICIPATION

1. All CQSRC meetings shall be announced and conducted according to the Brown Act. The general public, patients, their families and friends, Medical Staff, and District staff are always welcome to attend and provide input.

FREQUENCY REVIEW/REVISION

1. The CQSRC shall review the Charter biennially, or more often if required. If revisions are needed, they will be taken to the Board for action.

RETENTION AND DESTRUCTION OF RECORDS

Supersedes: Not Set

review

NORTHERN INYO HEALTHCARE DISTRICT
REPORT TO THE BOARD OF DIRECTORS
FOR ACTION

Date: November 7, 2024

Title: **Compliance Department Report**

Synopsis: The Compliance Department Quarterly Report provides information needed for the Board of Directors to provide the oversight required by the Health and Human Services Office of Inspector General (OIG). It provides specific insight into the work occurring in all areas of the seven essential elements of a Compliance Program as outlined by the HHS OIG. All information in the report has been summarized; however, additional details will be provided to the Board of Directors upon request.

This report provides the Northern Inyo Healthcare District Board of Directors insight into NIHD's compliance with the NIHD Compliance Program.

It is recommended that the Board of Directors approve this action item.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

COMPLIANCE REPORT SUMMARY

- NIHD has reported six privacy breaches to the California Department of Public Health (CDPH) through October 2024. 100% of alleged privacy breaches were reported to the California Department of Public Health, Office of Civil Rights, and the affected patient(s) within 15 days of discovery. (p. 7)

- CDPH Medical Breach Enforcement Section has assigned a $45,000 administrative penalty to NIHD. Compliance appealed and was able to negotiate a Settlement Stipulation for $30,000. NIHD has paid this penalty. This was for a 2022 breach that intentionally disregarded law and policies. (p. 7)

- In August 2024, the Centers for Medicare and Medicaid Services notified NIHD that our price transparency website is out of compliance with the Price Transparency Rules. NIHD was notified on November 8, 2024, that we are compliant and their case is closed. (p. 10)

- An unusual occurrence is an event not within our "usual" actions or outcomes. The Compliance team processed 446 unusual occurrence reports (UORs) through October CY2024. Some of the "take-away" points for NIHD and the patients we serve (p. 12):

    - Patient complaints make up 26% of unusual occurrence reports.
        - We are actively working on customer service training.
        - We are actively reviewing billing concerns related to annual wellness visits and annual preventative care.
    - NIHD has had 8 workplace violence events in 2024.
    - We provide responses to patient complaints and concerns within 7 days 97% of the time.
    - **We have implemented fourteen (14) systemic changes at NIHD based on responses to UORs. Five of the systemic changes were the result of patient complaints.**

- The NIHD team has a medication-administration accuracy rate greater than 99.95%, which is outstanding, especially compared to the national average of 75-92% accuracy.

- Compliance assigned additional customer service education and training to the Patient Access Team based on the number of concerns brought to our attention through UORs.

- Compliance work-plan audits and reviews show no indication of fraud, waste, or abuse.

- Compliance has responded to eleven public record requests in 2024.

- NIHD has provided 75,267 minutes of interpretive services to patients, in more than 10 different languages. (p. 4)

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Quarterly Compliance Report –Q4 2024
November 7, 2024

Comprehensive Compliance Program Definitions:

1. **Audits** - A wide variety of audits in the Compliance Program review for privacy concerns, language access issues, and fraud, waste, and abuse. Auditing and monitoring is one of the seven essential elements of an effective Compliance Program.
2. **Security Risk Assessment** - District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment is completed annually, and as needed, by Compliance and IT Security.
3. **SAFER** - Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) is completed annually by IT, Informatics, and Compliance.
4. **Compliance Workplan** - The Compliance Workplan is updated annually, and as needed, to adjust the focus of certain audits, in alignment with the Office of Inspector General of the Department of Health and Human Services, and our local Medicare Administrative Contractor (MAC), Noridian's audit priorities.
5. **Conflicts of Interest** – This component of the Compliance Program ensures that no parties use or conduct District business for personal financial gain.
6. **Privacy Investigations –** Privacy investigations can arise due to complaints, access audits, HIMS audits, and anonymous reporting.
7. **Investigations –** Other compliance related investigations are conducted to avoid regulatory non-compliance and respond to regulatory agency inquiries and investigations.
8. **Compliance Committees –** This section provides a brief overview of the work of the Compliance committees and sub-committees.
9. **Issues and Prevention** – The compliance team researches numerous questions, concerns and regulatory issues to allow other NIHD team members to take a proactive approach.
10. **California Public Records Act (CPRA) Requests** – The Compliance Officer is responsible for intake and review of public records requests, and research, investigation, redaction and fulfillment of those requests.

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11. **Policies and Procedures –** Policies and procedures are vital to the organization as they outline expectations and processes for members of the workforce. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program.
12. **Unusual Occurrence Reports** – The Compliance Team processes and tracks all unusual occurrence reports for the District. Compliance provides the quality data to leadership and teams for monitoring and trending. Compliance manages the software, reporting, user configuration and resolution of all UORs.

The Compliance Department consists of a team of two full time employees, Conor Vaughan, Compliance Analyst, and Patty Dickson, Compliance Officer.

Report

1. Audits

A. Electronic Health Record Access Audits - The Compliance Department Analyst, Conor Vaughan, completes audits for access of patient information systems to ensure employees, providers, and vendors access records only on a work-related, need-to-know, and minimum necessary basis.

i. Cerner semi-automated auditing software tracks all workforce interactions and provides a summary dashboard for the compliance team. The dashboard provides "flags" for unusual activity. Flags require further investigation and review by the Compliance Team.

ii. The following is CY24 August through October activity

a. New Employee Audits (30 day): 22

I. Flags: 0

II. Flags resulting in policy violations: 0

III. This 30 day audit for new employees was added following a PHI breach corrective action plan.

b. New Employee Audits (90 day): 36

I. Flags: 1

II. Flags resulting in policy violations: 0

c. For-Cause Audits: 9

I. Flags: 0

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II. Flags resulting in policy violations: 0
III. Flags resulting in disciplinary action: 0

d. In "own" chart flags: 8
   I. Flags resulting in policy violations: 2
      i. Provided education and training: 2
      ii. Repeat violations: 0
e. Same Last Name Search Flags: 224
   I. Resulted in follow up with employee: 3
   II. Flags resulting in policy violations: 0
f. 3rd Party Vendors (ex. Our billing or coding company): 0
   I. Flags: 0
   II. Flags resulting in policy violations: 0
g. High Profile Persons: 4
   I. Flags: 0
   II. Flags resulting in policy violations: 0
h. Random Employee Audits: 24
   I. Flags: 0
   II. Flags resulting in policy violations: 0

B. <u>Business Associates Agreements (BAA) audit</u>
   i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor meets the strict governmental regulations regarding how to handle, transmit, and store protected information to protect NIHD and NIHD patient information.

C. <u>Compliance Department Contract and Agreement reviews/audit</u>
   i. Documents processed for CY 24 (through August)
      a. 165 Agreements, Amendments or Termination Notices have been completed.
      b. ~8 are currently in progress

D. <u>HIMs (Health Information Management) scanning audit</u>
   i. To be conducted by HIMS and summary reports will be sent to Compliance

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ii. No reports received in to date

E. Email security audit/reviews
   i. Reviewed at least once a month
   ii. Review email security systems for violations of data loss prevention rules
      a. Typically results in reminder emails to use email encryption sent to members of workforce.
      b. Occasionally results in full investigations of potential privacy violations.
      c. 4 instances of education provided

F. Language Access Services Audit
   i. The Compliance Department is reviewing several language access tools that may be able to provide medically certified interpretive and translation services for a reduced cost.
   ii. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line.
      a. NIHD has provided a total of 75,267 minutes of interpreting services, through October 31, 2024, to our patients at a cost to the District of $83,521.43. (See attached Language Access Services spreadsheet)
      b. We have been working to troubleshoot issues with Cyracom services as they are nearly half the price of Language Line services, although many of our clinicians prefer Language Line. We made a big push with our clinical teams, assisted by ITS in June 2024.
      c. Through education and troubleshooting with Cyracom, the NIHD team has realized a significant decrease in costs to provide interpreter services
         I. CY24 Q3 – average price per minute - $1.02
         II. CY24 (July/Aug) – 0.94
         III. CY24 Q2 average price per minute - $1.197
         IV. CY24 Q1 average price per minute – $1.197
   iii. Translation services (written word) services are provided via Language Line Translation Services.
   iv. NIHD provided services in the following languages in 2024
      a. Spanish (21 countries claim Spanish as an official language),
      b. American Sign Language,

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c. Mandarin (China, Taiwan, and Singapore),
d. Gujarati (India/Pakistan),
e. Thai (Thailand)
f. Arabic (25 countries claim Arabic as an official language),
g. Armenian (Armenia)
h. Vietnamese (Vietnam)
i. Quechua (Andean regions of South America
j. French

v. Laws require providing language access services to all limited English proficiency patients at no cost to the patient.
vi. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.

G. 340B program audits
   i. The 340B drug program is designed to provide rural and underserved communities access to discount drug prices, allowing the facility to save several hundred thousand dollars annually. Those funds are used by the District to improve services provided to the community.
   ii. Annual 340B audit has been scheduled by SpendMend (formerly TurnKey)
      a. The Compliance Department recognizes Becky Wanamaker and Jeff Kneip for their excellent work on the 340B program.

H. Narcotic Administration/Reconciliation Audit
   i. Working in conjunction with Pharmacy to review narcotic administration.

I. Vendor Diversity Audit – NIHD has approximately 1400 vendors.
   i. NIHD currently has one certified diverse vendor.
   ii. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI, formerly OSHPD) to develop and administer a program to collect hospital supplier diversity reports, including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
   iii. There are currently no regulatory requirements for utilizing diverse vendors or outreach to diverse vendors.

J. Provider Verification Audits

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i. More than 380 referring providers were verified and were checked for state and federal exclusions so far in calendar year 2024
ii. No exclusions were found for verified providers.
iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

K. Coding Audits and Charge Master Audits
   i. Evaluation and Management (E & M) code audit completed for providers. Information shared with leadership team to discuss with coding trainers and providers.
      a. UASI has provided coding quality reports.
   ii. Charge Master Audit
      a. Conducted by CliftonLarsonAllen identified areas of opportunity in the multiple areas. These are the focus of multiple revenue cycle committees.

L. Collectively in 2024, NIHD employees have read 98.2% of assigned Compliance and Privacy policies.

2. **HIPAA Security Risk Assessment (SRA)** – Due in November 2024
   A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG
3. **Office of National Coordinator of Health Information Technology SAFER Audit** ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience))
   A. Nine of nine sections of the SAFER audit were completed by June 1, 2024.
   B. Completion of all nine sections is required for MIPS data submission.
   C. MIPS data is the quality data being submitted by the Quality Team. MIPS documents improvement in patient care measures and outcomes, and is worth millions of dollars for NIHD.
4. **Compliance Work Plan** – Updated October 2024 see attached
5. **Conflicts of Interest**
   A. All new employees complete and return COI questionnaire forms.
   B. Compliance, in conjunction with a significant amount of work from Lynda Vance, has rolled out a new process for completing and reviewing Conflict of Interest Questionnaires. This new process allows the data entered in a form by the employee to populate automatically a Smartsheet. Notifications are sent to notify members of the Business Compliance Team of action needed. The reviews occur independently

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via Smartsheet, unless there is disagreement. Once a determination is made for a conflict, conflict of interest letters of findings are virtually auto-generated to email the employee and their supervisor.

i. Roll-out occurred in July 2024
ii. We have received over 350 completed forms.
iii. We have reduced the time spent by the Compliance Department on this process by approximately 85%. This creates a savings to the District of over $25,000.

C. No COI forms submitted to the Compliance Department noted any knowledge or concern for the following:

i. Business transactions with an aim for personal gain.
ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
iii. Use of NIHD resources for purposes other than NIHD business, NIHD sponsored business activities, or activities allowed by policy.
iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
v. Use of NIHD money, goods, or services to influence government employees, or for special consideration or political contribution.
vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.

6. Privacy Investigations- see attached

A. Privacy investigations/potential breaches through October 31, 2024

i. Reported to Compliance – 28
ii. Reported to CDPH/OCR – 6
iii. Investigations still active in the Compliance Department - 2
iv. Investigations closed by the Compliance Department with no reporting required - 22

B. CDPH reported breach case status update

i. CDPH has notified NIHD that the Medical Breach Enforcement Section (MBES) will begin investigating their backlog of breaches. MBES can review and investigate breaches for 7 years. The MBES team were reassigned to contact tracing during the pandemic, and are now working to resolve oldest reported potential breaches first.

a. Privacy investigations from 2023

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I. Reported – 10
    i. 4 are closed

b. Privacy investigations from 2022
    I. Reported – 6
        i. 3 are closed
        ii. NIHD has received notice that CDPH has assigned a $45,000 administrative penalty for a breach that occurred in 2022.
            1. This was an intentional breach by the former-employee.
            2. Compliance was able to negotiate a Settlement Stipulation at $30,000. This Administrative Penalty has been paid by NIHD.

c. Privacy investigations from 2021
    I. Reported – 4
        i. 3 are closed

d. Privacy investigations from 2020
    I. Reported – 17
        i. 11 are closed
        ii. 3 may be assigned administrative penalty or fine

e. Privacy investigations from 2019
    I. Reported - 11
        i. 7 are closed

f. Privacy investigations from 2018
    I. Reported - 23
        i. 22 are closed

g. Privacy investigations from 2017
    I. Reported -22
        i. 17 are closed

h. Privacy investigations from 2016
        i. 1 is still being investigated by CDPH

ii. CDPH Status definitions
    a. Closed – CDPH investigation completed and a determination has been rendered.

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b. In Progress – CDPH has assigned an intake ID and may have completed some portion of the investigation.
c. Submitted – CDPH has not assigned an intake ID or reviewed the case.

iii. CDPH Determination definitions
a. Unsubstantiated – CDPH was unable to prove a violation of the privacy laws occurred (or the privacy law was updated in the interim between submission and their processing of the report)
b. Substantiated without deficiencies – CDPH found that a violation of the privacy laws occurred, but NIHD had the correct policies/procedures, training/education, and took corrective actions to ensure any harm had been mitigated and reduced risk for recurrence.
c. Substantiated with deficiencies – CDPH has found that a violation of the privacy laws occurred. CDPH has determined that further action by NIHD is needed to ensure reduced risk for recurrence. CDPH requires a corrective action plan to be submitted within a few days of receipt of the determination letter. Once the corrective action plan has been accepted, CDPH sends the case to CDPH Administration to determine if fines and administrative penalties will be assessed.

7. Investigations

A. Compliance conducted or assisted with around over 38 investigations through October 2024 including, but not limited to, the following:
i. California Department of Labor, Department of Industrial Relations
a. Response to investigation regarding California Labor Code, Division 2, Part 7 relating to a contractor participating in the Pharmacy/Infusion Construction Project.
ii. Health and Human Services Office of Inspector General
a. Business Associate Data Breach - Keenan
iii. California Department of Public Health, Licensing and Certification
iv. Internal investigations

B. Regulatory Submissions
i. Health Care Access and Information (HCAI – formerly OSHPD)
a. Vendor Diversity – On June 3, 2024, Compliance reported the information for the required vendor diversity reporting that was due by July 1, 2024. NIHD had three certified diverse vendors. NIHD spent

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~$66k with certified diverse vendors, which is approximately 0.08% of NIHD total procurement.

b. Hospital Fair Billing Practices – On June 11, 2024, Compliance reported NIHD's Financial Assistance and Charity Care Programs, along with postings in all registration areas of the District to HCAI. Additionally, all information was submitted explaining how NIHD complies with all language access regulations, as required.

c. CMS Hospital Price Transparency – on August 7, 2024, NIHD received a Notice of Non-Compliance from CMS. NIHD's Price Transparency webpage did not meet regulatory requirements. NIHD had 90 days to have a fully functional and compliant Price Estimator and Machine Readable Chargemaster file.

I. An NIHD team was assembled, led by Project Manager Lynda Vance, to assess, create and execute a corrective action plan.

II. NIHD received notification on November 8, 2024 that NIHD is now in compliance with Hospital Price Transparency regulations.

III. Thanks to Lynda's continuous follow-up and pressure on internal and external teams, NIHD avoided tens of thousands of dollars in fines.

C. Subpoenas

i. The Compliance Department also accepts and completes service for subpoenas for cases related to District business. This includes subpoenas for NIHD business records and appearances. Subpoenas for Medical Records are usually sent to the Health Information Department (HIM) for processing.

ii. The Compliance team has facilitated 70 subpoenas for records or appearances through 10/31/2024.

8. Compliance Committees

A. Compliance and Business Ethics Committee (CBEC)

i. No meetings since March 17, 2023

B. Billing and Coding Compliance Committee (BCCC) reports to the CBEC committee.

i. This group reviews billing/coding issues, chargemaster changes, and policies that affect billing/coding/accounting. Chair of this meeting is in the process of transitioning to the Billing Office Manager for this bi-weekly meeting.

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C. Business Compliance Team (BCT) reports to the CBEC Committee.
    i. This group reviews all Conflict of Interest questionnaires with potential conflicts to determine the appropriate and consistent method to address the conflict. This subcommittee is chaired by the Compliance Officer and meets on an ad hoc basis or via serial meetings using Smartsheet.

D. Forms Committee
    i. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. There are standardized templates, designated fonts, official translations, and mandatory non-discrimination and language access information.
    ii. We have added Barbara Laughon to this committee to ensure her review and approval of all signage and postings, other than those posters legally required by employment law.
    iii. One meeting has been held in 2024. District reorganization has slowed the Forms development and approval process.
    iv. The Forms Committee is transitioning to serial meetings via Smartsheet processes to facilitate faster forms approvals.

9. Issues and Prevention

A. Compliance researched over 100 issues for the District in 2024. They include adolescent privacy regulations; billing issues, and regulatory reporting. The compliance team takes a proactive approach for all issues brought to our attention.

10. CPRA (California Public Records Act) Requests

A. Compliance has received eleven (11) CPRA thus far in CY 2024.
    i. All eleven completed timely.

11. Policy and Procedures

A. Clear and current policies are the basis of an effective and efficient organization.

B. Policies are required to be reviewed and approved by the Board every two years. Procedures are required to be reviewed and approved by the Executive Team or the Medical Executive Committee every two years.

C. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program, per the Health and Human Services Office of Inspector General. User set up, policy administration, and other software optimization is managed by the Compliance Officer.

A. Policy and Procedure Audits:

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i. NIHD has approximately 1155 policies and procedures.
ii. Executive leadership was made aware of policies and procedures significantly overdue for review on September 9, 2024.

B. Leaders can also use reporting from the system to ensure NIHD team members are current with reviewing policies.
C. There is an administrative group that tracks policy life cycle and approval process, consisting of Ashley Reed, Sarah Rice, Dianne Picken, Cori Stearns, Patty Dickson, and Veronica Gonzalez.

12. Unusual Occurrence Reports (UOR)

A. UOR quality report data for January 1, 2024 through October 31, 2024, see attached
   i. Notable trends out of 446 UORs received so far in CY 2024:
      a. UORs regarding complaints and requests to review billing and care continue to be the highest volume. Communication issues and complaints represent 116 of the 446 UORs (26%).
         I. We are addressing some trending issues:
            i. Billing complaints – particularly wellness/annual visits
               1. This is under review by the Executive team.
            ii. Communication concerns - these are internal and external communication issues
      b. NIHD has had 8 reported workplace violence occurrences.
      c. Medication Occurrences and errors are the third highest volume in UORs. However, NIHD's medication error rates are well below national averages for error rates. Medication Errors are administration errors that reach the patient. See additional (see attached) data for NIHD Medication Administration accuracy following the UOR report.
      d. Fourteen (14) systemic changes have been put into place based on action plans developed during UOR review and investigation.
         I. Five systemic changes were the result of patient complaints.
         II. Three systemic changes resulted from safety and security occurrence reports.

B. The UOR process involves significant work and time from the Compliance team.
   i. All UORs in Complytrack are currently received by the Compliance Team.
      a. Many patient complaint and concern phone calls are transferred to the Compliance team for intake and assistance.

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b. The Compliance team provides response letters for the patient complaints, although the CMO assists on specific clinical matters.

ii. UORs are triaged and assigned to appropriate department leaders for review. Emails and phone calls are placed to leaders for urgent UORs.

iii. The Compliance team reviews replies, ensures thorough responses and corrective actions, provides follow up letters to patients, and ensures the executive team is aware of all areas of concern.

iv. The Compliance Officer follows up with leaders who are having difficulty with timely responses and attempts to assist them with resolution.

v. The Compliance team ensures UORs are closed after thorough review, corrective actions and, in most cases, resolution.

Language Acess Services

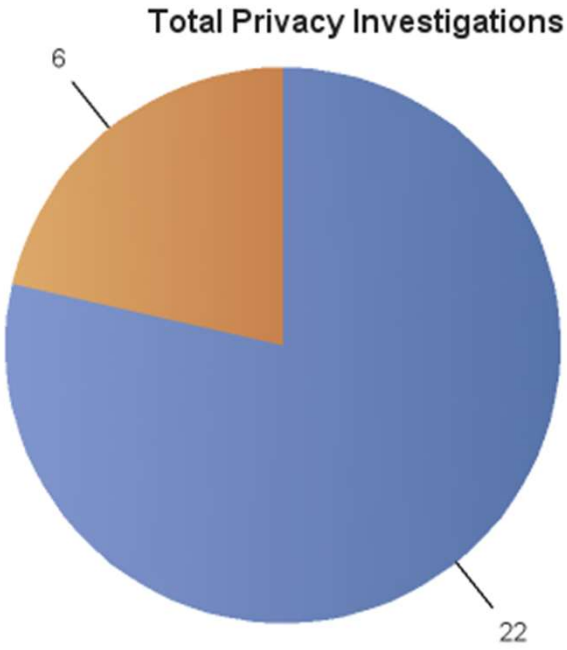
Interpreting	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	999	345	273	330	436	
Language Line - Phone - cost	$1,159.95	$1,380.35	$1,544.70	$1,619.75	$1,548.50	$949.05	$327.75	$259.35	$313.50	$414.20	
Language Line - Video - minutes provided	3,689	2,952	4,247	4,948	5,861	2,547	2,097	2,288	2,224	3,277	
Language Line - Video - Cost	$5,533.50	$4,426.00	$6,366.65	$7,422.00	$8,800.50	$3,820.50	$3,145.50	$3,432.00	$3,656.04	$4,915.20	
Cyracom - Phone - minutes provided	1,415	1,201	1,754	959	719	2,294	3,186	4,577	3,329	4,014	
Cyracom - Phone - Cost	$1,035.03	$855.15	$1,315.50	$616.65	$469.14	$1,720.50	$2,297.73	$3,183.48	$2,391.30	$2,841.21	
Cyracom - Video - minutes provided	154	142	232	77	243	1,692	1,689	1,844	775	823	
Cyracom - Video - Cost	$115.50	$106.50	$174.00	$57.75	$182.25	$1,269.00	$1,267.75	$1,389.50	$581.25	$617.25	
Total Minutes of interpretive services provided	**6479**	**5748**	**7859**	**7689**	**8453**	**7532**	**7317**	**8982**	**6658**	**8550**	**75267**
Total Cost of interpretive services provided	**$7,843.98**	**$6,768.00**	**$9,400.85**	**$9,716.15**	**$11,000.39**	**$7,759.05**	**$7,038.73**	**$8,264.33**	**$6,942.09**	**$8,787.86**	**$83,521.43**
Translation											
Language Line Translation Services - Cost	$1,000.85	$0.00	$107.55	$268.31	$1,265.07	$2,861.00	$99.00	$0.00	$1,105.86		**$6,707.64**
											$90,229.07

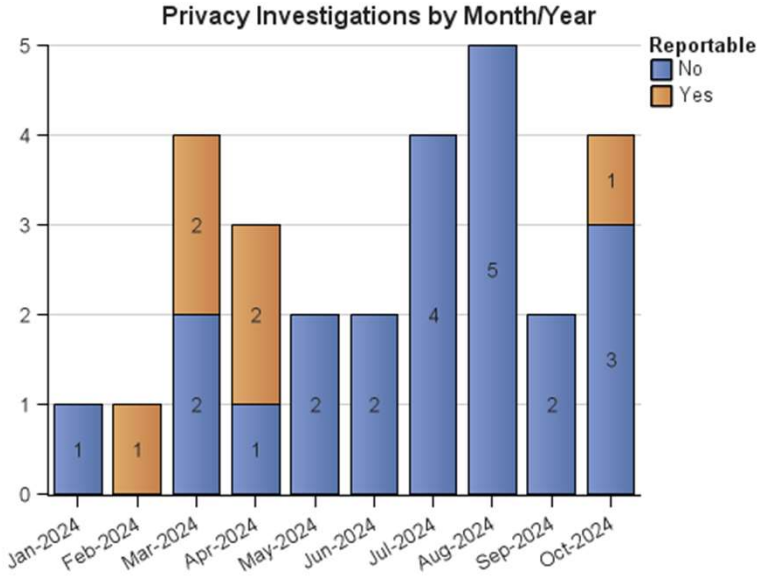
No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due Quarter 3 CY 2024
2.	Develop and deliver the annual briefing and training for the Board 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)	Presentation in June 2024
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		In progress
4.	District Policy and Procedure management		Policy Audit completed June 2024
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Policies for Compliance are in the review process as of May 2024
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)		Scheduled for August 2024
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Ongoing in conjunction with HR. Current to date.
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.		Relias reports, Policy Manager Reports due July 2024
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		Deferred to claims processing companies - 2024
9.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		In progress – also reviewing census lists access (May 2024
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or	Completed at Orientation.	Completed at orientation. False Claims Act Policy assigned annually.

	receiving remuneration to induce referrals and other current legal standards.		
Compliance Communication			
11.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Annual and quarterly reports submitted to appropriate committees and Board of Directors.
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Complytrack	Annual and quarterly reports submitted to appropriate committees and Board of Directors.
13.	Document test and review of Compliance Hotline.		Completed 02/2024 Due 08/2024
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Due 09/2024
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (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 referring providers. Medical Staff Office (MSO) verifies all medical staff. Accounting and Compliance verifies all vendors.	Current through 5/31/2024 Annual re-validation for vendor exclusions completed for 2023.
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		On hold due to current reorganization.
17.	Audits		
	a. Arrangements with physician (database)	Physician Contracts are now in a review cycle. All templates created/reviewed in conjunction with legal counsel (BBK).	Review in Q4 CY 2024
	b. EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 05/31/2024

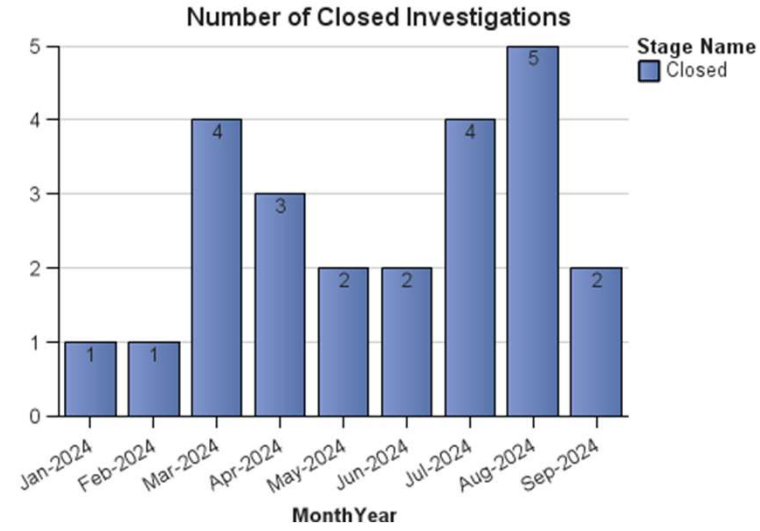
	c. Financial Audits	FY 2024	CLA Audit completed. Cost Report and audit completed.
	d. Payment patterns		Due quarter Q3 CY 2024
	e. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office
	f. Non-Physician vendor contract/payment audit	Incidental finding	Q3 – in progress - July
	g. DME (Durable Medical Equipment)	HHS OIG target	NIHD may provide and charge for "off-the-shelf, non-customized" medical equipment. Chargemaster is being updated. Review Q3 2024
	h. Lab services	MAC target	Deferred
	i. Imaging services (high cost/high usage)	MAC target	Deferred
	j. Rehab services	HHS OIG workplan	Deferred
	k. Language Access Audits	OIG target	Due Q3 2024 – in progress
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Security risk assessment November 2024 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due Oct/Nov 2024
	b. Periodic update to Security Risk Assessment		As needed
	c. Monthly employee access audits		Daily, ongoing
19.	Audit required signage		Deferred to 2024
20.	Audit HIMS (Health Information Management) scanned document accuracy		Deferred
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		Deferred
22.	Review CMS Conditions of Participation		Ongoing
23.	CMS Hospital Price Transparency Audit	MRF, SSPE, PE	Weekly
Response to Detected Problems and Corrective Action			
23.	Verify that all identified issues related to potential fraud are promptly investigated and documented		Current through May 2024
24.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Monitored by Revenue Cycle Team and Accounting.

			Reporting to Compliance as needed.
25.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Board Report for Q2 CY 2024, attached.
	a. Provide trend feedback to leadership to allow for data-driven decision-making		Quarterly
	I. Overall UOR process		Nov 2024
	II. Workplace Violence		Nov 2024
	III. Falls		Nov 2024
26.	Patient complaints		Documented and tracked in Unusual Occurrence Reporting system
27.	Breach Investigations	HIPAA, HITECH, CMIA	4 ongoing privacy investigations as of 6/6/2024. CDPH has started completing reported breach investigations from before 2021.

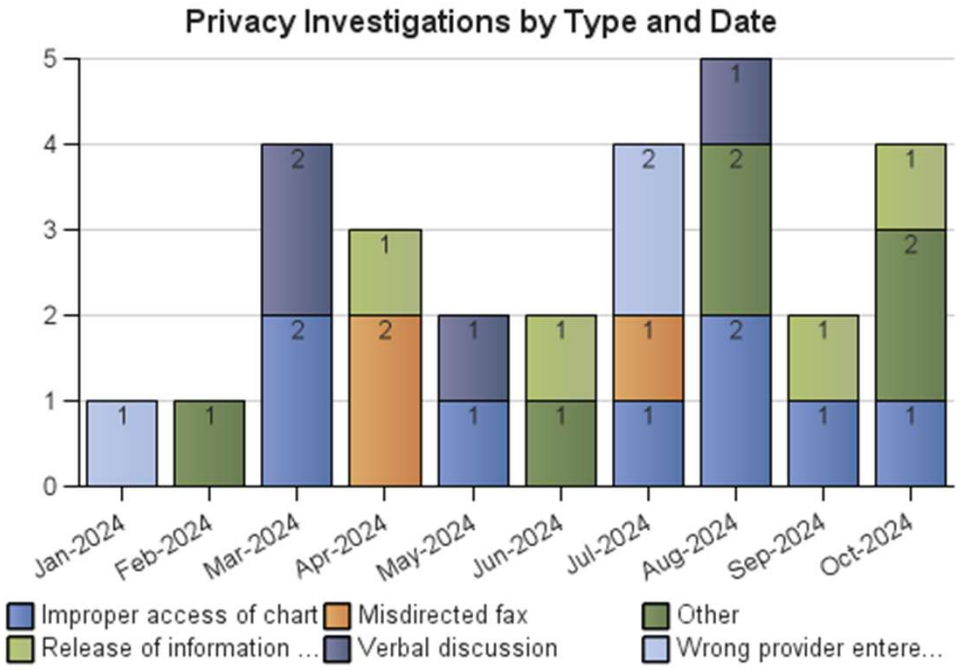




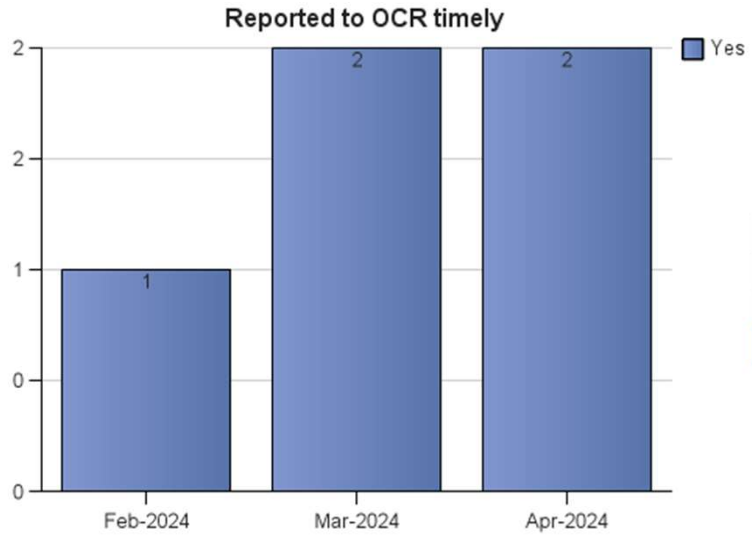
	No	Yes	Total
Jan-2024	1		1
Feb-2024		1	1
Mar-2024	2	2	4
Apr-2024	1	2	3
May-2024	2		2
Jun-2024	2		2
Jul-2024	4		4
Aug-2024	5		5
Sep-2024	2		2
Oct-2024	3	1	4
Total	**22**	**6**	**28**



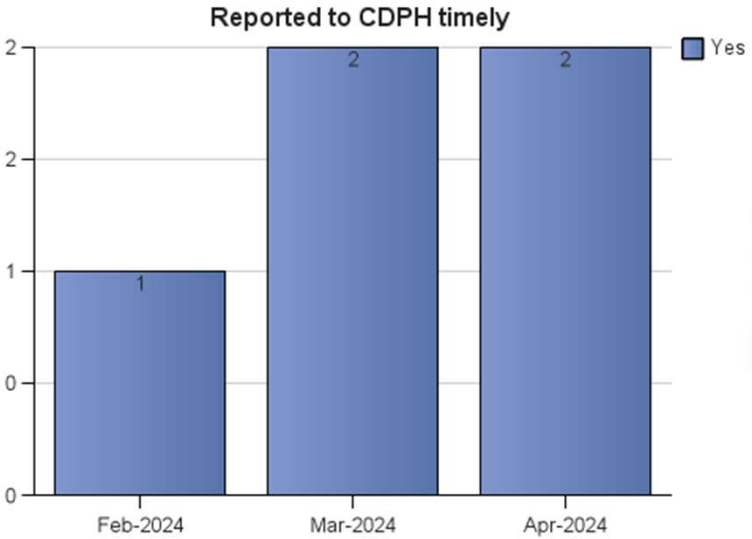
	Closed	Total
Sep-2024	2	2
May-2024	2	2
Mar-2024	4	4
Jun-2024	2	2
Jul-2024	4	4
Jan-2024	1	1
Feb-2024	1	1
Aug-2024	5	5
Apr-2024	3	3
Total	**24**	**24**



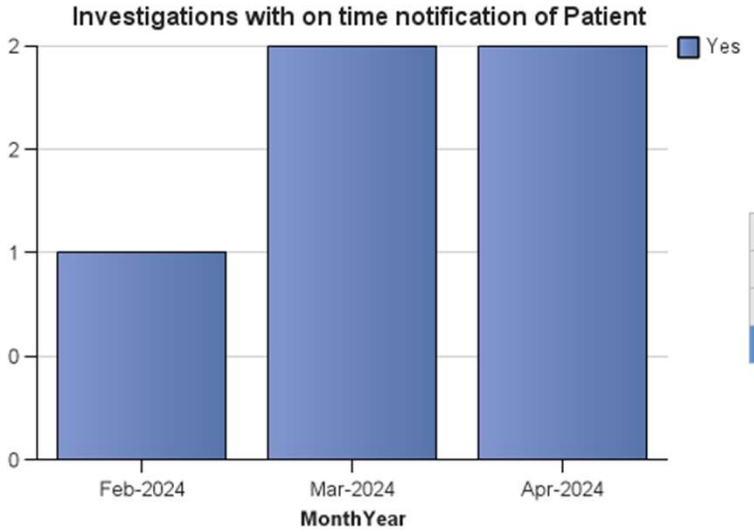
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Improper access of chart			2		1		1	2	1	1	8
Misdirected fax				2			1				3
Other		1				1		2		2	6
Release of information concern				1		1			1	1	4
Verbal discussion			2		1			1			4
Wrong provider entered/selected	1						2				3
Total	**1**	**1**	**4**	**3**	**2**	**2**	**4**	**5**	**2**	**4**	**28**



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5



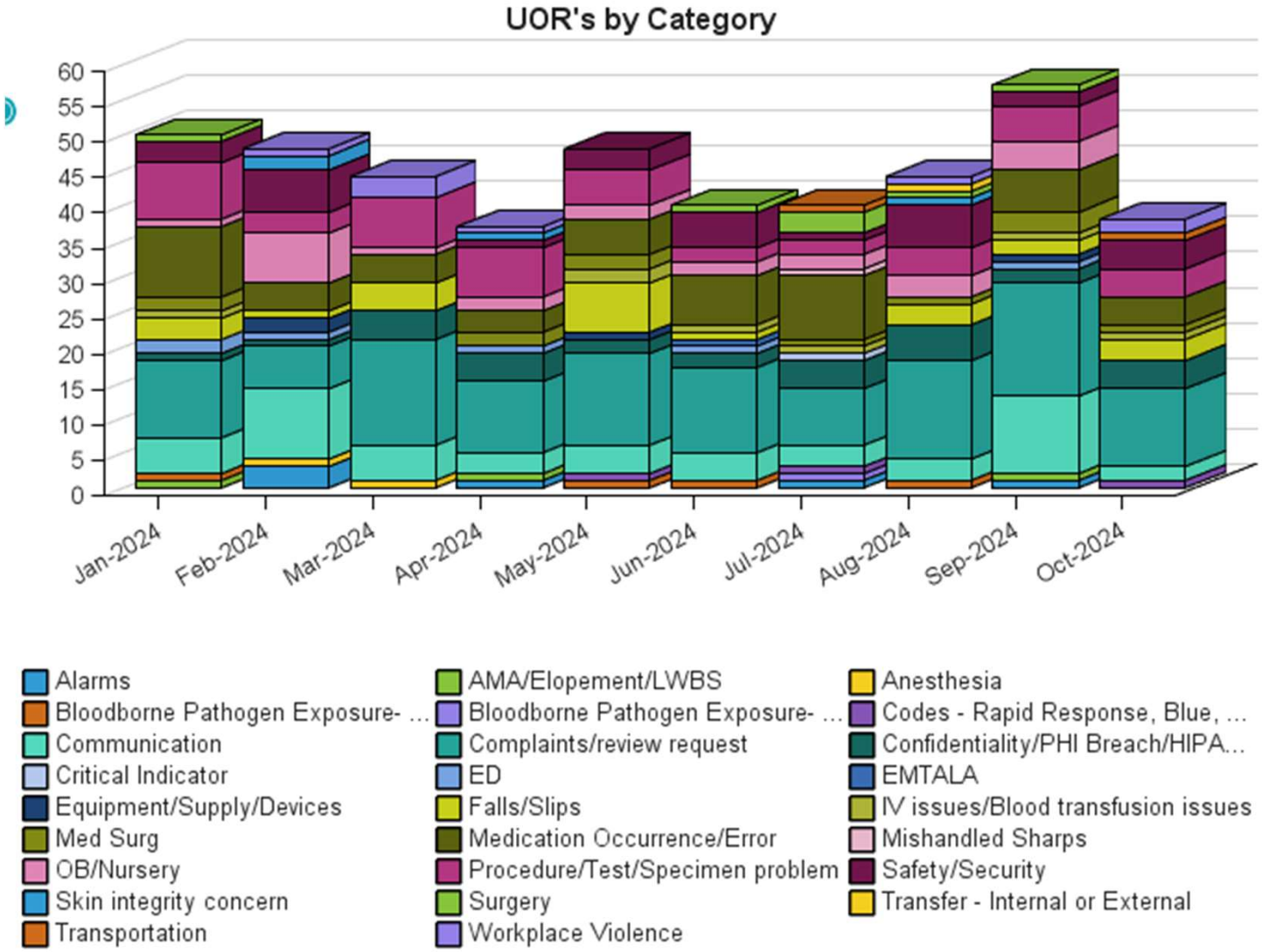
	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5

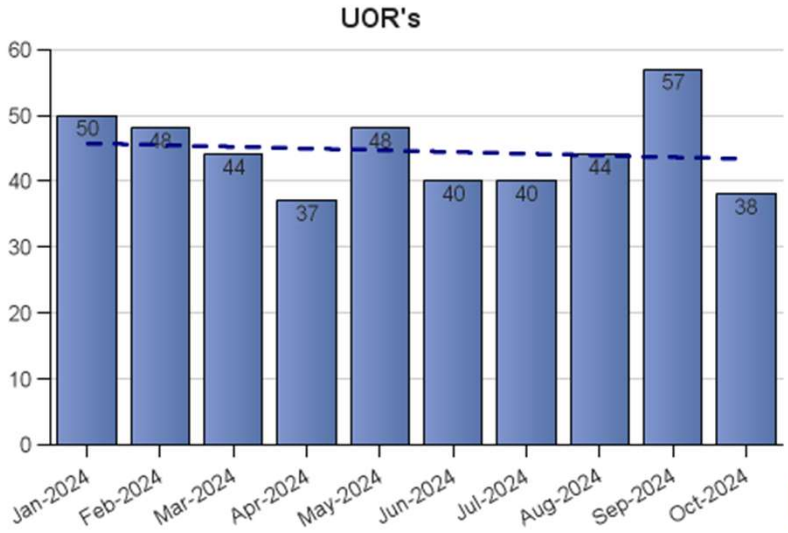
No new reportable breaches for May through September. October data is not completed yet.

Calendar Year 2024
Unusual Occurrence Report (UOR) Data

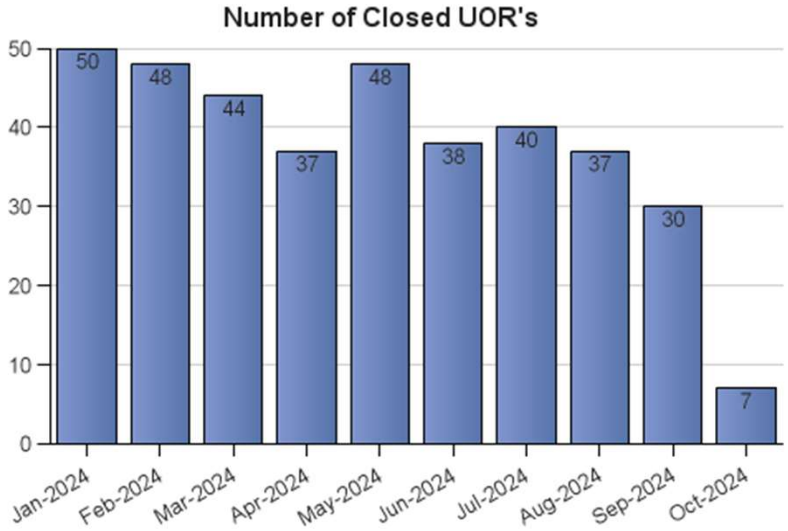

UOR's by Category
60
55
50
45
40
35
30
25
20
15
10
5
0
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
EMTALA
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

Data for previous slide

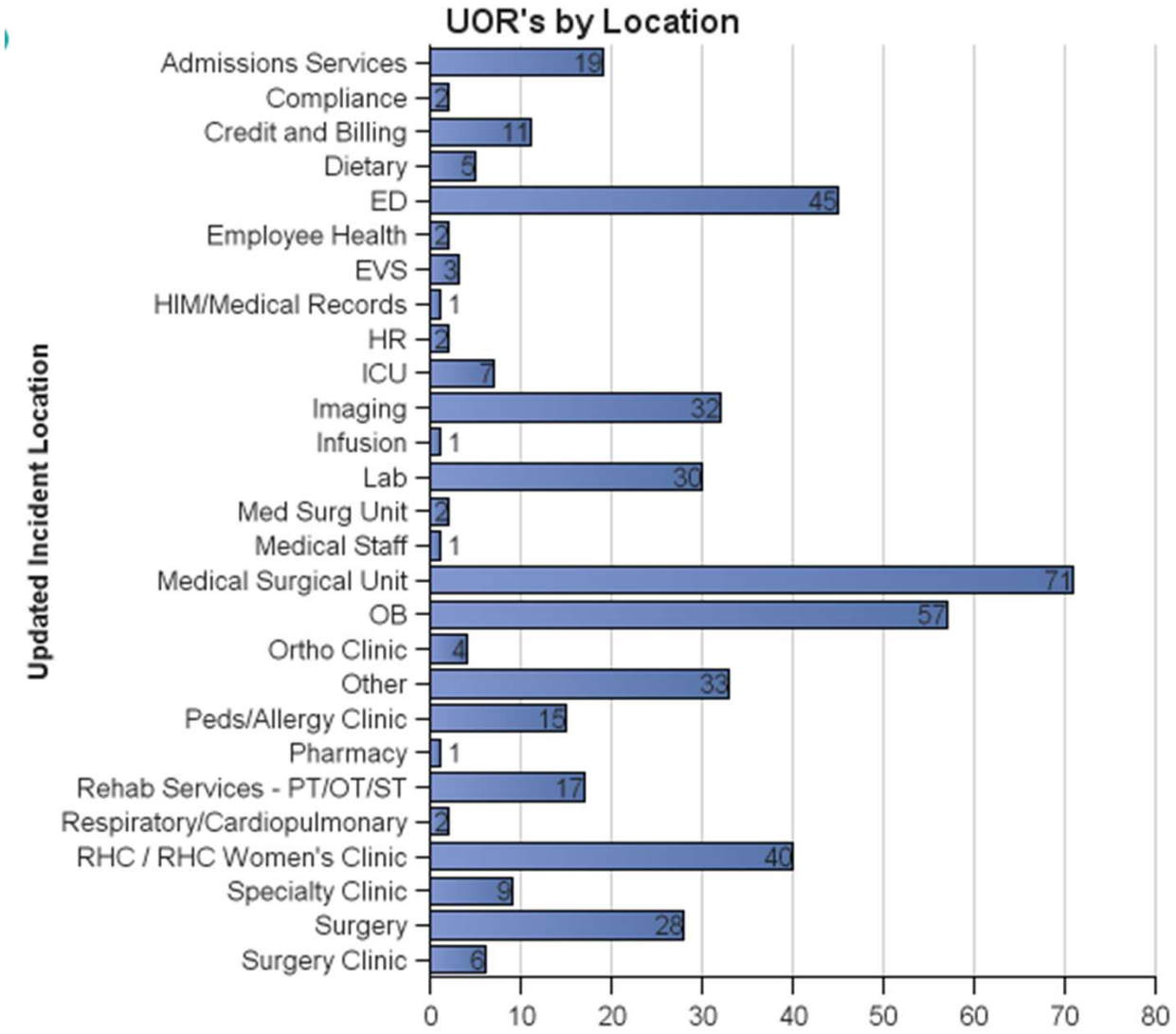
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Alarms		3		1			1		1		6
AMA/Elopement/LWBS	1			1					1		3
Anesthesia		1	1								2
Bloodborne Pathogen Exposure- Sharps Injury	1				1	1		1			4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane							1				1
Codes - Rapid Response, Blue, Deescalation					1		1			1	3
Communication	5	10	5	3	4	4	3	3	11	2	50
Complaints/review request	11	6	15	10	13	12	8	14	16	11	116
Confidentiality/PHI Breach/HIPAA violation	1	1	4	4	2	2	4	5	2	4	29
Critical Indicator							1				1
ED	2	1		1		1			1		6
EMTALA						1					1
Equipment/Supply/Devices		2			1				1		4
Falls/Slips	3	1	4		7	1		3	2	3	24
IV issues/Blood transfusion issues	1				2	1	1		1	1	7
Med Surg	2			2	2		1	1	3	1	12
Medication Occurrence/Error	10	4	4	3	5	7	9		6	4	52
Mishandled Sharps							1				1
OB/Nursery	1	7	1	2	2	2	2	3	4		24
Procedure/Test/Specimen problem	8	3	7	7	5	2	2	4	5	4	47
Safety/Security	3	6		1	3	5	1	6	2	4	31
Skin integrity concern		2		1				1			4
Surgery	1					1	3	1	1		7
Transfer - Internal or External								1			1
Transportation							1			1	2
Workplace Violence		1	3	1				1		2	8
Total	**50**	**48**	**44**	**37**	**48**	**40**	**40**	**44**	**57**	**38**	**446**



Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	40
Jul-2024	40
Aug-2024	44
Sep-2024	57
Oct-2024	38
Total	**446**

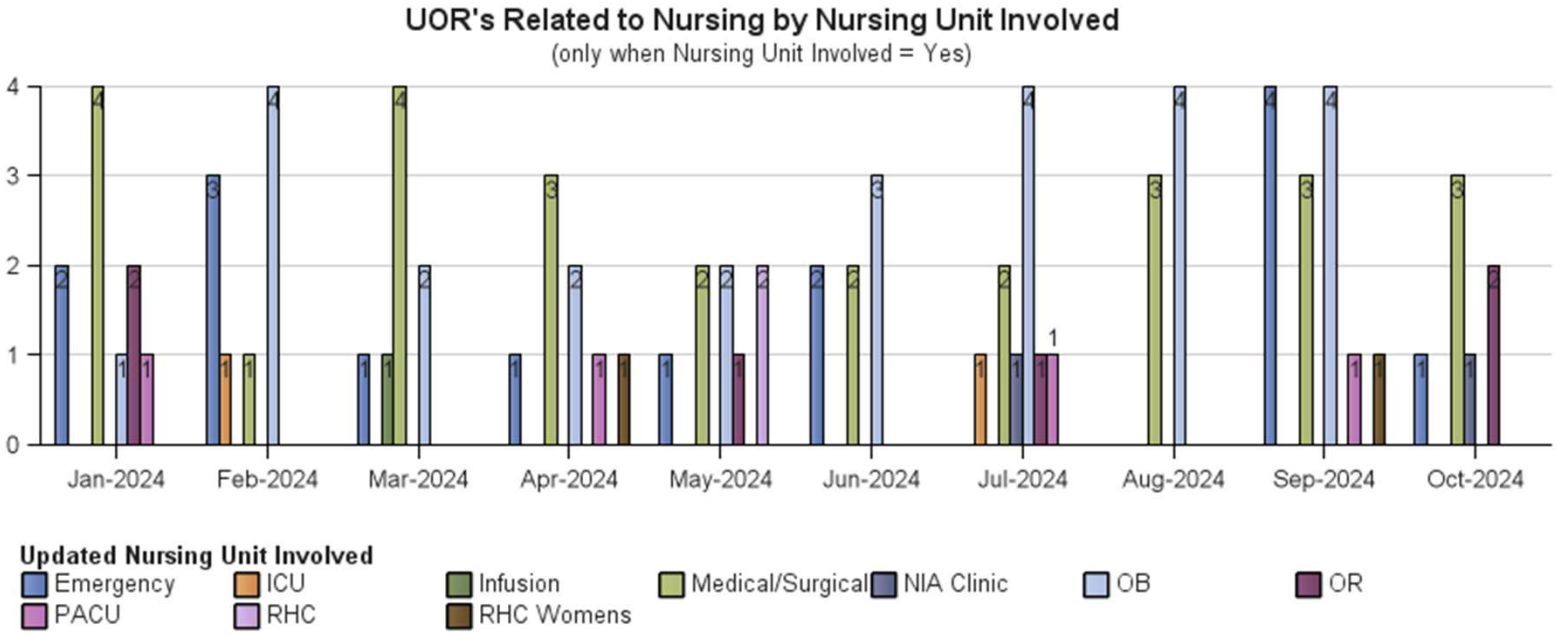


	Closed
Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	38
Jul-2024	40
Aug-2024	37
Sep-2024	30

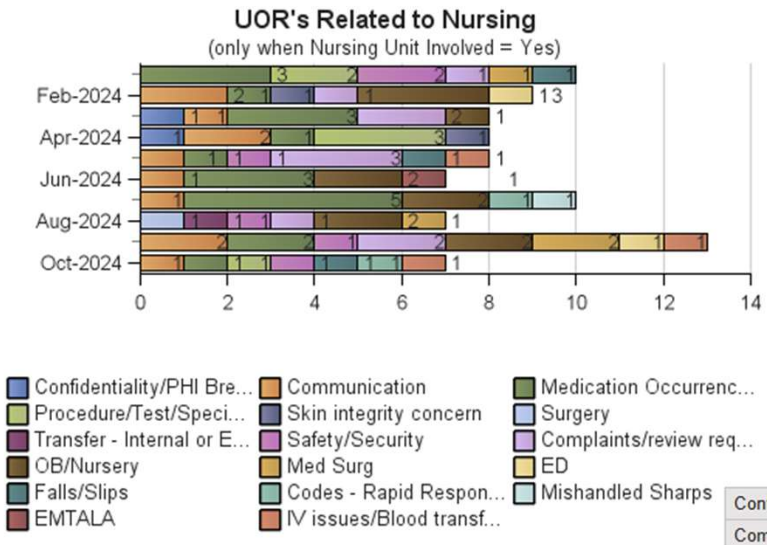

UOR's by Location
Updated Incident Location
Admissions Services 19
Compliance 2
Credit and Billing 11
Dietary 5
ED 45
Employee Health 2
EVS 3
HIM/Medical Records 1
HR 2
ICU 7
Imaging 32
Infusion 1
Lab 30
Med Surg Unit 2
Medical Staff 1
Medical Surgical Unit 71
OB 57
Ortho Clinic 4
Other 33
Peds/Allergy Clinic 15
Pharmacy 1
Rehab Services - PT/OT/ST 17
Respiratory/Cardiopulmonary 2
RHC / RHC Women's Clinic 40
Specialty Clinic 9
Surgery 28
Surgery Clinic 6
0 10 20 30 40 50 60 70 80

Data for previous slide

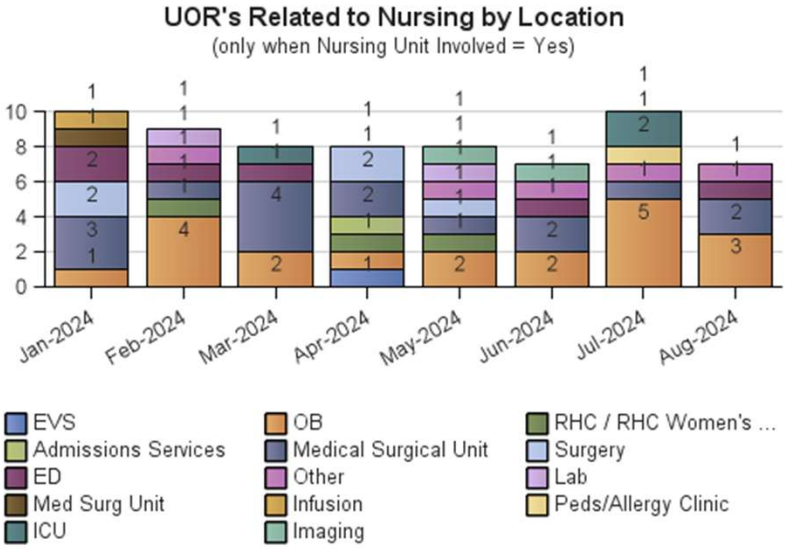
Admissions Services	19
Compliance	2
Credit and Billing	11
Dietary	5
ED	45
Employee Health	2
EVS	3
HIM/Medical Records	1
HR	2
ICU	7
Imaging	32
Infusion	1
Lab	30
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	71
OB	57
Ortho Clinic	4
Other	33
Peds/Allergy Clinic	15
Pharmacy	1
Rehab Services - PT/OT/ST	17
Respiratory/Cardiopulmonary	2
RHC / RHC Women's Clinic	40
Specialty Clinic	9
Surgery	28
Surgery Clinic	6
Total	**446**



	Yes
Emergency	15
ICU	2
Infusion	1
Medical/Surgical	27
NIA Clinic	2
OB	26
OR	6
PACU	4
RHC	2
RHC Womens	2
Total	**87**

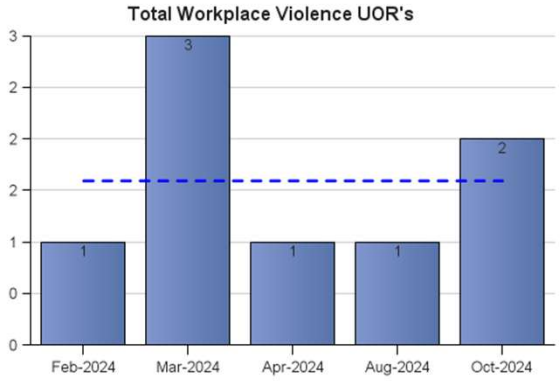


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Confidentiality/PHI Breach/HIPAA violation			1	1							2
Communication		2	1	2	1	1	1		2	1	11
Medication Occurrence/Error	3	1	3	1	1	3	5		2	1	20
Procedure/Test/Specimen problem	2			3						1	6
Skin integrity concern		1		1							2
Surgery								1			1
Transfer - Internal or External								1			1
Safety/Security	2				1			1	1	1	6
Complaints/review request	1	1	2		3			1	2		10
OB/Nursery		3	1			2	2	2	2		12
Med Surg	1							1	2		4
ED		1							1		2
Falls/Slips	1				1					1	3
Codes - Rapid Response, Blue, Deescalation							1			1	2
Mishandled Sharps							1				1
EMTALA						1					1
IV issues/Blood transfusion issues					1				1	1	3
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**13**	**7**	**87**

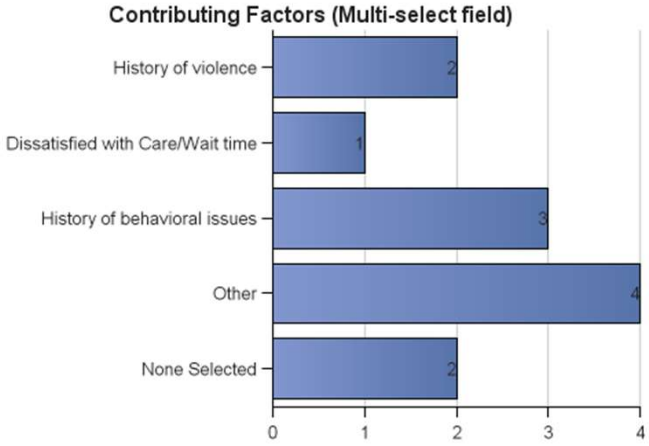


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
EVS				1					**1**
OB	1	4	2	1	2	2	5	3	**20**
RHC / RHC Women's Clinic		1		1	1				**3**
Admissions Services				1					**1**
Medical Surgical Unit	3	1	4	2	1	2	1	2	**16**
Surgery	2			2	1				**5**
ED	2	1	1			1		1	**6**
Other		1			1	1	1	1	**5**
Lab		1			1				**2**
Med Surg Unit	1								**1**
Infusion	1								**1**
Peds/Allergy Clinic							1		**1**
ICU			1				2		**3**
Imaging					1	1			**2**
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**67**

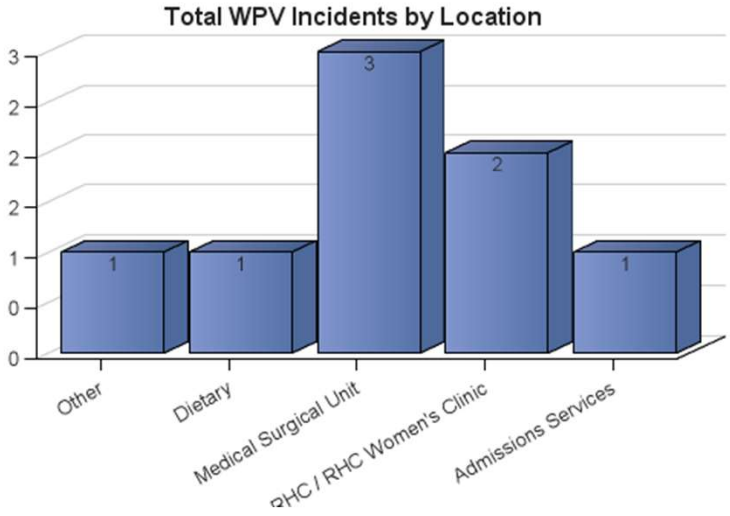
WORKPLACE VIOLENCE



	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Total
Workplace Violence	1	3	1	1	2	8
Total	**1**	**3**	**1**	**1**	**2**	**8**

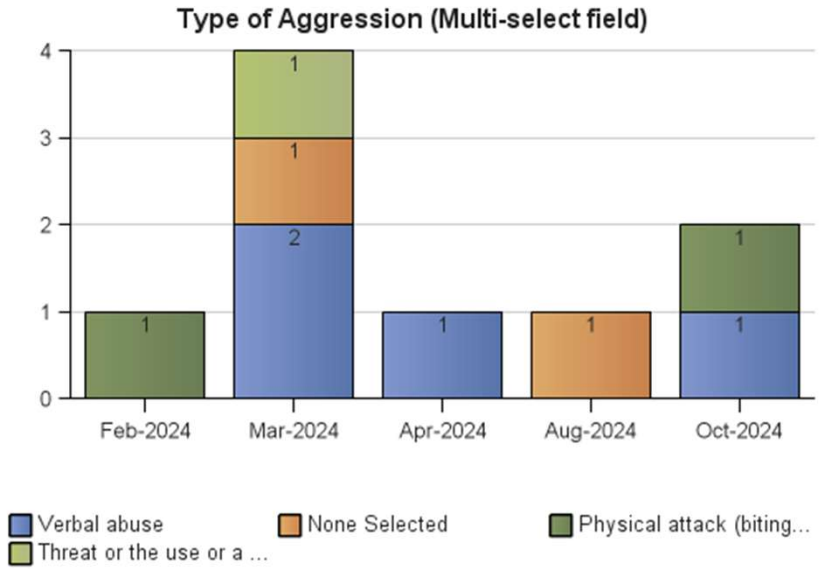


None Selected	2
Dissatisfied with Care/Wait time	1
History of behavioral issues	3
History of violence	2
Other	3
Total	**11**



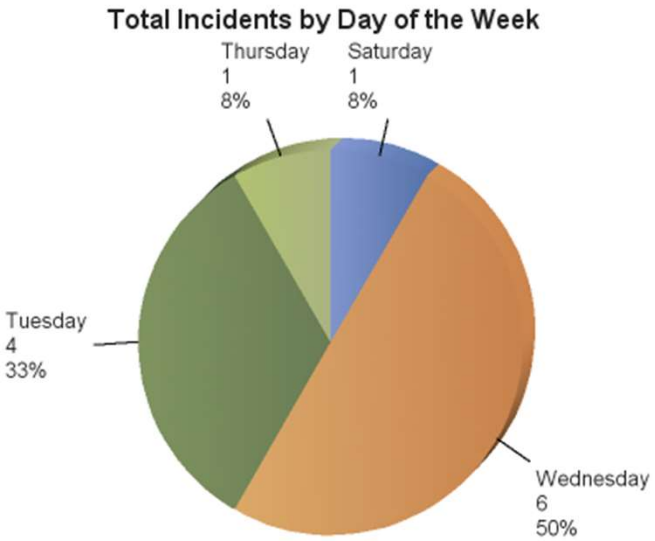
Other	1
Dietary	1
Medical Surgical Unit	3
RHC / RHC Women's Clinic	2
Admissions Services	1
Total	**8**

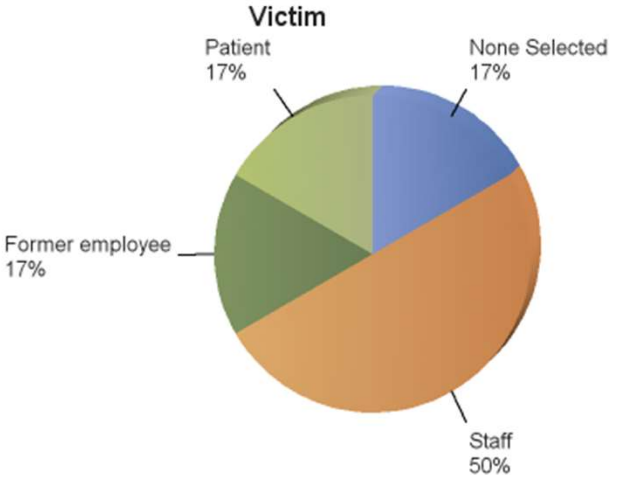
WORKPLACE VIOLENCE

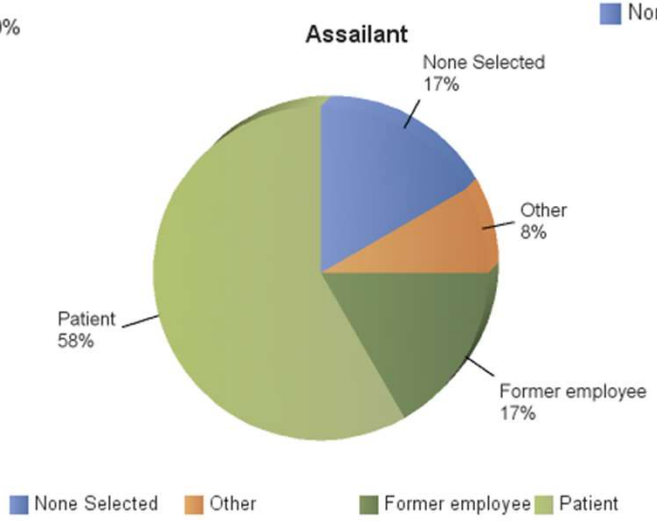


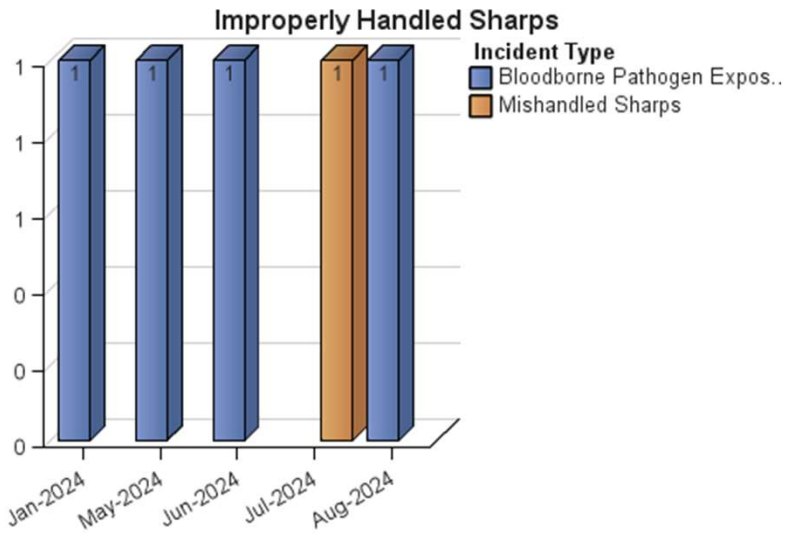
	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Total
Verbal abuse		2	1		1	4
None Selected		1		1		2
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1				1	2
Threat or the use or a weapon/object		1				1
Total	**1**	**4**	**1**	**1**	**2**	**9**

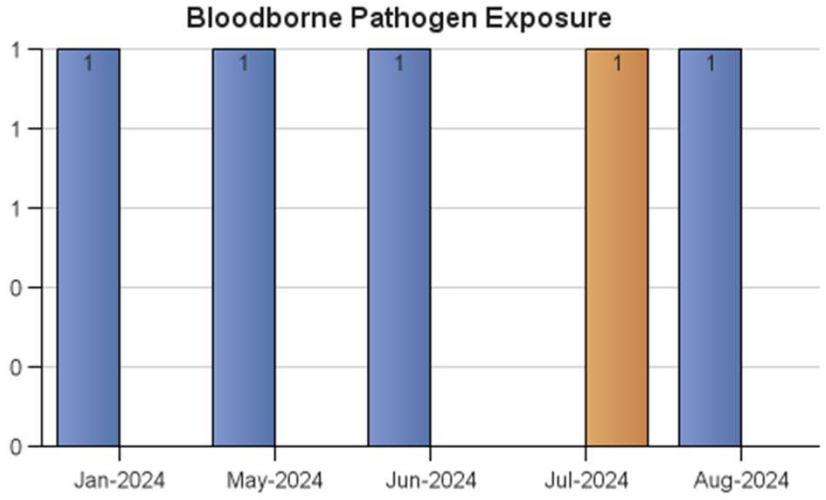
WORKPLACE VIOLENCE







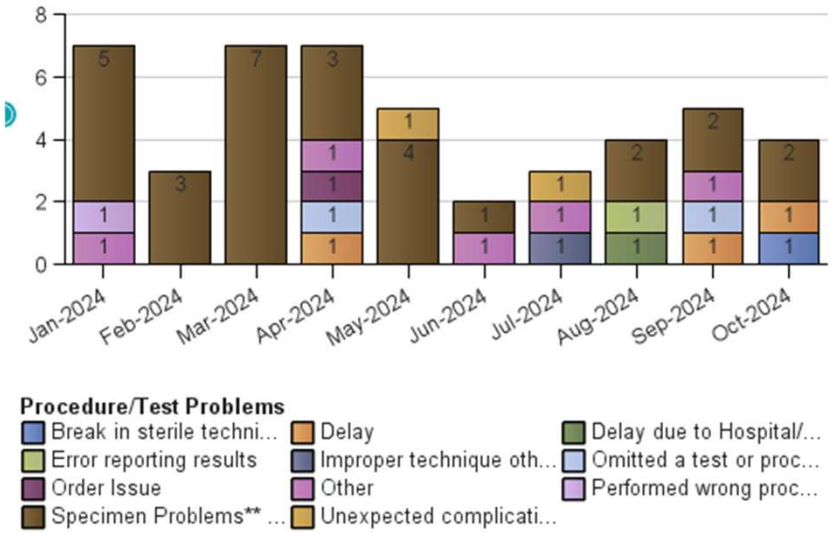




	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Mishandled Sharps				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

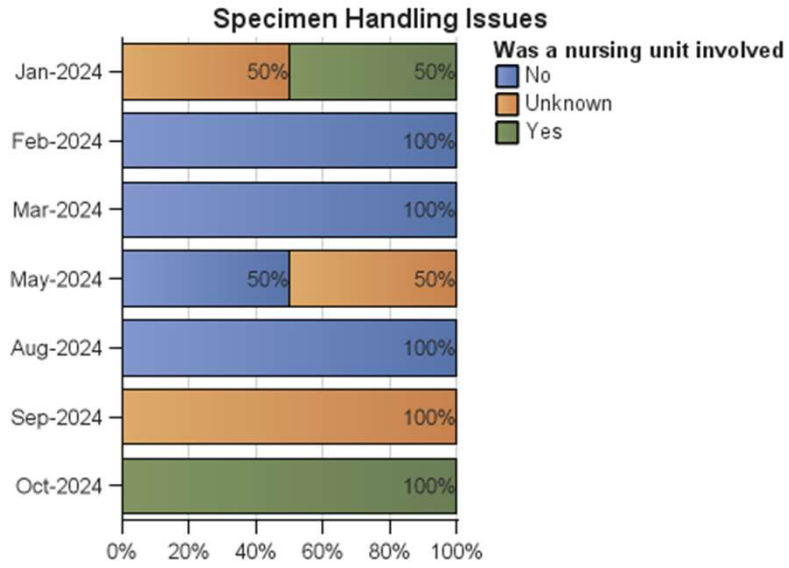
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

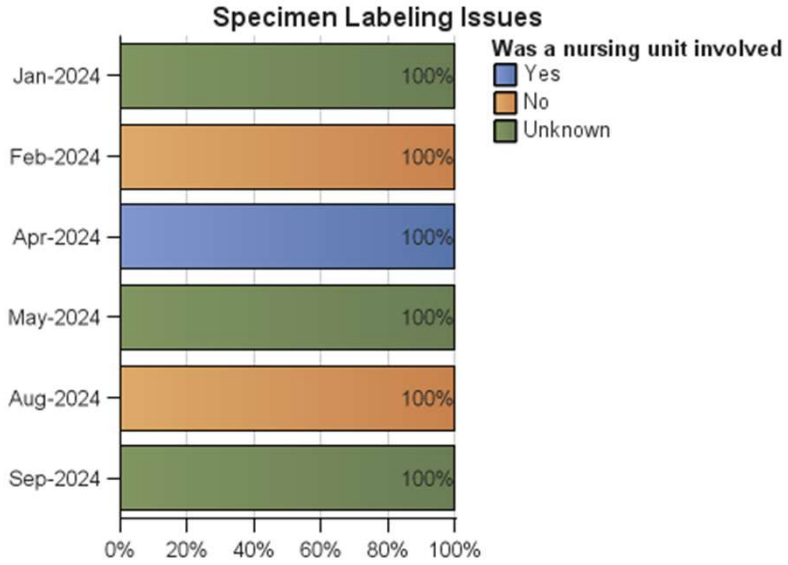
UOR's Related Diagnostic Services



	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Break in sterile technique										1	1
Delay				1					1	1	3
Delay due to Hospital/Radiology systems problems or communication issues								1			1
Error reporting results								1			1
Improper technique other than a break in sterile technique							1				1
Omitted a test or procedure				1					1		2
Order Issue				1							1
Other	1			1		1	1		1		5
Performed wrong procedure	1										1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	5	3	7	3	4	1		2	2	2	29
Unexpected complications					1		1				2
Total	**7**	**3**	**7**	**7**	**5**	**2**	**3**	**4**	**5**	**4**	**47**

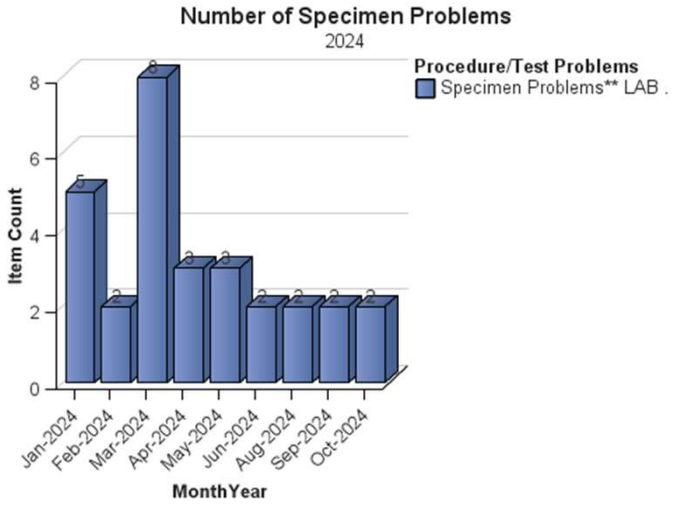
See new reports in the following pages

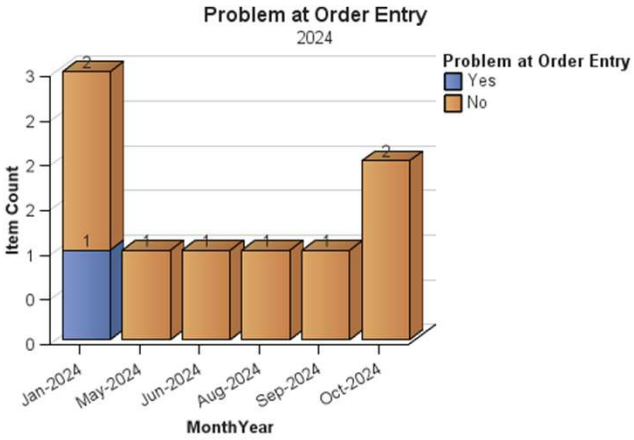


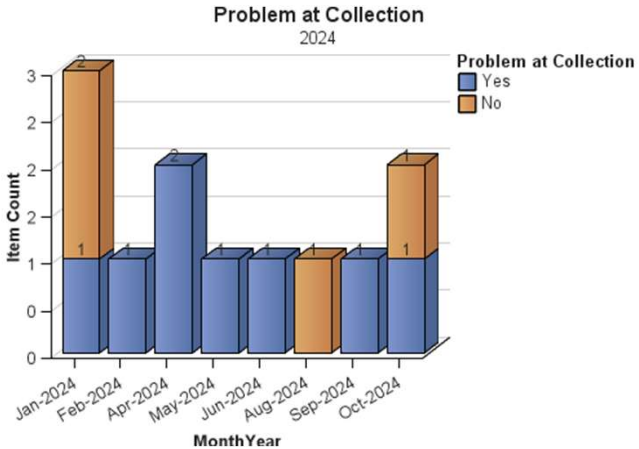


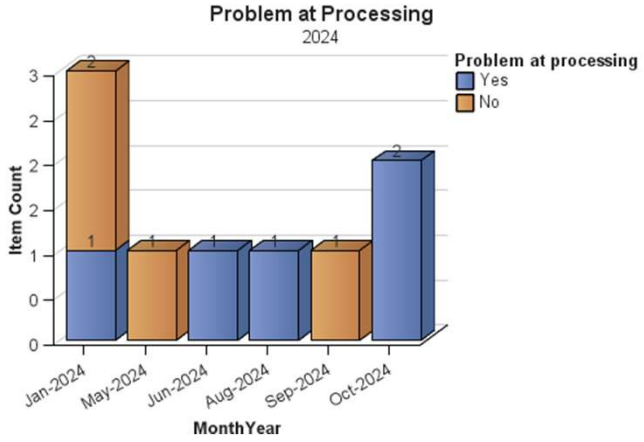
	Jan-2024	Feb-2024	Mar-2024	May-2024	Aug-2024	Sep-2024	Oct-2024	Total
No		1	7	1	1			10
Unknown	1			1		1		3
Yes	1						1	2
Total	**2**	**1**	**7**	**2**	**1**	**1**	**1**	**15**

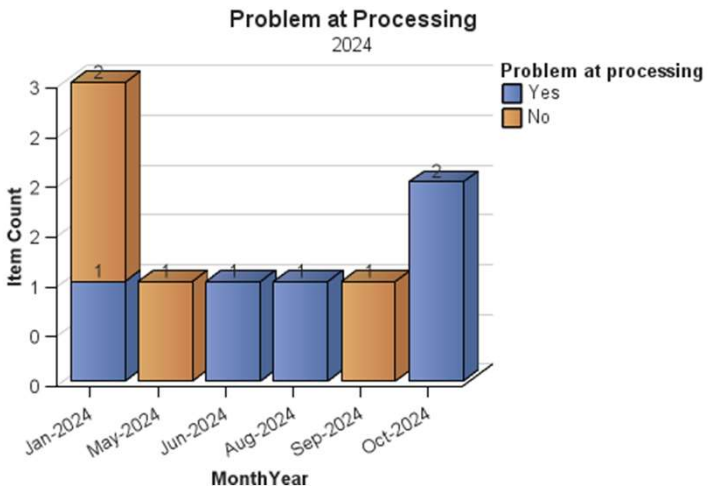
	Jan-2024	Feb-2024	Apr-2024	May-2024	Aug-2024	Sep-2024	Total
Yes			2				2
No		1			1		2
Unknown	1			2		1	4
Total	**1**	**1**	**2**	**2**	**1**	**1**	**8**

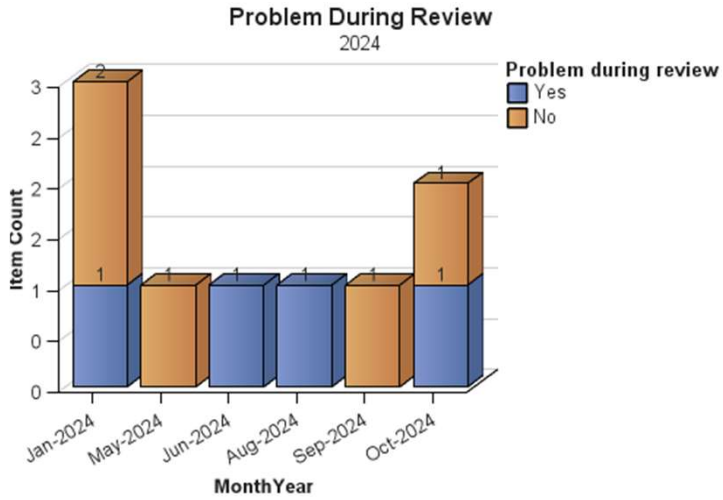

Number of Specimen Problems
2024
Procedure/Test Problems
Specimen Problems** LAB .
Item Count
MonthYear
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

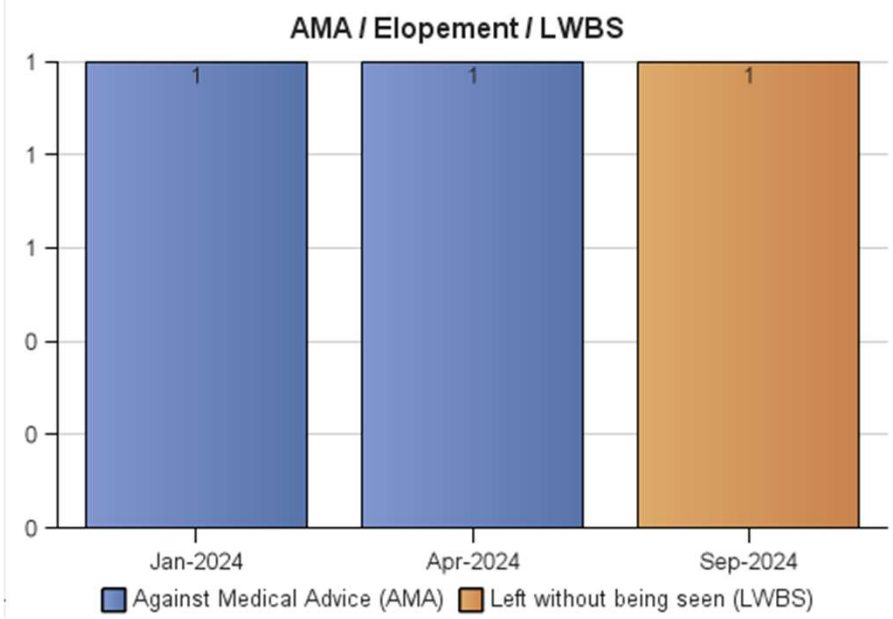

Problem at Order Entry
2024
Problem at Order Entry
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Collection
2024
Problem at Collection
Yes
No
Item Count
MonthYear
Jan-2024
Feb-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Processing
2024
Problem at processing
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Processing
2024
Problem at processing
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

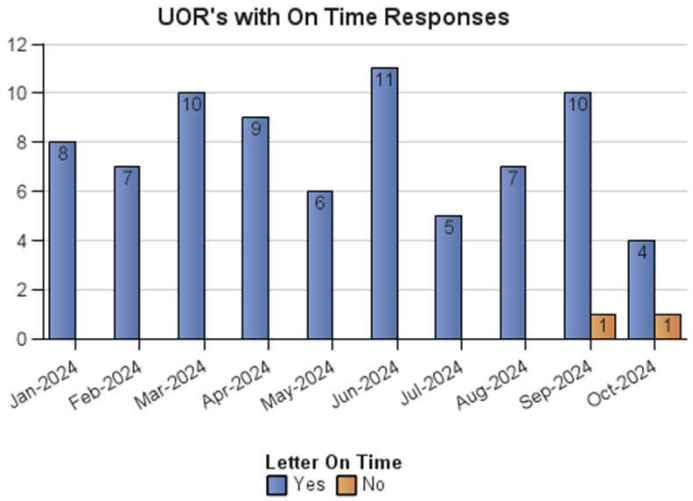

Problem During Review
2024
Problem during review
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024



	Jan-2024	Apr-2024	Sep-2024	Total
Against Medical Advice (AMA)	1	1		**2**
Left without being seen (LWBS)			1	**1**
Total	**1**	**1**	**1**	3

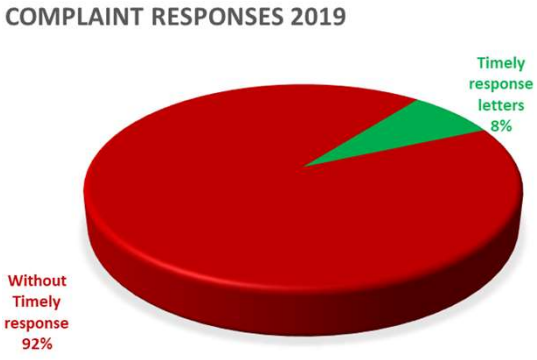
AMA – Against Medical Advice
LWBS – Left Without Being Seen

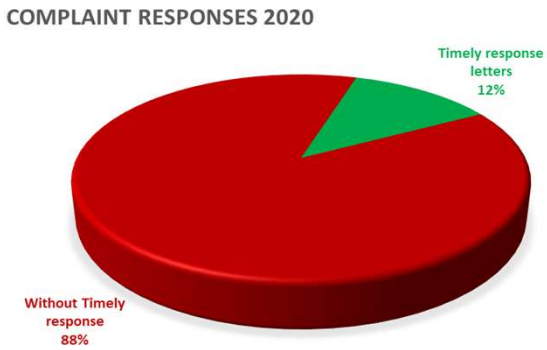
Jan-2024	8
Feb-2024	7
Mar-2024	10
Apr-2024	9
May-2024	6
Jun-2024	11
Jul-2024	5
Aug-2024	7
Sep-2024	11
Oct-2024	5
Total	**79**

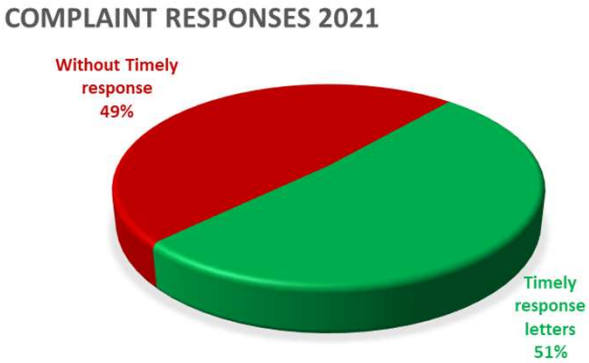


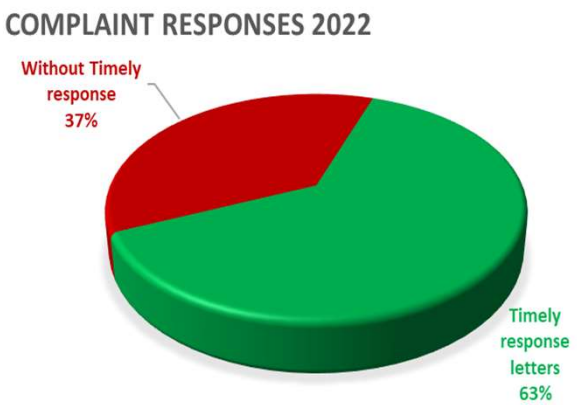
	Yes	No	Total
Jan-2024	8		**8**
Feb-2024	7		**7**
Mar-2024	10		**10**
Apr-2024	9		**9**
May-2024	6		**6**
Jun-2024	11		**11**
Jul-2024	5		**5**
Aug-2024	7		**7**
Sep-2024	10	1	**11**
Oct-2024	4	1	**5**
Total	**77**	**2**	**79**

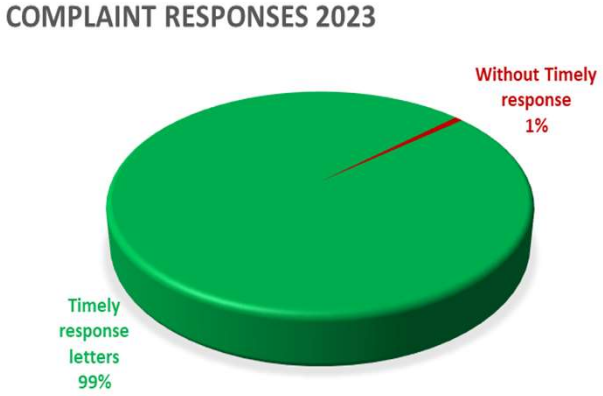
*April 2024 – One letter had previously been marked untimely; however, it was a date calculation error.







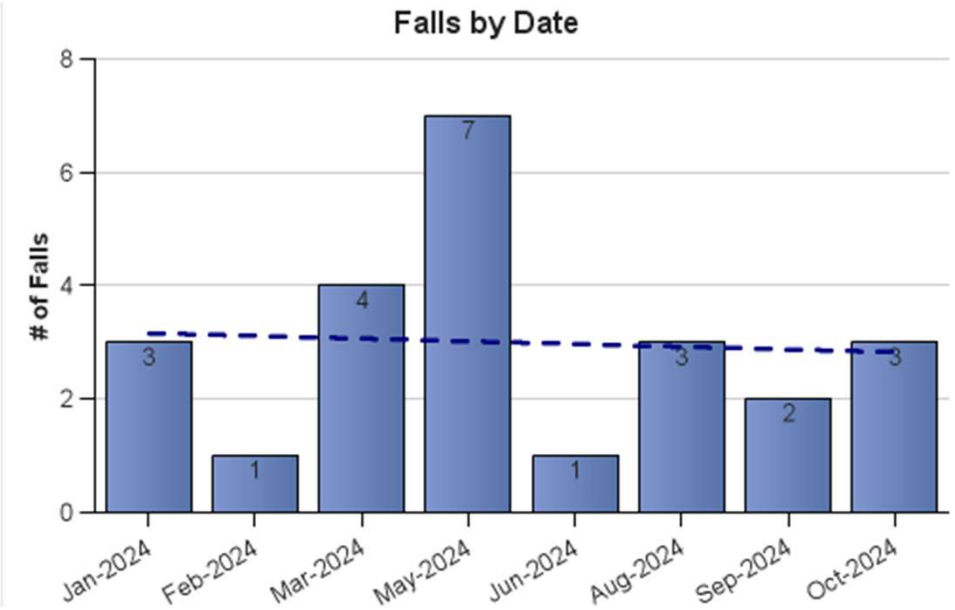




2024
10 months

Goal is 100% Green (timely responses)

On average, a time frame of seven (7) business days for the provision of the response is the NIHD standard. (Requirement from NIHD POLICY)



# of Falls	Was there any injury?			
	Not Identified	Unknown	No	Total
Not Identified	7			7
ED	1		1	2
Inpatient		2	5	7
Outpatient	8			8
Total	**16**	**2**	**6**	**24**

# of Falls	Falls/Slip Problem(s)								Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Other	Other Person	
Not Identified	1	3		1	1	6	3	1	16
Confused		2	1						3
Oriented		2	3	1					6
Total	**1**	**7**	**4**	**2**	**1**	**6**	**3**	**1**	**25**

# of Falls	Falls/Slips	Total
Dietary	1	1
ED	2	2
EVS	1	1
Imaging	1	1
Medical Surgical Unit	7	7
OB	1	1
Other	3	3
Rehab Services - PT/OT/ST	6	6
Specialty Clinic	1	1
Surgery	1	1
Total	**24**	**24**

# of Falls	Was the Patient Assessed for Fall Risk		
	Not assessed	Yes	Total
Workforce	7		7
Outpatient	8		8
Inpatient		7	7
ED	1	1	2
Total	**16**	**8**	**24**

# of Falls	Was the Patient Assessed for Falls Protocol		
	Not assessed	Yes	Total
Workforce	7		7
Outpatient	8		8
Inpatient		7	7
ED	1	1	2
Total	**16**	**8**	**24**

# of Falls	Received a Sedative w/in the Last 4 Hours			
	Not assessed	Yes	No	Total
Workforce	7			7
Outpatient	8			8
Inpatient		1	6	7
ED	1	1		2
Total	**16**	**2**	**6**	**24**

# of Falls	The Patient Is			
	Not assessed	Oriented	Confused	Total
Workforce	7			7
Outpatient	8			8
ED	1	1		2
Inpatient		5	2	7
Total	**16**	**6**	**2**	**24**

# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	7		7
ED	1	1	2
Inpatient		7	7
Outpatient	8		8
Total	**16**	**8**	**24**

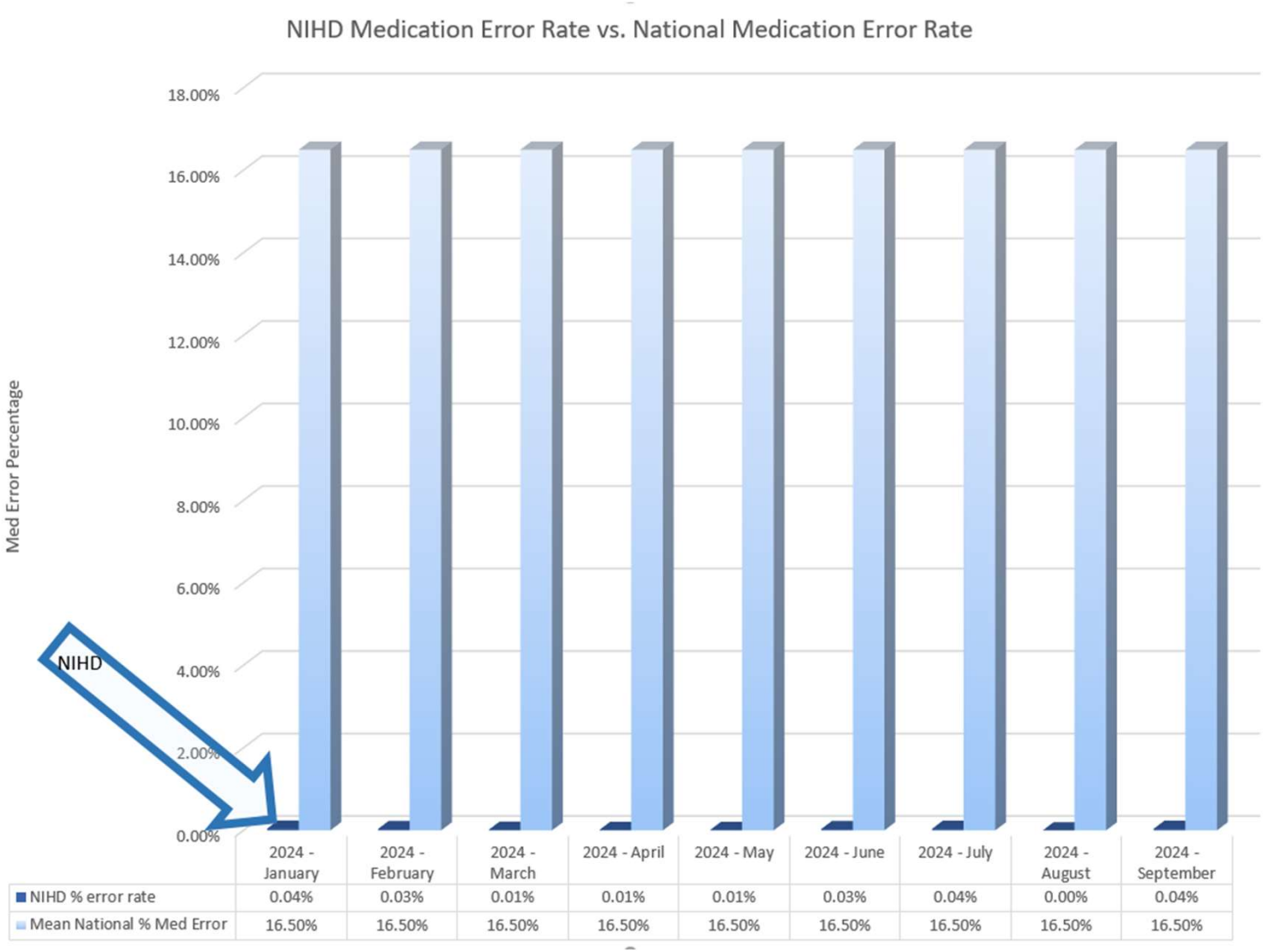
# of Falls	Siderails			
	Not assessed	Siderails down	Siderails up	Total
Workforce	7			7
Outpatient	8			8
ED	1	1		2
Inpatient		1	6	7
Total	**16**	**2**	**6**	**24**

# of Falls	Restraints		
	Not assessed	None	Total
Workforce	7		7
Outpatient	8		8
Inpatient		7	7
ED	1	1	2
Total	**16**	**8**	**24**

# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	7			7
Outpatient	8			8
Inpatient		3	4	7
ED	1	1		2
Total	**16**	**4**	**4**	**24**

# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	7			7
Outpatient	8			8
Inpatient		5	2	7
ED	1	1		2
Total	**16**	**6**	**2**	**24**

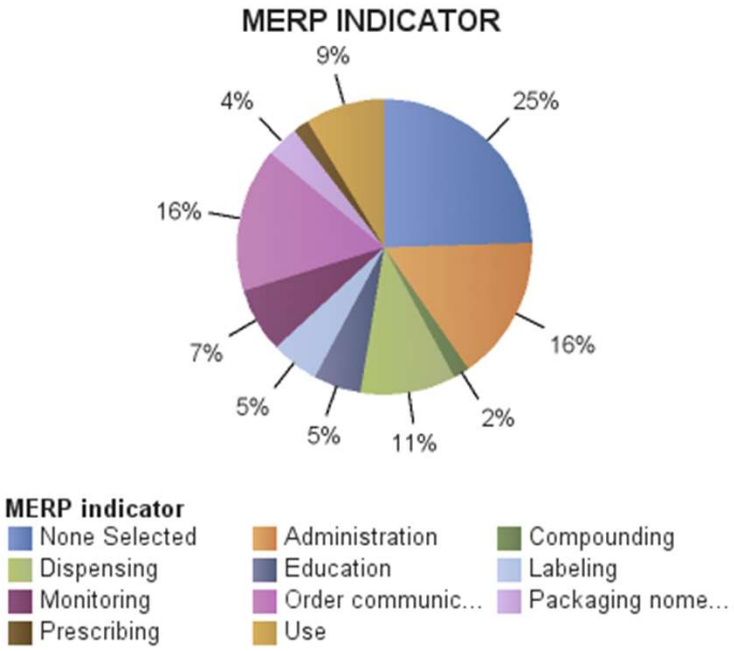
# of Falls	Fall Witnessed				Fall Alleged				Assisted to Floor				Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total
Not Identified	7			7	7			7	7			7	7			7
ED	1		1	2	1	1		2	1	1		2	1		1	2
Inpatient	1	4	2	7	5		2	7	3	3	1	7	3	1	3	7
Outpatient	8			8	8			8	8			8	8			8
Total	**17**	**4**	**3**	**24**	**21**	**1**	**2**	**24**	**19**	**4**	**1**	**24**	**19**	**1**	**4**	**24**


NIHD Medication Error Rate vs. National Medication Error Rate
Med Error Percentage
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
NIHD
2024 - January
2024 - February
2024 - March
2024 - April
2024 - May
2024 - June
2024 - July
2024 - August
2024 - September
NIHD % error rate 0.04% 0.03% 0.01% 0.01% 0.01% 0.03% 0.04% 0.00% 0.04%
Mean National % Med Error 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50% 16.50%

Data for previous slide

Month/Year	Total number of Medications administered	NIHD Total number of errors	NIHD % error rate	National % Medication Error	Mean National % Med Error	NIHD % Medication Administration accuracy	References
2024 - January	16,772	7	0.04%	8%-25%	16.50%	99.96%	In a review of 91 direct observation studies of medication errors in hospitals and long-term care facilities, investigators estimated median error rates of 8%–25% during medication administration.
2024 - February	12,671	4	0.03%	8%-25%	16.50%	99.97%	
2024 - March	13,815	2	0.01%	8%-25%	16.50%	99.99%	
2024 - April	14,886	2	0.01%	8%-25%	16.50%	99.99%	reference for above: https://psnet.ahrq.gov/primer/medication-administration-errors#:~:text=In%20a%20review%20of%2091,%E2%80%932
2024 - May	15,273	2	0.01%	8%-25%	16.50%	99.99%	Occurrences not included, as they are not errors that are administered to a patient.
2024 - June	12,566	4	0.03%	8%-25%	16.50%	99.97%	
2024 - July	16,173	6	0.04%	8%-25%	16.50%	99.96%	
2024 - August	15,416	0	0.00%	8%-25%	16.50%	100.00%	None reported. Will review.
2024 - September	16,221	6	0.04%	8%-25%	16.50%	99.96%	

Medication Error Reduction Plan (MERP)

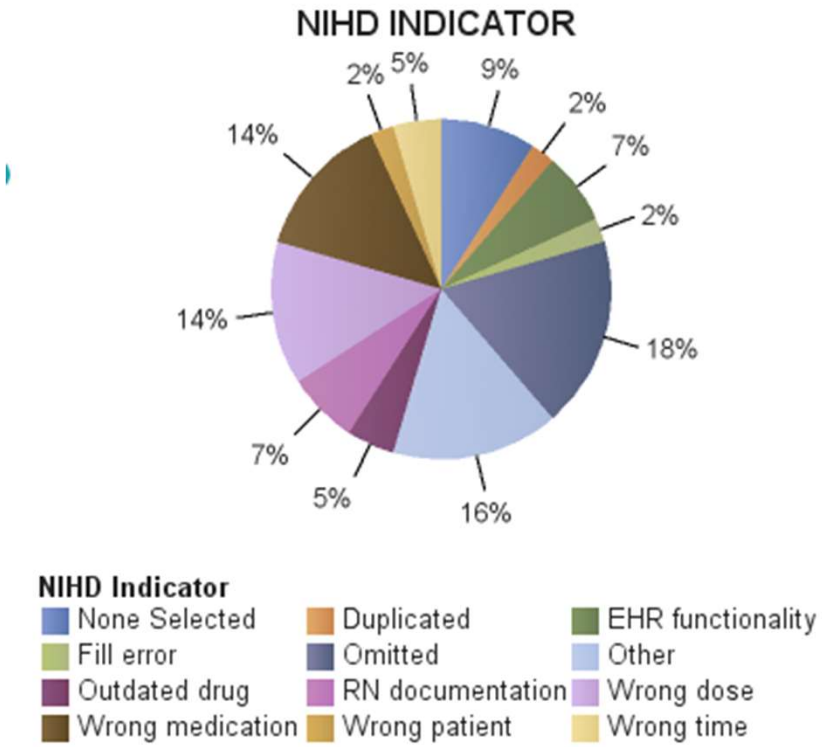


None Selected	14
Administration	9
Compounding	1
Dispensing	6
Education	3
Labeling	3
Monitoring	4
Order communication	9
Packaging nomenclature	2
Prescribing	1
Use	5
Total	**57**

	# of Errors	# of Occurrences	Total
Jan-2024	7	3	**10**
Feb-2024	4		**4**
Mar-2024	2	1	**3**
Apr-2024	2	1	**3**
May-2024	2	3	**5**
Jun-2024	4	3	**7**
Jul-2024	6	1	**7**
Sep-2024	6		**6**
Oct-2024	3	1	**4**
Total	**36**	**13**	**49**

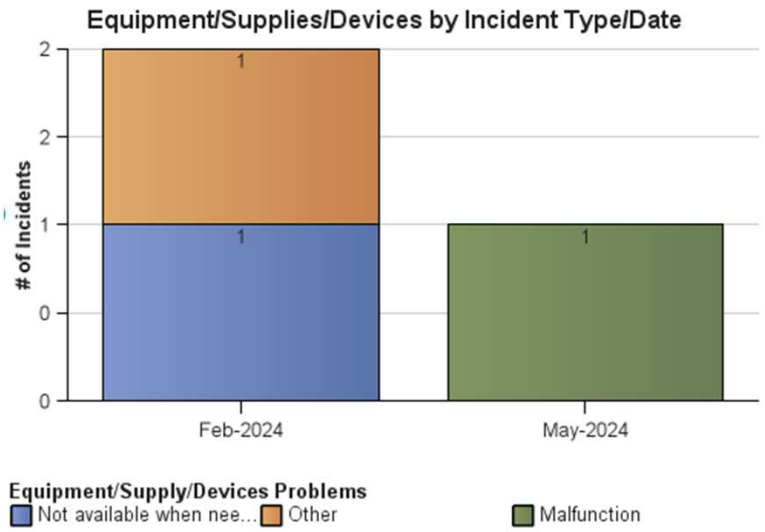
All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

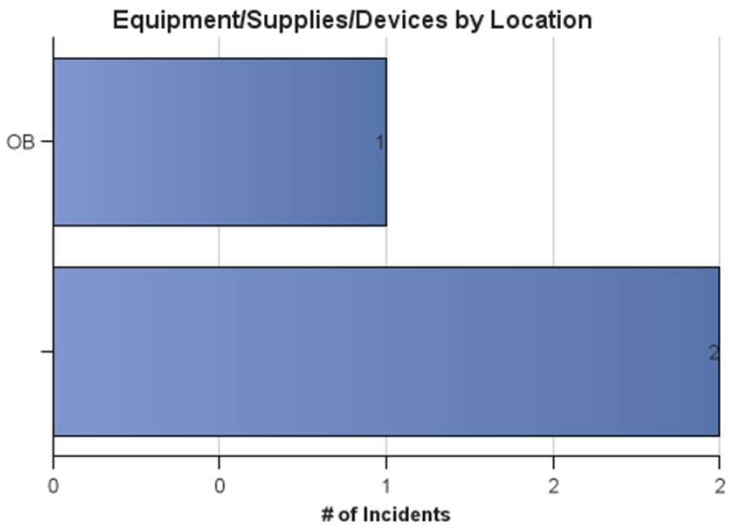
Medication errors are errors that reach the patient. Medication occurrences are errors that are caught before they reach the patient.



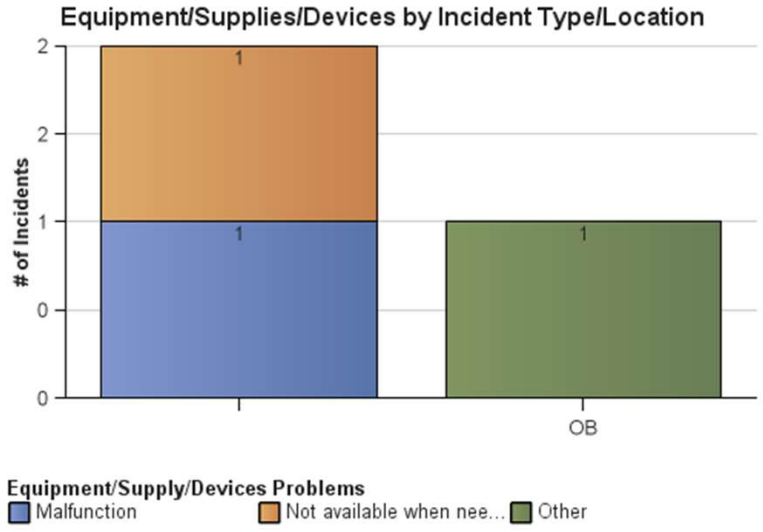
None Selected	4
Duplicated	1
EHR functionality	3
Fill error	1
Omitted	8
Other	7
Outdated drug	2
RN documentation	3
Wrong dose	6
Wrong medication	6
Wrong patient	1
Wrong time	2
Total	**44**

Total numbers of errors and occurrences are not equal to the indicators since some error/occurrences have more than one indicator.





No Data Available



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

DATE: December 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Robin Christensen, Manager of Employee Health and Infection Control

RE: Employee Health and Infection Control – FY 2025 Q1

Introduction

This report provides an update on NIHD current infection prevention strategies and Employee Health. The goal is to ensure the Board of Directors is informed about our ongoing efforts, recent outcomes, and future plans to maintain a healthy and safe workplace.

Focus Areas

1. Reducing Infection Rates: Continuous monitoring and adaptation of infection prevention protocols.
2. Enhancing Patient and Employee Health & Safety: Provide education, vaccinations, and other employee health requirements to promote a culture of safety
3. Regulatory Compliance: Ensuring adherence to relevant infection control regulations and industry standards.

Goals: Goals are established each fiscal year and tracked through quarterly progress reports.

1. Annual Goal Setting: Goals are established each fiscal year and tracked through quarterly progress reports.
2. Regular Accountability: Regular updates are provided to committees to ensure oversight and accountability.

Pillars of Excellence

Focused on maintaining consistent standards of care and improving performance through robust quality assurance processes.

1. Quality: Aimed at continuously improving patient care outcomes, ensuring adherence to best practices, and delivering high-quality healthcare services.
2. Service: Ensuring exceptional patient experience through compassionate, efficient, and patient-centered care.
3. People: Investing in the development, support, and engagement of healthcare staff to enhance team performance and satisfaction.
4. Safety: Prioritizing patient and staff safety by proactively identifying risks and implementing safety protocols to reduce harm.
5. Finance: Managing financial resources effectively to ensure sustainability, optimize cost-efficiency, and align financial decisions with organizational goals.

Pillars: Color Legend

LEGEND	
	Best-in-Class Performance, Exceeds Goal
	Above Average, Meets Goal
	About Average, Does Not Meet Goal
	Below Average, Does Not Meet Goal

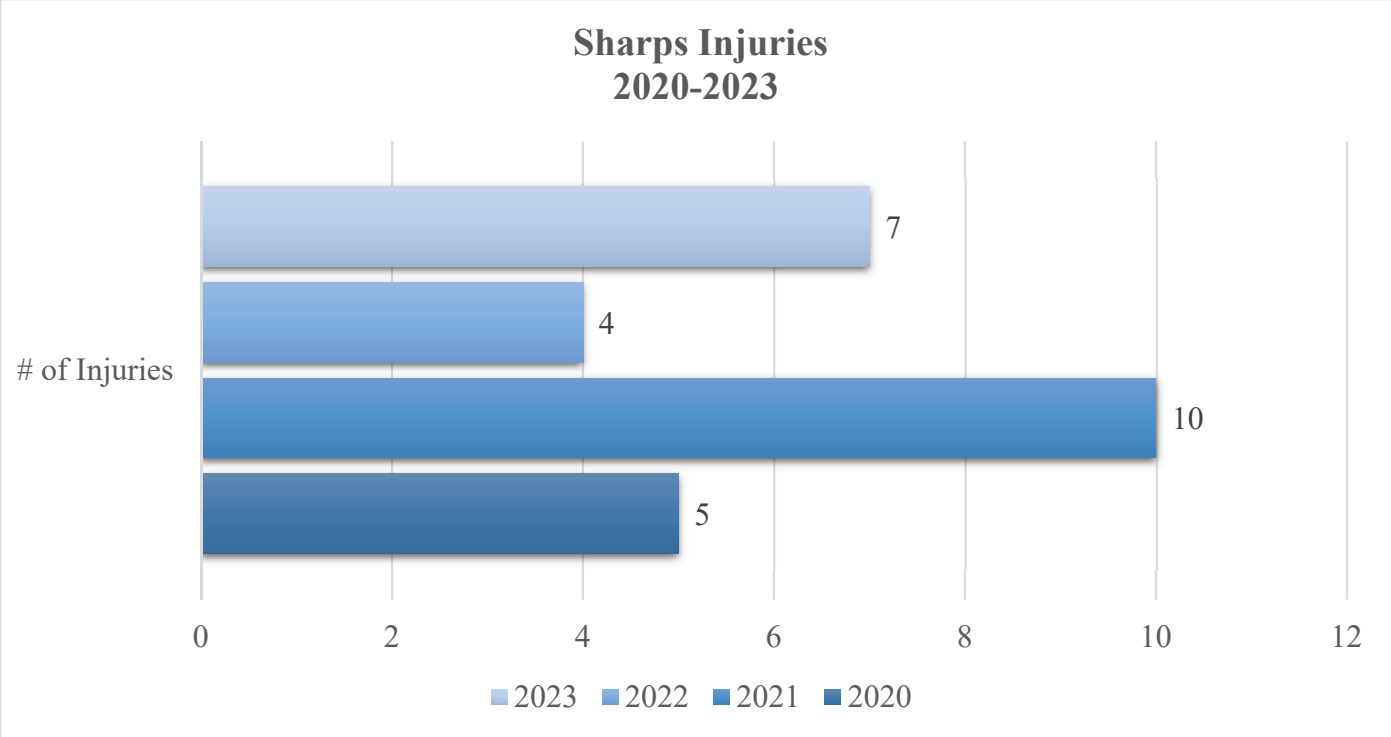
Important Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero. For example, on Surgical Site infections for Quarter 1, FY 15-16, we did not meet our goal of zero defects, but are still outperforming most of the country with an infection rate of 4 times LOWER than the national average of 2.0%.
2. Patient Satisfaction/Patient Experience-For each department the highest number of frequencies determines the overall assignment of Red (Below Average), Yellow (About Average), Green (Above Average), or Blue (Best in Class). It is recommended that specific performance categories be assessed by area leadership to identify opportunities for improvement.
3. Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal.

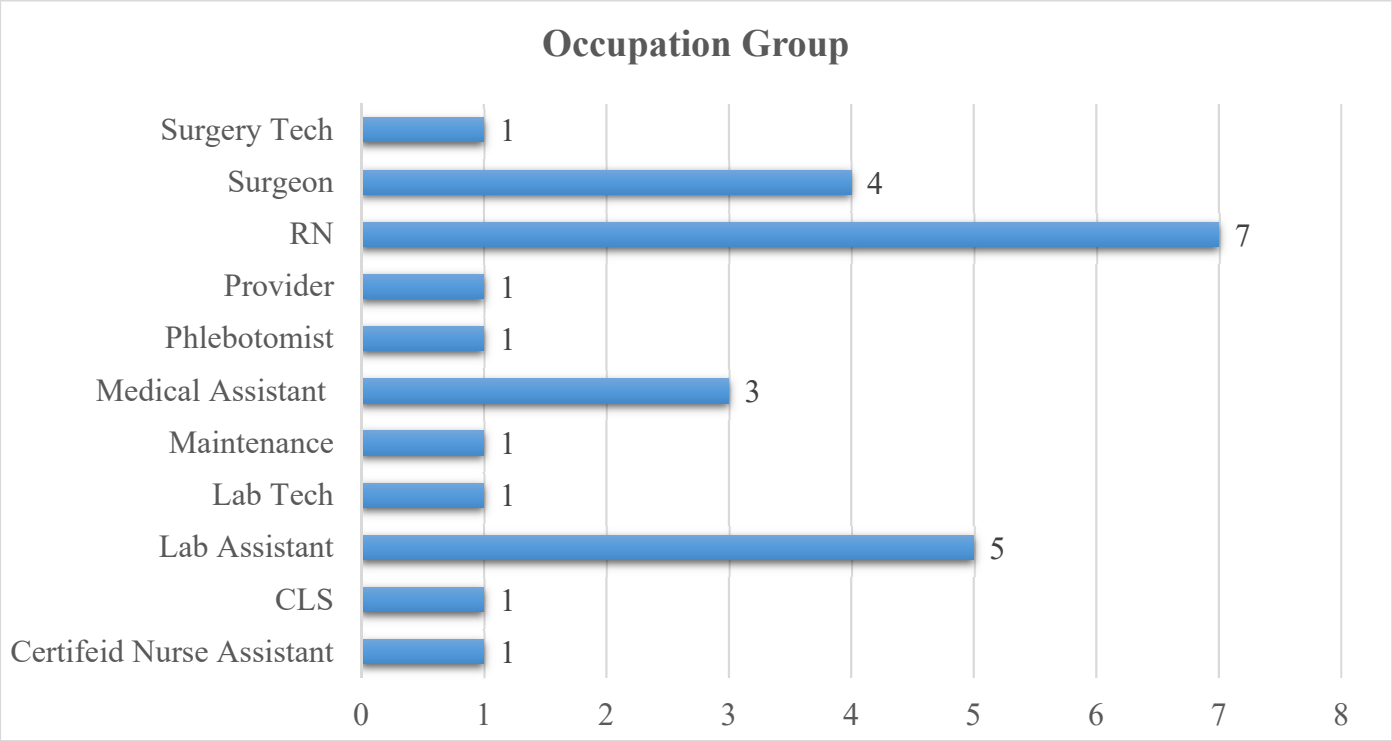
Sharps Committee

1. Objective: The goal of the Northern Inyo Healthcare District (NIHD) Sharps Prevention Program is to continue to progress in reducing the risk of sharps injuries to NIHD healthcare workforce, patients and visitors.
2. Goals
    a. Reduce incidence of sharps injuries by 10%
    b. Enhance healthcare worker education and training.
    c. Encourage and improve communication and feedback for healthcare workers to report safety concerns related sharps injuries.

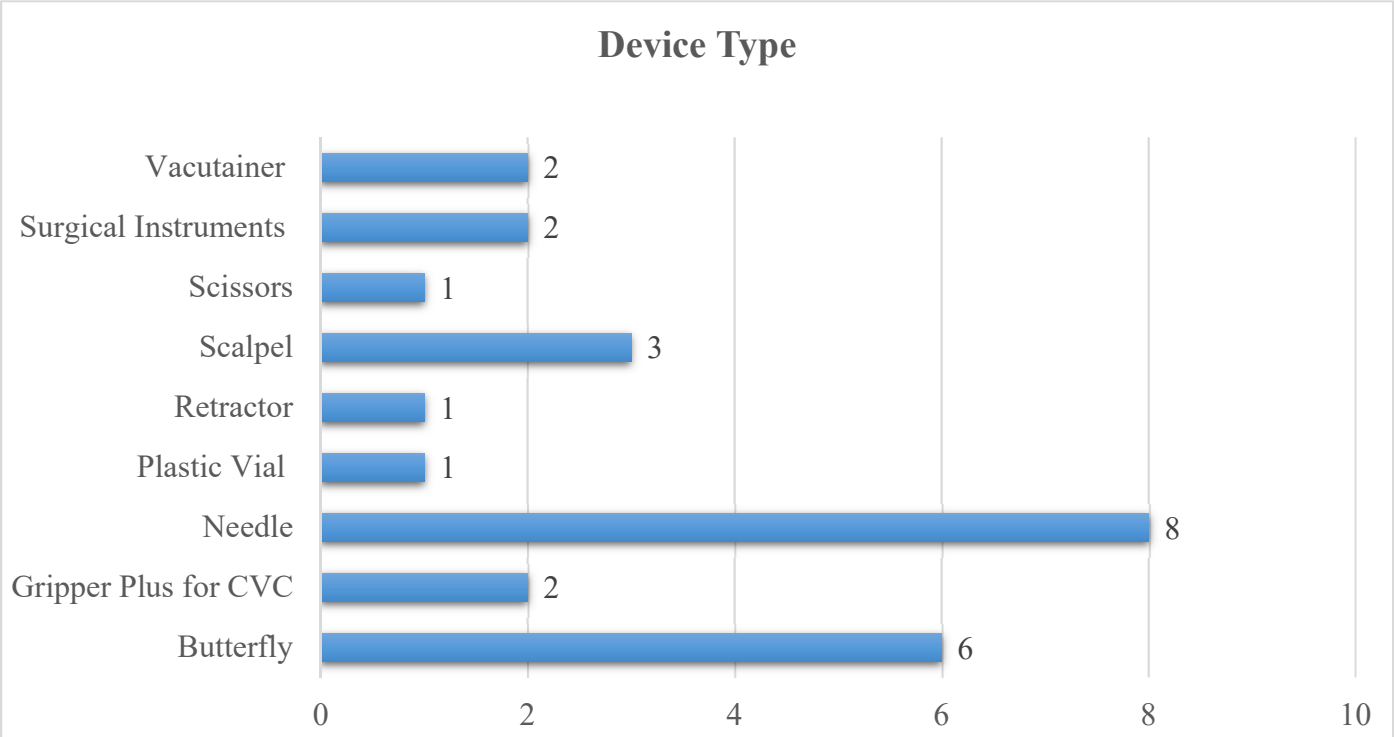
Sharps Injury Data
2020-2023 by Year



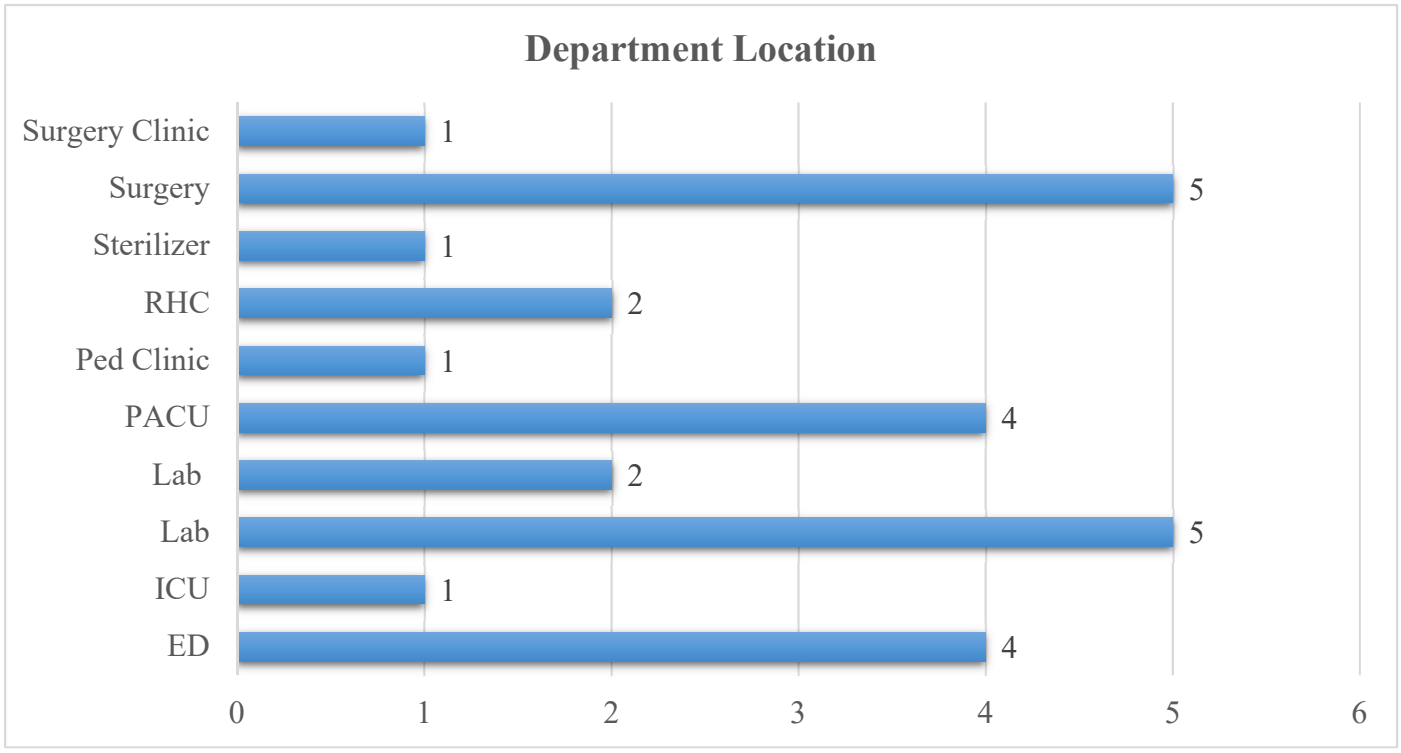
Sharps Injury Data
2020-2023 Occupation Group



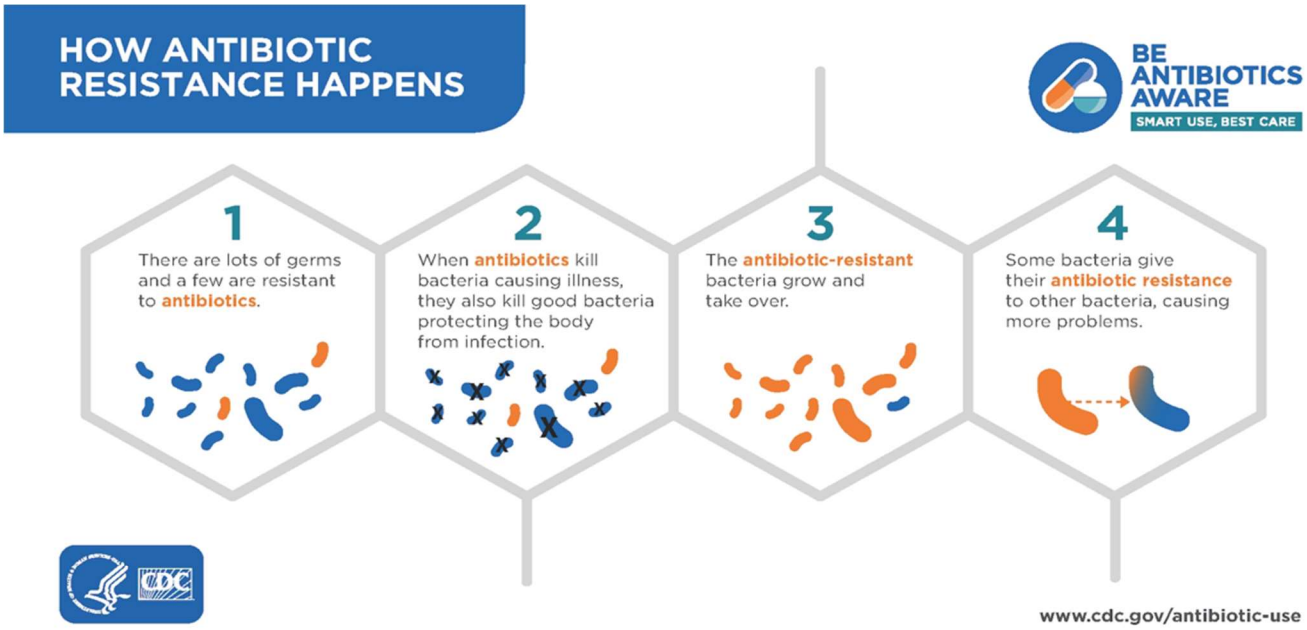
Sharps Injury Data
2020-2023 by Device Type

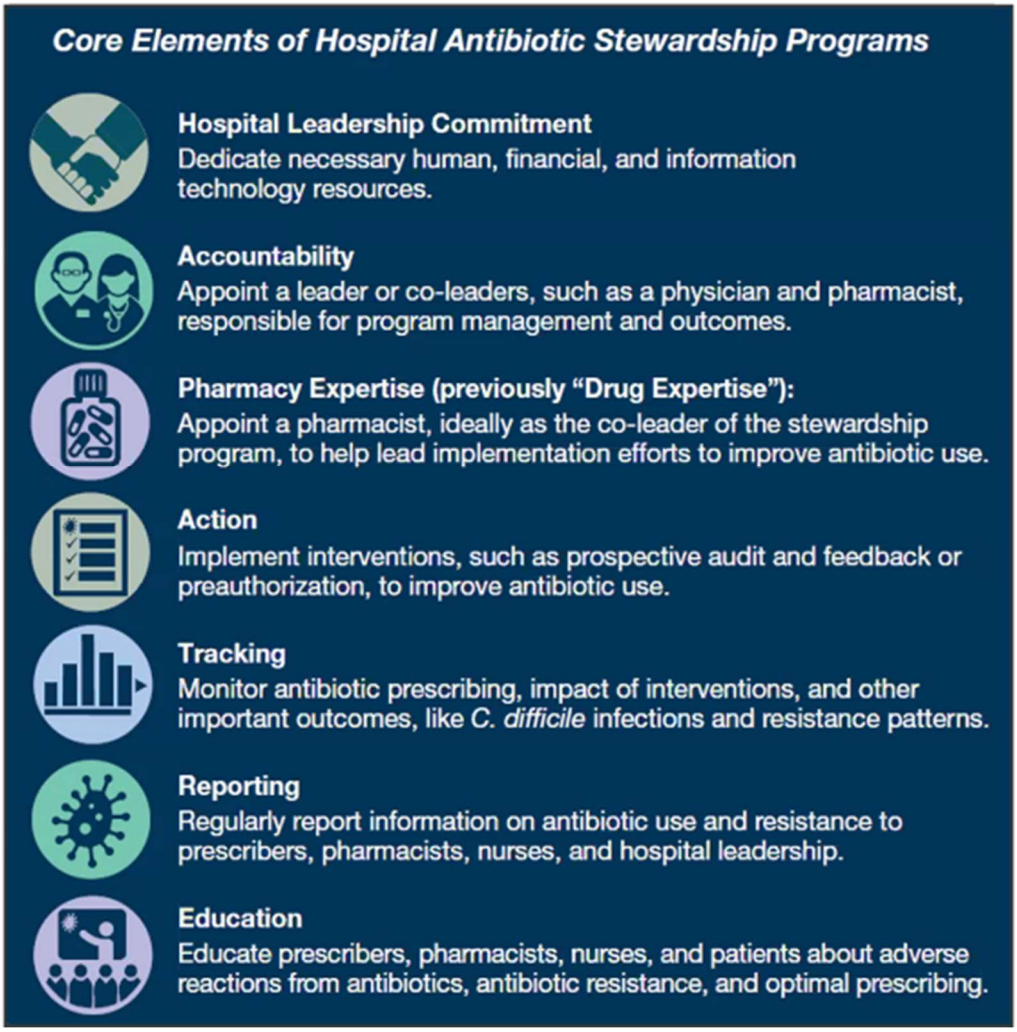


Sharps Injury Data
2020-2023 by Department Location



Antibiotic (ATB) Stewardship Concept

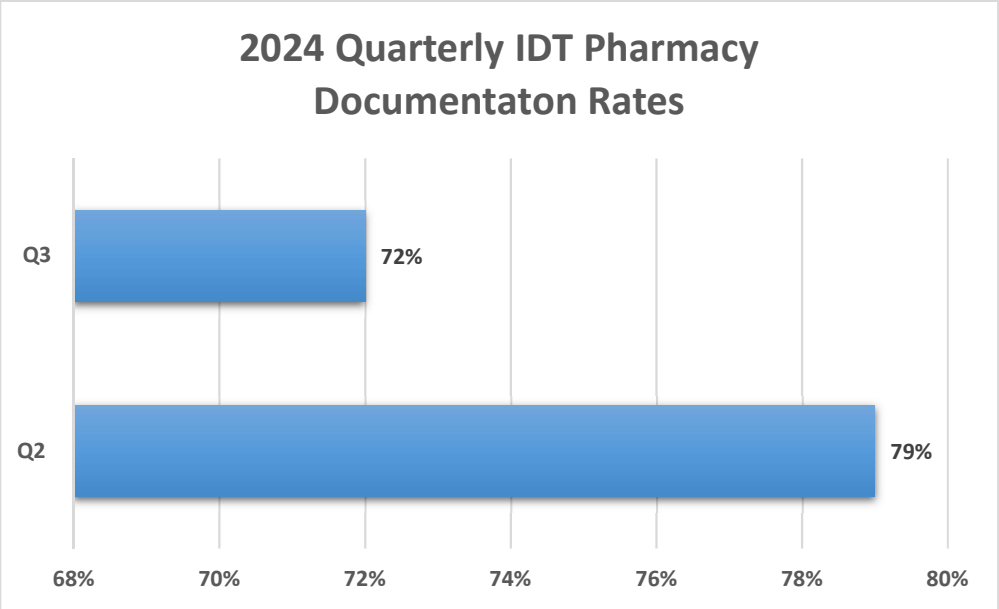




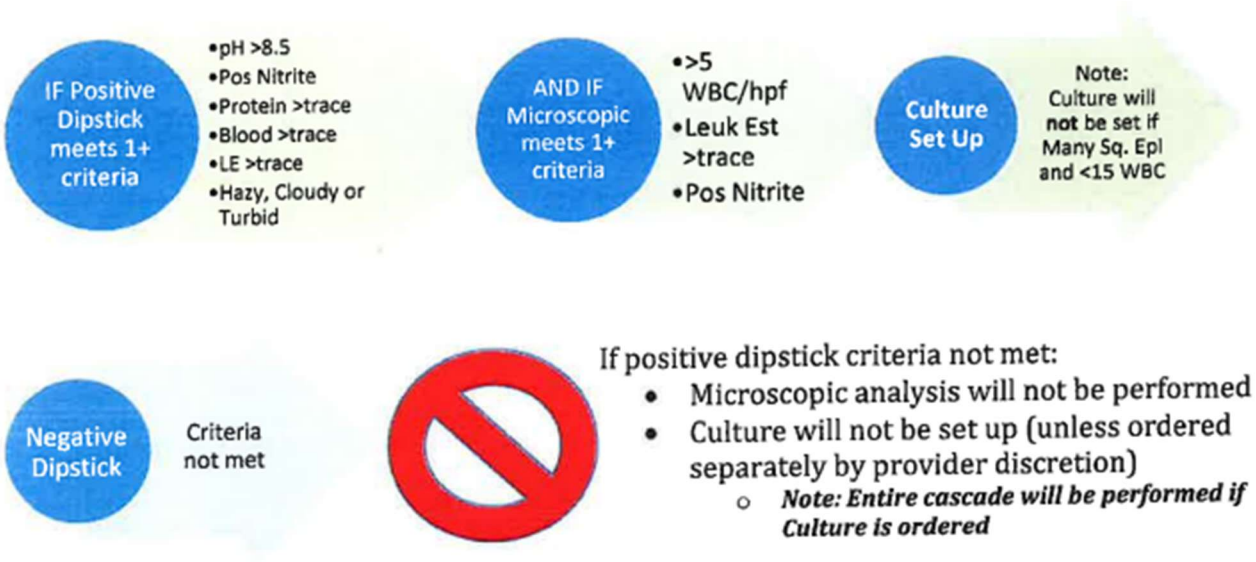
Antibiotic Stewardship

1. Objective
    a. To optimize the use of antibiotics in healthcare settings, ensuring the Right Drug "antibiotics" are used at the Right Time, for the Right Duration, and at the Right Dose. This is key to preventing antibiotic resistance, improving patient outcomes, and supporting overall infection prevention efforts.
    b. To comply with evidence-based guidelines or best practices by promoting the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration, and route of administration to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.
    c. Serves as the foundation of the commitment to continuously improve antimicrobial stewardship practices at Northern Inyo Healthcare District (NIHD) and to monitor outcomes and antimicrobial use.
2. Goals
    a. 80% - Improve communication and documentation within Electronic Health Record on antibiotic therapy with Inpatient Med-Surgical and ICU patients.
    b. Decrease mixed flora urine cultures throughout the organization.

3. Implementation Details
    a. Implement baseline tracking
    b. Baseline Data as of September 2023 – 17% (34/200)
    c. Build in Cerner – Urine cascade: urine dipstick analysis with microscopic analysis if indicated with culture if indicated
    d. Lab: Urinalysis Cascade Decision Tree Dated May 2024
    e. Letter to providers regarding cascade complete 6-13-2024
    f. Cerner order sets pending. Order code for cascade available
    g. Implementation of preservative tubes completed
    h. Staff and Patient Education Completed. Instructional information for patients available in English and Spanish
    i. Cerner Urine Culture Reports created in Cerner. Manually auditing is still required.



Urine Cascade Logic



Antibiotic (ATB) Stewardship Urine Result Tracker

Total Urine cultures	Month	Work-up	No growth	Normal flora	Contamination	HOLD	Amend
176	March	63	9	66	34	4	0
173	April	47	24	67	24	11	3
197	May	57	16	86	18	20	6
	June	Implementation Urine Cascade 6/13/2024					
177	July	58	16	59	27	17	2
	August						
	September						
	October						
	November						
	December						

Infection Prevention Tracers

1. Objective: To enhance infection prevention practices through targeted tracer and rounding activities that focus on improving staff education, ensuring survey readiness, and strengthening infection control measures throughout the hospital.
2. Goals
    a. Improve infection prevention practices and compliance hospital-wide.
    b. Ensure readiness for infection control and prevention surveys.
    c. Enhance staff education and awareness of infection prevention best practices.
3. Implementation Details
    a. The number of tracer activities in clinical areas will be determined at a later time.
    b. Rounding frequency will be based on patient census and the presence of specific devices (e.g., Foley catheters, central lines, etc.).
4. Report
    a. Data will be tracked and reported on compliance rates, specifically the percentage of compliance observed during tracer rounds.

NORTHERN INYO HOSPITAL

Nursing Services
Department: Employee Health
Pillars of Excellence: FY 2025
July 1, 2024-June 30, 2025

Indicator	Baseline	Goal	FY Q1	FY Q2	FY Q3	FY Q4	FY YTD
Service	Data FY 2024 251 total						
Number of NIHD workforce on boarded		NA					
a. Employees on Payroll	a. 98		a. 22	a.	a.	a.	a. 22
b. Travelers	b. 43		b. 15	b.	b.	b.	b. 15
c. Providers	c. 30		c. 8	c.	c.	c.	c. 8
d. Medical Students/APP/PA	d. 22		d. 2	d.	d.	d.	d. 2
e. Clinical Students (ex: Rehab, LVN)	e. 2		e. 0	e.	e.	e.	e. 0
f. Volunteers	f. 2		f. 0	f.	f.	f.	f. 0
	197 total						
Number of NIHD workforce off boarded		NA					a. 18
a. Employees on Payroll	a. 106		a. 18	a.	a.	a.	b. 12
b. Travelers	b. 39		b. 12	b.	b.	b.	c. 3
c. Provider	c. 21		c. 3	c.	c.	c.	d. 3
d. Medical Students/APP/PA	d. 19		d. 3	d.	d.	d.	e. 0
e. Clinical Students (ex: Rehab, LVN)	e. 1		e. 0	e.	e.	e.	f. 0
f. Volunteers	f. New		f. 0	f.	f.	f.	
	186 total						
Number of Workforce Cancelled	NEW	N/A					
a. Employees on Payroll			a. 4	a.	a.	a.	a. 4
b. Travelers			b. 0	b.	b.	b.	b. 0
c. Provider			c. 0	c.	c.	c.	c. 0
d. Medical Students/APP/PA			d. 0	d.	d.	d.	d. 0
e. Clinical Students (ex: Rehab, LVN)			e. 0	e.	e.	e.	e. 0
f. Volunteers			f. 0	f.	f.	f.	f. 0

Indicator	Baseline	Goal	FY Q1	FY Q2	FY Q3	FY Q4	FY YTD
Service	Data FY 2024 251 total						
Quality							
1. Total Number of Employees Injured due to unsafe Safe Patient Handling	1	0	0				
2. Number of NIHD Workforce with TB conversion	1	NA	0				
3. Percentage of HCW Influenza vaccinated	434/632 69%	≥ 72%	NA	358/582 62%			358/582 62%
4. Percentage of HCW with Documented declination	153/632 24%	< 21 %	NA	26/582 4%			26/582 4%
4. Percentage of HCW with Medical Contraindications.	NA	NA	NA	3/582 0.5%			3/582 0.5%
5. Number of HCW with Unknown Status **Note: Per CMS/CDC guidelines this will be counted as declination*	43/632 7%	< 7%	NA	195/582 33.5%			195/582 33.5%
People							
1. # Department Ergonomic/Safety Rounds completed	15	15	1				1
2. Total Number of NIHD Workforce Workstation Assessments	FY 24: 17 FY 23: 29	No goal	12				12
3. Workstation assessments that became department Projects/shared space	New	No goal	2				2

***Quality #3-4-5: Flu vaccination summary 10/31/24 1400**

582 Total HCW on site as of 10/1/24

Vaccinated	358	62%
Signed Declinations	26	4%
Medical Contraindications	3	0.5%
Unknown status	195	33.5%

Unknown vaccination status

Employees	119
Providers	51
Contractors/Travelers (on site)	6
Students	1
Volunteers	15
Separated	3

NORTHERN INYO HOSPITAL

Nursing Services
Department: Infection Prevention
Pillars of Excellence: FY 2025
July 1, 2024-June 30, 2025

Indicator	Baseline	Goal	FY Q1	FY Q2	FY Q3	FY Q4	FY YTD
Service	Data FY 2024						
1. Monthly NIHD Blood Culture Contamination Rates *Note: See Monthly/CY Below Screen shots*	FY 2024 1.7%	<= 3%	July 3.9 Aug 3.6 Sept 1.4 8.9/3 3%	2.7			July 3.9 Aug 3.6 Sept 1.4 8.9/3 3%
2. C-Diff Standard Infection Ratio (SIR) SIR=: # of Hospital Onset Infections Predicted # if Infection *Note: See SIR definition below*	0.715	<=1	0 # predicted 0.189				0 # predicted 0.189
Quality Control							
1. Carbapenem-Resistant Organisms (CRO) or Carbapenem- Resistant Producing (CPO) results	8	New	1				1
Quality							
1. Hand Hygiene compliance per W.H.O guidelines a. N= Compliant D =Observed	95% N= 1542 D= 1616	96%	98% N = 470 D = 477				98% N = 470 D = 477
People							
1. Total Healthcare Workers exposure to Blood borne Pathogens							
a Blood via percutaneous sharps injury	9	7	1				1
b Blood splash or spray to mucous membranes.	0	2	1				1

Indicator	Baseline	Goal	FY Q1	FY Q2	FY Q3	FY Q4	FY YTD
Finance							
1. The number of CLABSI Reported to NHSN (Patient Days)	0 99	0	0 34				0 34
2. The Number of : a. Catheter Associated UTI's (CAUT's) b. B. Non-Catheter reported to NHSN	a. 0 b. 1	a. 0 b. 0	a. 0 b. 0 75				a. 0 b. 0 75
3. Number of Hospital Onset C-diff *PD = # Total InPt days **w/out** baby, Incl. OBS & Swing*	0 PD 3235	0	0 PD 856	1			0 PD 856
4. The number Surgical Site Infections (SSI) Reported to **NHSN** a. Superficial Incisional (SIP) b. Deep Incisional Primary (DIP) **c.** Organ Space	6 a. 1 b. 2 c. 3	0	3 a. 2 b. 0 c. 1				3 a. 2 b. 0 c. 1
5. Number of NHSN Reportable Surgeries with **PATOS** when SSI identified a. Superficial Incisional (SIP) b. Deep Incisional Primary (DIP) **c.** Organ Space	NEW a. 0 b. 0 c. 1	0	 a. 0 b. 0 c. 0				 a. 0 b. 0 c. 0
6. The number Surgical Site Infections (SSI) Reported **Internally** a. Superficial Incisional (SIP) b. Deep Incisional Primary (DIP) c. Organ Space	 a. b. c. 1	0	 a. 0 b. 0 c. 0				 a. 0 b. 0 c. 0
7. Number of NHSN **non**-reported surgeries with PATOS when SSI identified. This include reportable Outpatient surgeries and internal reporting	a. 0 b. 1 c. 1		a. 0 b. 0 c. 0				a. 0 b. 0 c. 0

Overview SIR

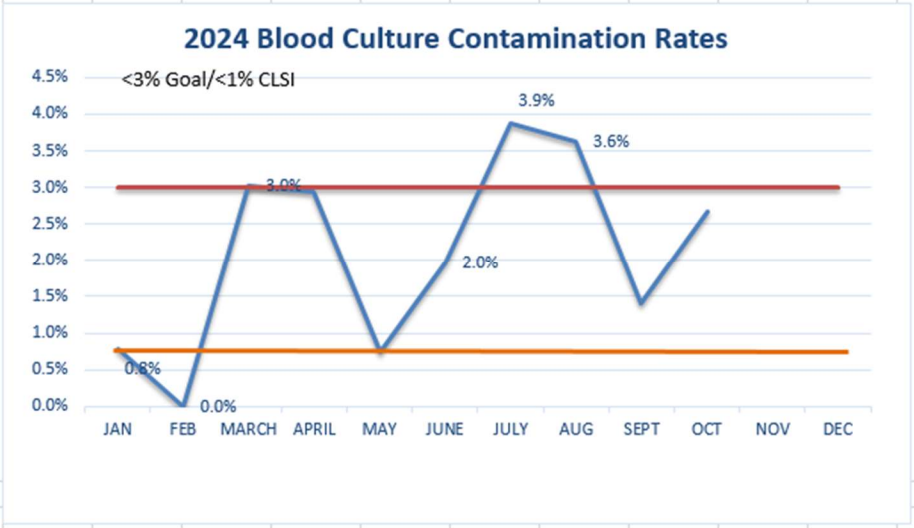
What is the SIR? The standardized infection ratio (SIR) is a summary measure used to track HAIs at a national, state, or local level over time. The SIR adjusts for various facility and/or patient-level factors that contribute to HAI risk within each facility. The method of calculating an SIR is similar to the method used to calculate the Standardized Mortality Ratio (SMR), a summary statistic widely used in public health to analyze mortality data.

In HAI data analysis, the SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population (i.e., NHSN baseline), adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. In other words, an SIR greater than 1.0 indicates that more HAIs were observed than predicted; conversely, an SIR less than 1.0 indicates that fewer HAIs were observed than predicted.

2024 Contaminated Blood Cultures

Northern Inyo Hospital Collections

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	2024
% Contaminated	0.8%	0.0%	3.0%	2.9%	0.7%	2.0%	3.9%	3.6%	1.4%	2.7%			
Benchmark (NIHD)	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
2022 Benchmark (CLSI)	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Total # Blood Culture	128	89	99	102	136	102	103	110	143	112			
# Contaminated	1	0	3	3	1	2	4	4	2	3			



LD Form 480
January 2024

Dev. 3/1

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

DATE: December 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Alison Feinberg, Manager of Quality and Survey Readiness

RE: Quality – FY 2025 Q1

The Quality Department drives the development of quality and performance improvement activities, fulfilling the District's responsibility to ensure patients receive quality care that complies with regulatory and accreditation organization requirements.

The Quality Department oversees an interdisciplinary district-wide approach to monitor, assess, and improve patient care and services.

Components of Quality Care:

1. Safe
    a. Avoiding injuries to patients from the care that is intended to help them
2. Effective
    a. Providing services based on scientific knowledge to those who could benefit, and refraining from providing services to those not likely to benefit
3. Patient-centered
    a. Providing care that is respectful of and responsive to individual patient preferences, needs, and values
4. Timely
    a. Reducing delays in providing and receiving healthcare
5. Efficient
    a. Avoiding waste of equipment, supplies, and energy
6. Equitable
    a. Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

Regulatory Reporting Requirements are reported on a quarterly and annual basis

1. Centers for Medicare and Medicaid Services (CMS) Inpatient Quality Report (IQR)
    a. Health Equity
    b. Maternal Health
    c. Severe Sepsis
2. Centers for Medicare and Medicaid Services (CMS) Outpatient Quality Reporting (OQR)
    a. Stroke
    b. Emergency Department (ED) throughput times
        i. Throughput - refers to the amount of time it takes for a patient to move through the entire emergency department process, from the moment they arrive until they are discharged

3. Promoting Interoperability (PI)
    a. Optimized use of electronic health record (EHR)
4. Electronic Clinical Quality Measures (eCQMs)
    a. Measures taken directly from the electronic health record (EHR), including safe use of opioids, C-section rates, stroke, severe hypoglycemia, and severe maternal complication measures
5. Medicare Beneficiary Quality Improvement Project (MBQIP)
    a. Emergency Department transfer communication (EDTC)
    b. Social Determinants of Health (SDoH)
    c. Commitment to healthy equity
    d. Safe use of opioids
    e. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
    f. Hospital-wide readmission
    g. Emergency department thoughput times
    h. Left Without Being Seen (LWBS)
    i. Critical Access Hospital (CAH) Quality Infrastructure Assessment
6. Joint Commission ORYX measures
    a. C-section rate
    b. Exclusive breastfeeding
    c. Emergency department throughput
7. Merit-Based Incentive Payment System (MIPS) (reported per qualifying provider: none in 2024)
    a. Use of Prescription Drug Monitoring Program (PDMP)
    b. Electronic Clinical Quality Measures (eCQMs)
    c. Improvement activities by providers

Publicly reported quality metrics can be found on the Center for Medicare and Medcaid's (CMS) Care Compare website: https://www.medicare.gov/care-compare/

Quality Incentive Pool (QIP)

1. Department of Health Care Services (DHCS)-led program directing Managed Care Plans to make quality incentive payments to hospitals based on their performance on specific quality metrics.
2. Supports the State's goal of delivering effective, efficient, affordable care.
3. Large source of funding tied to performance-based measures.
4. NIHD successfully reported the maximum number of metrics in 2023, 12.

Internal Quality Auditing

1. Monitors performance of internal quality metrics that align with CMS and Joint Commission requirements, as well as internal goals.

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

DATE: December 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Dianne Picken, Medical Staff Director

RE: Medical Staff Report – FY 2025 Q1

The Medical Staff is responsible to the Board of Directors for maintaining a credentials program to assess the qualifications and competency of all applicants. The Medical Staff Office supports the Medical Staff in carrying out these duties. Below is a short introduction into the terms "Credentialing" and "Privileging" that will often be used in a credentials program.

Credentialing

The Joint Commission defines credentialing as "the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization." You may think of it as a robust background check process.

1. Who is credentialed?
    a. Anyone providing a medical-level of service or otherwise required by law (Physicians, Dentists, Podiatrists, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives).
2. Why do we credential?
    a. Credentialing is important for patient safety and risk management. A robust credentials program ensures Medical Staff are properly vetted prior to delivering care to our patients.
    b. If anyone is interested in a harrowing story of how a more robust credentialing program could have protected patients, you may lookup "Christopher Duntsch," aka "Doctor Death," the first doctor to have ever been criminally charged for his surgical malpractice.

Privileging

Privileging is the process of evaluating all the elements obtained through the credentialing process to determine what patient care services a practitioner is permitted to perform (for example, admit to the hospital, repair a hernia, deliver a baby). It also includes a plan for evaluating a practitioner's performance of these privileges.

1. Who is privileged?
    a. Same as those that are credentialed.
2. Why do we privilege?
    a. Like credentialing, the privileging process is important for patient safety and for ensuring a standard of care is delivered.
    b. New privileges emerge with technological advances in medicine. The Medical Staff must determine what additional education, training, or experience is necessary to obtain competency in a specific privilege (for example, robotic-assisted surgery).
    c. Privileging standards also ensure we apply criteria consistently to all applicants for a fair process.

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

DATE: December 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Scott Hooker, Director of Facilities

RE: Facilities – FY 2025 Q1

The Safety Committee at NIHD held regular meetings over the third quarter of 2024 (July, August, and September) to monitor and address critical safety and environmental care activities. Key areas discussed include Environment of Care (EOC) and ergonomic rounding, policy reviews, fall prevention, MRI safety, injury and sharps data, and infrastructure projects under Infection Control Risk Assessments (ICRA). The meetings aimed to enhance safety, improve compliance, and identify areas needing corrective action.

Key Findings

1. Environmental and Ergonomic Rounding
    a. EOC rounding activities were conducted and tracked monthly, with the next session scheduled for October. Ergonomic assessments were completed across multiple departments, including Rehab, Perinatal, and ICU, with updates and adjustments to ensure staff safety in Med-Surg and Lab areas. Plans for ergonomic rounding in 2024 are under review.
2. Policy Review and Updates
    a. Ongoing reviews of critical safety policies included Bloodborne Pathogen protocols, Musculoskeletal Injury Prevention, and updated policies around maintaining equipment, grounds, and handling patients under legal restraint. A new charter for the Sharps Committee was also introduced in September to strengthen sharp injury prevention efforts.
3. Falls Prevention Initiatives
    a. Monthly updates from the Falls Prevention Committee showed progress in reducing fall incidents. The committee continues to work on training and implementing preventive measures across departments to maintain patient and staff safety.
4. MRI Safety and Safe Patient Handling
    a. MRI Safety was reviewed, with continued attention to compliance and best practices for safe operation. The Safe Patient Handling initiatives aimed to minimize injuries during patient transfers and mobility assistance, with ergonomic aids and training for staff as needed.
5. Injury and Sharpe Data
    a. Sharps injury incidents were reported monthly to monitor trends and address immediate safety concerns. Regular analysis of injury data and ergonomic adjustments in high-risk departments aims to reduce injury rates and enhance worker safety.
6. Open ICRA Projects
    a. Updates were provided on active ICRA projects, including improvements in Pharmacy, MRI remodeling, OR gauge additions, and the PMA Roof Replacement. These infrastructure projects are integral to maintaining safe and compliant facilities, with ongoing monitoring and risk mitigation.
7. VPAT and Employee Injury Reporting

    a. The VPAT Committee's activities were reviewed, with updates on workplace violence prevention training and compliance with California's specific safety standards. Employee injuries were reported and reviewed monthly, focusing on identifying causes and implementing preventive measures.
8. Rainbow Chart Updates and Anonymous Safety Reporting
    a. The Rainbow Chart was continuously updated to track progress on safety goals. An Anonymous reporting link was added to encourage staff to report safety concerns without hesitation, fostering a culture of transparency and proactive safety management.

Key Outcomes and Next Steps

1. Ongoing EOC and Ergonomic Rounding
    a. Ensure monthly EOC and department-specific ergonomic evaluations to address hazards.
2. Policy Adherence and Updates
    a. Continue reviewing and updating safety policies to remain compliant and align with best practices.
3. Injury Prevention Initiatives
    a. Further strengthen employee injury reporting mechanisms and analyze data for actionable insights.
4. ICRA Project Monitoring
    a. Prioritize completion of open infrastructure projects while minimizing patient and staff risk.
5. Promote Safety Culture
    a. Enhance the visibility and accessibility of anonymous reporting tools to encourage safety feedback from all staff members.

Conclusion

The committee's ongoing efforts align with NIHD's goals to maintain a safe environment of care, meet regulatory requirements, and improve overall safety outcomes for patients, staff, and visitors.

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

DATE: December 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Bryan Harper, ITS Director

RE: Cybersecurity – FY 2025 Q1

The healthcare sector is increasingly becoming a prime target for cyberattacks due to the sensitive nature of the data it handles and its often complex IT infrastructures. Hospitals and healthcare providers are constantly threatened by cybercriminals, nation-state actors, and insiders who exploit vulnerabilities in outdated systems, human error, and the increasing interconnectedness of medical devices. This risk report outlines key cybersecurity challenges healthcare organizations face and provides actionable recommendations to enhance security, ensure patient data privacy, and protect critical systems.

Key Findings

1. Data Breaches
    a. Healthcare data remains one of the most valuable assets on the black market. Sensitive patient data, including personal health records (PHR), social security numbers, and medical histories, are highly targeted.
2. Ransomware
    a. Hospitals are frequent victims of ransomware attacks, where hackers encrypt critical systems and demand payments to restore access. These attacks disrupt medical services, jeopardize patient care, and can lead to substantial financial losses.
3. Third-Party Risks
    a. Healthcare organizations rely on numerous third-party vendors for various services, including IT support, medical equipment maintenance, and cloud services. Compromised third-party systems can be an entry point for cybercriminals.
4. Internet of Things (IoT) and Medical Device Vulnerabilities
    a. Medical devices like infusion pumps, imaging systems, and pacemakers are increasingly connected to hospital networks. However, many of these devices have weak or outdated security protocols, making them vulnerable to cyberattacks.
5. Lack of Cybersecurity Awareness
    a. Healthcare staff, including doctors, nurses, and administrative personnel, are often the weakest link in a hospital's cybersecurity defense. Phishing attacks and social engineering tactics continue to be major threats.

Cybersecurity Risk Areas

1. Patient Data Privacy and Security
    a. Unauthorized access to patient data can lead to identity theft, fraud, and legal consequences.
2. Critical Infrastructure and Systems
    a. Downtime in hospital IT systems, including electronic health records (EHR) systems and patient management systems, can severely impact patient care.
3. Compliance Failures

   a. Hospitals must comply with strict regulations such as the Health Insurance Portability and Accountability Act (HIPAA) in the U.S. Failing to meet these compliance requirements can result in significant penalties.
4. Network Vulnerabilities
   a. Hospitals' IT networks, including outdated legacy systems, present numerous attack vectors. Poor network segmentation and insufficient firewalls increase the risk of a breach.

Detailed Risk Analysis

1. Cyberattack Risks
   a. Ransomware: Hospitals are prime targets due to the life-or-death nature of their services. Attackers often launch ransomware attacks to lock critical medical systems or threaten to release sensitive data unless a ransom is paid.
      i. Risk Impact: High
         1. Disruption of services, financial loss, potential loss of life in extreme cases
      ii. Likelihood: High
         1. Continued trend of ransomware targeting healthcare
      iii. Mitigation: Regular backups, network segmentation, security patches, and employee training on phishing and ransomware detection.
   b. Phishing and Social Engineering: Healthcare professionals and administrative staff are frequent targets of phishing scams designed to steal credentials or introduce malware.
      i. Risk Impact: Medium
         1. Credential theft, malware deployment
      ii. Likelihood: High
         1. Wide distribution of phishing emails and social engineering tactics
      iii. Mitigation: User training, multi-factor authentication (MFA), and email filtering solutions.
2. Medical Device Vulnerabilities
   a. Internet of Things (IoT) Device Security: Many modern hospitals use interconnected medical devices. These devices often run on legacy software or unpatched firmware, creating vulnerabilities that attacker can exploit.
      i. Risk Impact: Medium to High (Potential to compromise patient safety, disruption of care)
      ii. Likelihood: Medium (Growing number of connected medical devices)
      iii. Mitigation: Regular patching of device firmware, network segmentation for medical devices, and secure communication protocols.
   b. Unsecured Medical Devices: Devices such as pacemakers, infusion pumps, and diagnostic imaging machines can be compromised through insecure networks, putting patient safety at risk.
      i. Risk Impact: High
         1. Life-threatening outcomes, liability issues
      ii. Likelihood: Medium
         1. Many hospitals lack proper oversight of connected devices
      iii. Mitigation: Secure device configurations, network isolation, and daily vulnerability assessments.
3. Third Party Vendor Risks

   a. Third-Party Access: Many healthcare providers rely on third-party vendors for IT support, cloud storage, and software solutions. These vendors may have inadequate security controls, which can be exploited by cybercriminals to gain access to hospital networks.
      i. Risk Impact: High
         1. Breaches via compromised third-party services
      ii. Likelihood: Medium
         1. Increasing third-party dependence
      iii. Mitigation: Vendor risk management, strong contractual agreements, access control, and continuous monitoring of third-party activities.
4. Network and Infrastructure Risks
   a. Legacy Systems: Many hospitals still rely on outdated or legacy IT systems that are not equipped to defend against modern cyber threats.
      i. Risk Impact: Medium
         1. Vulnerabilities that are easy to exploit
      ii. Likelihood: High
         1. Many hospitals operate with outdated systems
      iii. Mitigation: Upgrading and patching legacy systems, applying security updates, and conducting regular vulnerability assessments.
   b. Insufficient Network Segmentation: A lack of network segmentation in hospital IT infrastructures makes it easier for attackers to move laterally across systems once they gain access to one vulnerable device or system.
      i. Risk Impact: High
         1. Wide-ranging network compromise, data exfiltration
      ii. Likelihood: Medium
         1. Hospitals often have complex and interconnected networks
      iii. Mitigation: Implementing network segmentation, intrusion detection systems (IDS), and network access control.
5. Human Error and Insider Threats
   a. Insider Threats: Employees with access to sensitive information may intentionally or unintentionally leak data or facilitate cyberattacks, due to either negligence or malicious intent.
      i. Risk Impact: Medium
         1. Potential data leaks, system compromise
      ii. Likelihood: Medium
         1. Human error and disgruntled employees
      iii. Mitigation: User monitoring, strong access controls, regular security awareness training, and a clear insider threat policy.

Key Outcomes and Next Steps

1. Conduct Regular Risk Assessments
   a. Continuously evaluate the cybersecurity posture of all hospital IT systems, including networks, devices, and third-party services. This helps identify new vulnerabilities and allows for proactive mitigation strategies.
2. Enhance Employee Training
   b. Healthcare workers should receive regular training on recognizing phishing emails, the importance of using strong passwords, and the procedures to follow when encountering suspicious activity.

3. Implement Multi-Factor Authentication (MFA)
    a. MFA should be mandated across all critical systems to reduce the risk of unauthorized access due to stolen credentials.
4. Network Segmentation
    a. Ensure that critical hospital systems, especially those related to patient care and medical devices, are isolated from general office networks to limit the spread of attacks.
5. Upgrade Legacy Systems
    a. Outdated software and hardware should be replaced or upgraded to ensure that security patches are applied and vulnerabilities are mitigated.
6. Data Encryption
    a. Encrypt all sensitive data at rest and in transit, including patient health records and personally identifiable information, to ensure data confidentiality.
7. Vendor Risk Management
    a. Implement a robust third-party risk management program to ensure that external vendors adhere to the same cybersecurity standards as the hospital.
8. Develop an Incident Response Plan
    a. Establish a detailed incident response plan that includes specific protocols for responding to cyberattacks and data breaches, including communication strategies with patients, regulators, and the public.

Conclusion

Cybersecurity in hospitals and healthcare systems is more critical than ever. With the increasing sophistication of cyberattacks and the sensitive nature of healthcare data, hospitals must take proactive steps to protect their infrastructure, maintain patient trust, and ensure the continuity of care. By implementing a robust cybersecurity framework, regularly assessing risk, and prioritizing employee awareness, healthcare organizations can significantly reduce their risk exposure and better safeguard against evolving cyber threats.