Northern Inyo Healthcare District

Board Meetings

Board of Directors

February 19, 2025

Compliance Officer Report

Chief Executive Officer Reports

Financial and Statistical Reports

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS – REGULAR MEETING

February 19, 2025, at 5:00 pm
Northern Inyo Healthcare District invites you to join this meeting:

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

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

The Board meets 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.

Board Member, David McCoy Barrett, will attend from 401 Mercer Street, Seattle, WA 98109, via Zoom.

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1. Call to Order at 5:00 pm.
2. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comments unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. Public comments on closed session items
4. Adjournment to closed session to/for:

a. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1). Title: CEO FY 2025 performance.
b. Discuss trade secrets (Health & Safety. Code § 32106 and Civ. Code 3426.1). The discussion will concern a new service line. The estimated date of public disclosure is September 2025.

5. Return to open session and report on any actions taken in closed session

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6. Consent Agenda – *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*
    a. Approval of minutes for the January 9/10, 2025 Special Board Meeting.
    b. Approval of minutes for the January 15, 2025 Regular Board Meeting
    c. CEO Credit Card Statements
    d. Approval of Policies and Procedures
        i. AIDS/HIV Testing and Orders
        ii. Billing and Collections
        iii. Billing Write Off
        iv. Chemical Hygiene Plan for Clinical Laboratory
        v. Conducting Hot Work
        vi. Decorations, Receptacles & Heating Devices
        vii. Designing Building Systems and Risk Management
        viii. Drugs and Abuse Maternal and Infant
        ix. Emergency Response Plan-HVAC Failure
        x. Extension Cords
        xi. Finance and Audit Committee Charter
        xii. Financial Assistance and Charity Care Policy
        xiii. Fire Drills
        xiv. Mandated Reporting Child Abuse/Neglect: Dependent Adult/Elder Abuse: Injury by Firearm by Assault/Abuse
        xv. Newborn Hearing Screening Program
        xvi. Northern Inyo Hospital Surge Plan
        xvii. Patient Restraints (Behavioral &Non-Behavioral)

xviii. Policy on Trans filling of Medical Gas Cylinders
xix. Standardized Procedure – Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife
xx. Standardized Procedure for Registered Nurse First Assistant
xxi. Standardized Procedure – Well Child Care Policy for the Nurse Practitioner
xxii. Standardized Protocol – Well Child Care Policy for the Physician Assistant
xxiii. Value Analysis Committee

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7. New Business:
    a. Chief of Staff Report, Sierra Bourne MD
        i. Medical Staff Reappointments – *Action Item*
        ii. Request for Additional Privileges – *Action Item*
        iii. Medical Staff Initial Appointments – *Action Item*
        iv. Medical Staff Initial Appointments – Proxy Credentialing – *Action Item*
    b. Compliance Officer Report
        i. 2024 Annual Compliance Report – *Action Item*
        ii. Language Access Services – *Information Item*
    c. Chief Executive Officer Report *(Board will receive this report)*
        i. CEO Report
            1. Customer Service Training – Feb 2025 – *Information Item*
            2. Jorie/AI – *Information Item*
            3. Bishop City Council – Jan 13, 2025 – *Information Item*
            4. Townhall Community Meeting – Feb 6, 2025 – *Information Item*
        ii. Chief Medical Officer Report – *Information Item*
        iii. Chief Financial Officer Report
            1. Financial & Statistical Reports (*Board will consider the approval of these reports)*
            2. CFO Quarterly Report – *Information Item*

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8. General Information from Board Members (*Board will provide this information)*

9. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board 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 Jean Turner called the meeting to order at 9:00 am.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary Laura Smith, Member at Large Stephen DelRossi, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
ABSENT	David McCoy Barrett, Treasurer
PUBLIC COMMENT	Chair Turner 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.
ALL THINGS LEGAL	Chair Turner called attention to All Things Legal. Attorney Noel Caughman presented.
MATRIX OF LEADERSHIP	Chair Turner called attention to the Matrix of Leadership. CEO DelRossi presented.
TEAM BUILDING	Executives and Directors engaged in a team-building activity.
PLANNING FOR THE FUTURE – STRATEGIC PLAN	Chair Turner called attention to the Strategic Plan. CEO DelRossi reviewed the strategic plan goals. Discussion ensued.
GOVERNANCE 101	Chair Turner called attention to Governance 101. CEO DelRossi reviewed the standing committees (Governance, Finance and Audit, and Compliance, Quality, Safety, and Risk) and their charters. Discussion ensued.
BEHIND THE FINANCIAL NUMBERS	Chair Turner called attention to Behind the Financial Numbers. CFO Mossman presented and explained how to read the financial reports.

ADJOURNMENT	Adjournment 4:00 pm, January 9, 2025.
RECONVENE	Reconvene 9:00 am, January 10, 2025.
GOVERNANCE 201	Chair Turner called attention to Governance 201. CEO DelRossi presented differences between operations and governance.
EMPLOYEE RELATIONS	Chair Turner called attention to Employee Relations. CHRO/CBDO Murray presented information about the workforce, labor relations, collective bargaining, grievances, mediation, and arbitration. Discussion ensued.
BUSINESS DEVELOPMENT	Chair Turner called attention to Business Development. The Executive Team presented Business Development information. The discussion included the importance of meeting the community's needs while analyzing the stability of the hospital by adding or canceling service lines. Discussion ensued.
TEAM BUILDING	Executives and Directors engaged in a team-building activity.
COMMUNITY RELATIONS	Chair Turner called attention to Community Relations. The Executive Team presented information about community relations. The discussion included information on how the district handles complaints, and how the board can handle constituent complaints, marketing, community engagement, the auxiliary, and the foundation. Discussion ensued
ADJOURNMENT	Adjournment at 3:00 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:03 pm.
PRESENT	Jean Turner, Chair David Lent, Secretary David McCoy Barrett, Treasurer Laura Smith, Member at Large Stephen DelRossi, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer Sierra Bourne, MD, Chief of Staff
ABSENT	Melissa Best-Baker, Vice Chair
TELECONFERENCING	Notice has been posed and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Chair Turner 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.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	There were no comments from the public.
ADJOURNMENT TO CLOSED SESSION	Adjournment to closed session at 5:03 pm.
RETURN TO OPEN SESSION	Called back to order at 6:39 pm Chair Turner stated there were no reportable actions from the closed session.
NEW BUSINESS	
GOVERNANCE COMMITTEE	Chair Turner called attention to the Governance Committee Appointments. David Lent, Jean Turner, and Stephen DelRossi were appointed the members of the Governance Committee. Motion to appoint members for the Governance Committee: Lent 2nd: Smith Roll Call Vote Turner - Pass Lent - Pass Barrett - Pass

Smith - Pass
Pass 4-0

CHIEF EXECUTIVE OFFICER REPORT

Chair Turner called attention to the CEO report.

1. Audit
   a. Discussion ensued, the goal is to present the final audit in March 2025.
2. Seminar
   a. Discussion ensued, and preparation for next year's Seminar is underway.
   b. Board members commented that the Seminar went well, it was very informative.
3. Financial Policies
   a. Discussion ensued.
   b. Policies will be reviewed and the proposed adoption is February 2025.
4. UCSF Alumni Achievement Award – Colleen McEvoy
   a. DelRossi shared that UCSF awarded Colleen McEvoy the 2025 UCSF Alumni Practitioner Award.

CHIEF FINANCIAL OFFICER REPORT

Chair Turner introduced the CEO report.

1. Financial and Statistical Reports

Motion to accept the Financial and Statistical Reports: Barrett
2nd: Smith
Vote by roll call
Turner - Pass
Lent - Pass
Barrett – Pass
Smith – Pass
Pass 4-0

2. Jorie
   a. CFO Mossman expressed we are on track with Jorie's implementation. CEO DelRossi thanked the team for working diligently to implement Jorie in a crunched timeframe.
3. Finance and Audit Committee meeting report
   a. Discussion ensued

CHIEF OF STAFF REPORT

Chair Turner introduced the Chief of staff report.

1. Dr. Manzanares – Family Medicine
   a. Discussion ensued. Manzanares gave general updates regarding: Imaging, MAT, Staffing, patient appointments, appointment reminder system,
2. Medical Executive Committee meeting report
   a. Chief of Staff Bourne expressed that Dr. Richardson with Inyo County Public Health came and spoke with the medical executive committee.

CONSENT AGENDA

Chair Turner called attention to the consent agenda.

Motion to accept the consent agenda: Lent
2nd: Smith
Vote by roll call
Turner - Pass
Lent - Pass
Barrett – Pass
Smith – Pass
Pass 4-0

ADJOURNMENT

Adjournment at 7:02 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

February 2025 Statement

Open Date: 01/07/2025 Closing Date: 02/05/2025

Account: [redacted]

[redacted]

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service
BUS 30 USB 8

New Balance	**$5,773.99**
Minimum Payment Due	**$58.00**
Payment Due Date	**03/01/2025**

Activity Summary

Previous Balance	+	$4,062.57
Payments	-	$4,062.57 CR
Other Credits	-	$1,656.64 CR
Purchases	+	$7,430.63
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	**=**	**$5,773.99**
Past Due		**$0.00**
Minimum Payment Due		**$58.00**
Credit Line		$37,500.00
Available Credit		$31,726.01
Days in Billing Period		30

Payment Options: [redacted]

[redacted]

Account Number	[redacted]
Payment Due Date	3/01/2025
New Balance	$5,773.99
Minimum Payment Due	$58.00

24-Hour Cardmember Service: [redacted]

. to pay by phone
. to change your address

Amount Enclosed $_____

[redacted]

[redacted]

What To Do If You Think You Find A Mistake On Your Statement

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at: Cardmember Service, P.O. Box 6335, Fargo, ND 58125-6335.

In your letter or call, give us the following information:

- *Account information:* Your name and account number.
- *Dollar amount:* The dollar amount of the suspected error.
- *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.

You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:

- We cannot try to collect the amount in question, or report you as delinquent on that amount.
- The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
- While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
- We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service, P.O. Box 6335, Fargo, ND 58125-6335

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

Important Information Regarding Your Account

1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you.To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, P.O. Box 790408, St. Louis, MO 63179-0408 or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.
3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
01/22	01/21	8810	HOTELCOM73011220960457 HOTELS.COM WA MERCHANDISE/SERVICE RETURN	$24.33CR	Rev Cycle Travel
01/22	01/21	8935	HOTELCOM73011220960457 HOTELS.COM WA MERCHANDISE/SERVICE RETURN	$465.39CR	Rev Cycle Travel
01/23	01/21	9947	UNITED 0164465843989 UNITED.COM TX MERCHANDISE/SERVICE RETURN GUTIERREZ /OTH 01/21/25 OHARE TO HOUSTON	$14.99CR	Rev Cycle Travel
01/23	01/21	9954	UNITED 0164465843990 UNITED.COM TX MERCHANDISE/SERVICE RETURN GUTIERREZ /OTH 01/21/25 OHARE TO HOUSTON	$14.99CR	Rev Cycle Travel
01/23	01/21	9962	UNITED 0164465844082 UNITED.COM TX MERCHANDISE/SERVICE RETURN GUTIERREZ /OTH 01/21/25 OHARE TO HOUSTON	$35.00CR	Rev Cycle Travel
01/23	01/21	9970	UNITED 0164465844083 UNITED.COM TX MERCHANDISE/SERVICE RETURN GUTIERREZ /OTH 01/21/25 OHARE TO HOUSTON	$35.00CR	Rev Cycle Travel
01/24	01/22	9631	UNITED 0162452431698 UNITED.COM TX MERCHANDISE/SERVICE RETURN	$533.47CR	Rev Cycle Travel
01/24	01/22	9649	UNITED 0162452431699 UNITED.COM TX MERCHANDISE/SERVICE RETURN	$533.47CR	Rev Cycle Travel
01/29	01/29	0000	INTERNET PAYMENT THANK YOU	$4,062.57CR	Rev Cycle Travel
			TOTAL THIS PERIOD	**$5,719.21CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
01/09	01/08	5700	SMART AND FINAL 380 BISHOP CA	$99.00	Board Seminar
01/10	01/09	4830	SQ *LOONEY BEAN OF BIS BISHOP CA	$80.50	Board Seminar
01/13	01/10	6899	SMART AND FINAL 380 BISHOP CA	$5.99	Board Seminar
01/13	01/09	3415	VONS #1753 BISHOP CA	$16.49	Board Seminar
01/21	01/17	2237	UNITED 0162452288970 UNITED.COM TX DELROSSI/STEPH 04/27/25 LAS VEGAS TO OHARE OHARE TO LAS VEGAS	$1,028.89	CEO - Beckers
01/21	01/17	7018	UNITED 0164465726885 UNITED.COM TX	$109.99	CEO - Beckers
01/21	01/17	7026	UNITED 0164465726886 UNITED.COM TX	$109.99	CEO - Beckers

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NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Transactions

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
01/21	01/18	7034	UNITED 0164465843989 UNITED.COM TX	$14.99	CEO - Beckers
01/21	01/18	7042	UNITED 0164465843990 UNITED.COM TX	$14.99	CEO - Beckers
01/21	01/18	3710	UNITED 0164465844082 UNITED.COM TX	$35.00	CEO - Beckers
01/21	01/18	3728	UNITED 0164465844083 UNITED.COM TX	$35.00	Rev Cycle
01/21	01/18	8129	HOTELCOM73011220960457 HOTELS.COM WA	$489.72	Rev Cycle
01/21	01/18	4903	UNITED 0162452431698 UNITED.COM TX GUTIERREZ/CHRI 01/22/25 SALT LAKE CI TO DENVER DENVER TO BISHOP BISHOP TO SAN FRANCISC SAN FRANCISC TO SALT LAKE CI	$533.47	Rev Cycle
01/21	01/18	4911	UNITED 0162452431699 UNITED.COM TX GUTIERREZ/PAUL 01/22/25 SALT LAKE CI TO DENVER DENVER TO BISHOP BISHOP TO SAN FRANCISC SAN FRANCISC TO SALT LAKE CI	$533.47	Rev Cycle
01/21	01/20	6187	SCCE/HCCA/CCB WWW.CORPORATE MN	$1,370.00	Board Clerk Conf.
01/22	01/21	5333	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
01/23	01/22	6560	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
01/24	01/23	1746	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
01/28	01/27	7676	HOTELCOM73018334317403 HOTELS.COM WA	$784.72	Rev Cycle
01/29	01/27	6484	UNITED 0162454960967 UNITED.COM TX GUTIERREZ/CHRI 02/08/25 SALT LAKE CI TO SAN FRANCISC SAN FRANCISC TO BISHOP BISHOP TO DENVER DENVER TO SALT LAKE CI	$477.69	Rev Cycle
01/29	01/27	6492	UNITED 0162454960968 UNITED.COM TX GUTIERREZ/PAUL 02/08/25 SALT LAKE CI TO SAN FRANCISC SAN FRANCISC TO BISHOP BISHOP TO DENVER DENVER TO SALT LAKE CI	$477.69	Rev Cycle
01/29	01/27	0549	UNITED 0164468021137 UNITED.COM TX	$35.00	Rev Cycle
01/29	01/27	0556	UNITED 0164468021138 UNITED.COM TX	$35.00	Rev Cycle
01/31	01/30	1803	WWW.HFMA.ORG WWW.HFMA.ORG IL	$920.00	Membership Fee
02/03	01/31	7287	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7360	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7444	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7519	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7691	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7774	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7857	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	7931	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	8012	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	8194	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/31	8277	NPDB NPDB.HRSA.GOV 800-767-6732 VA	$2.50	Pharmacy
02/03	01/30	7061	TST*GREAT BASIN BAKERY Bishop CA	$42.77	Beta Lunch
02/03	01/31	3054	FACEBK *WKC4DH4KU2 650-5434800 CA	$114.22	Marketing

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NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Transactions

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
02/04	02/03	0146	USPS.COM POSTAL STORE 800-782-6724 MO	$31.05	CFO Mailing
			TOTAL THIS PERIOD	**$7,430.63**	

2025 Totals Year-to-Date	
Total Fees Charged in 2025	$0.00
Total Interest Charged in 2025	$0.00

Company Approval *(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

**APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	$0.00	$0.00	YES	$0.00	23.24%	
**PURCHASES	$5,773.99	$0.00	YES	$0.00	23.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

[redacted]

End of Statement

January 2025 Statement

[redacted]

Open Date: 12/05/2024 Closing Date: 01/06/2025

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

[redacted]

New Balance	**$4,062.57**
Minimum Payment Due	**$41.00**
Payment Due Date	**02/01/2025**

Activity Summary

Previous Balance	+	$4,401.91
Payments	-	$4,401.91CR
Other Credits		$0.00
Purchases	+	$4,062.57
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	**=**	**$4,062.57**
Past Due		**$0.00**
Minimum Payment Due		**$41.00**
Credit Line		$37,500.00
Available Credit		$33,437.43
Days in Billing Period		33

[redacted]

[redacted]

24-Hour Cardmember Service: [redacted]

. to pay by phone
. to change your address

[redacted]

Account Number	[redacted]
Payment Due Date	2/01/2025
New Balance	$4,062.57
Minimum Payment Due	$41.00

Amount Enclosed $_____

[redacted]

What To Do If You Think You Find A Mistake On Your Statement

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at:

In your letter or call, give us the following information:

▶ *Account information:* Your name and account number.

▶ *Dollar amount:* The dollar amount of the suspected error.

▶ *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.

You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:

▶ We cannot try to collect the amount in question, or report you as delinquent on that amount.

▶ The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.

▶ While you do not have to pay the amount in question, you are responsible for the remainder of your balance.

▶ We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)

2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.

3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service,

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

Important Information Regarding Your Account

1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you.To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.

2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.

3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

IMPORTANT NOTICE: Please see the enclosed insert for changes being made to the late fees and returned payment fees on your account.

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at usbank.com/lcgin.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
12/26	12/26	0000	INTERNET PAYMENT THANK YOU	$4,401.91CR	
			TOTAL THIS PERIOD	**$4,401.91CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
12/05	12/04	[redacted]	MANOR MARKET [redacted]	$59.98	Gift - Board
12/06	12/05		SMART AND FINAL 380 [redacted]	$52.97	Gift - Board
12/06	12/05		DOLLARTREE [redacted]	$82.92	Holiday Party
12/06	12/05		TST* WHISKEY CREEK [redacted]	$167.00	CEO Dinner
12/09	12/06		EASTSIDE SPORTS [redacted] CA	$20.00	Gift Card
12/09	12/06		AMAZON [redacted]	$27.18	Holiday Party
12/09	12/06		VONS [redacted]	$32.60	Holiday Party
12/09	12/06		ANNE MARIE'S HOME [redacted]	$20.00	Gift Card
12/11	12/10		DOLLARTREE [redacted]	$58.45	Holiday Party
12/13	12/11		BISHOP COUNTRY CLUB [redacted]	$400.00	Auxiliary Luncheon
12/13	12/11		BISHOP COUNTRY CLUB [redacted]	$63.00	Auxiliary Luncheon
12/13	12/11		VONS [redacted]	$57.63	Holiday Party
12/16	12/12		TST*GREAT BASIN BAKERY [redacted]	$50.97	Holiday Party
12/16	12/13		TST* WHISKEY CREEK [redacted]	$1,550.00	Employee Gift Card
12/18	12/17		TST*THE UPPER CRUST PI [redacted]	$127.36	CNO Lunch
12/19	12/18		TST* WHISKEY CREEK [redacted]	$200.00	CEO Dinner
12/27	12/24		CIELO HOTEL [redacted]	$596.82	Nurse Traveler
12/27	12/26		FACEBK [redacted]	$400.00	Marketing
12/30	12/27		CA SECRETARY OF STATE [redacted]	$10.00	Printing
01/02	12/31		FACEBK *D85QLHGKU2 [redacted]	$85.69	Marketing
			TOTAL THIS PERIOD	**$4,062.57**	

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

2025 Totals Year-to-Date	
Total Fees Charged in 2025	$0.00
Total Interest Charged in 2025	$0.00

Company Approval

(This area for use by your company)

Signature/Approval: _____ Accounting Code: _____

Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

**APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	$0.00	$0.00	YES	$0.00	23.24%	
**PURCHASES	$4,062.57	$0.00	YES	$0.00	23.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

[redacted]

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: AIDS/HIV Testing and Orders		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 01/29/2025	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/01/1991	

PURPOSE:
To provide guidance for employees and medical staff on the legal requirements and responsibilities for Human immunodeficiency virus (HIV) consent and testing

POLICY:
1. Per California law, NIHD does not require written consent for HIV testing.
2. Patients must be verbally informed of the intent to test and given the opportunity to consent or refuse testing.
3. No one may be forced to have an HIV test.
   a. Exception: Law enforcement officers may obtain a court order for HIV testing without consent; HIV testing may be performed on blood already collected from the patient in cases of healthcare worker's exposure events.
4. If a person is incompetent, written consent for the test, as well as disclosure of the results, may be given by the patient's parents, guardian, conservator, or other person lawfully authorized to make health care decisions for the patient.
5. Notwithstanding, first sentence in #4, when the subject of the HIV test is a minor adjudged to be a dependent child of the court pursuant to Section 360 of the Welfare and Institutions Code, written consent for the test to be performed may be obtained from the court pursuant to its authority under Section 362 or 369 of the Welfare and Institutions Code. HIV results for the patient may be known to healthcare workers involved in the care and treatment (those who "need to know") of HIV tested patients.
6. Positive HIV test results must be reported to their county local health officer per Title 17.

PROCEUDRE:
1. California Health and Safety (H&S) Code section 120990 (a), a medical care provider must:
   a. Inform the patient that an HIV test is planned;
   b. Provide information about the test; See attachments in English and Spanish. For other languages access link. https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_hivhcv.aspx
   c. Inform the patient of the many treatment options available to people who test HIV positive;
   d. Inform the patient that a person who tests HIV negative should continue to be routinely tested for HIV; and
   e. Inform the patient he or she has the right to decline the test. The refusal must be documented in the patient's medical record.
2. California Health and Safety Code (H&S) section 125090 states HIV testing for pregnant women is routine prenatal care. See NIHD HIV Prevention Program, Perinatal Policy.
3. Per California Health and Safety (H&S) 125090 for pregnant women the medical provider shall ensure the woman is informed:

a. Of the intent to perform a HIV test;
b. The routine nature of the test;
c. The purpose of the testing;
d. The risks and benefits of the test;
e. The risk of perinatal transmission of HIV;
f. The approved treatments are known to decrease the risk of perinatal transmission of HIV;
g. That the patient has the right to decline the testing.

(An information sheet with all of the required information is available at the California Department of Public Health (CDPH) Web site at:
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_hivhcv.aspx

4. Written authorization from the patient is not required to disclose HIV results to healthcare workers providing direct patient care.
5. Written authorization from the patient is required to release HIV results to other individuals or insurance companies. See NIHD Policy and Procedure AIDS/HIV Testing and Orders.
6. For minors below 12 years old, the parent, guardian or other person lawfully authorized to make health care decisions on their behalf must generally provide written authorization for a physician to disclose the minor child's test results.
7. HIV orders do not need to be on a separate order page, separated from other electronic orders, or in the confidential area of the patient chart.
8. If the HIV test results are **positive** they must be confidential and kept with the patient's medical record either electronically or on downtime form.
8. If there has been a potential exposure to a healthcare worker, please see *NIHD Policy Initial Evaluation of Exposure Incident.*

REFERENCES:

1. California HIV/AIDS Policy Research Centers. March 2019. California HIV Laws. Retrieved from https://www.californiaaidsresearch.org/topic-areas/hiv-laws_final.pdf
2. California Department of Public Health (CDPH). October 19, 2022. HIV and HCV Testing. Retrieved from https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_hivhcv.aspx
3. MMWR, September 30, 2005 - Update: Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm
4. California Consent Manual, California Hospital Association, 2021. Retrieved from file:///H:/Public/CHA/CHA%20Consent%20Manual%202021.pdf
5. Centers for Disease Control and Prevention. March 8, 2017. State HIV Testing Laws: Consent and Counseling Requirements. Retrieved from https://www.cdc.gov/hiv/policies/law/states/testing.html

CROSS REFERENCE P&P

1. Blood Borne Pathogen Exposure - Initial Evaluation of NIHD HCW
2. HIV Testing Without Consent for Occupational Exposures
3. Bloodborne Pathogen Exposure Control Plan
4. Lippincott Procedures Reportable Disease https://procedures.lww.com/lnp/view.do?pId=3260871&hits=reportable,reported,reports,reporting,report&a=false&ad=false&q=reportable
5. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations

RECORD RETENTION AND DESTRUCTION: All provider orders and test results become a part of the medical record. Medical records are maintained by the NIHD Medical Records Department.

Supersedes: v.5 AIDS/HIV Testing and Orders

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Billing and Collections		
Owner: Chief Executive Officer	Department: Administration	
Scope: Patient Access, Billing and Collections		
Date Last Modified: 02/29/2024	Last Review Date: 02/22/2024	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To provide clear and consistent guidelines for conducting cash and cash equivalent collection functions in a manner that promotes compliance with federal, state, and District rules, patient satisfaction, and efficiency.

POLICY:
In non-emergent circumstances, at or before the time of service, NIHD will collect the patient's co-pay, deductible, and patient's share on insurance eligibility. In emergent circumstances, collection will occur after the patient has been stabilized and is no longer in distress from the medical emergency.

PROCEDURE:
General Rules:
With respect to the collection of medical debt, the statute of limitations for breach of written contract is typically four years. The start time is either the most recent payment date, or the date on which the breach occurred – whichever happened later.

Under state law, NIHD must allow a 180-day negotiation period, which is roughly equivalent to five months, for the determination of a payment plan. NIHD will not send medical bills to a debt collection agency until the 180-day period has elapsed.

The Fair Debt Collection Practices Act (FDCPA) and the California Fair Debt Collection Practices Act (CFDCPA) - Rosenthal Fair Debt Collection Practices Act - protects consumers from abusive or deceptive debt collection practices. The FDCPA prohibits numerous consumer debt collection strategies. The following actions will not be taken by NIHD:

- Call repeatedly for the purpose of causing annoyance or distress.
- Make threats of any kind.
- Pretend to be lawyers, credit reporting company representatives, or government representatives.
- Use abusive or obscene language.

Before assigning a bill to collections or selling patient debt, NIHD will, at a minimum, provide the following:

- Date or services of the bill;
- Name of the entity to which the bill is being assigned or sold;
- Declaration as to how to obtain an itemized bill and an application for the hospital's financial assistance and charity care program.

Section 127430 - Written notice prior to commencing collection activities against patient

(a) Prior to commencing collection activities against a patient, the hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency, shall provide the patient with a clear and conspicuous written notice containing both of the following:
(1) A plain language summary of the patient's rights pursuant to this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C (commencing with Section 1788) of Part 4 of Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V (commencing with Section 1692) of Chapter 41 of Title 15 of the United States Code). The summary shall include a statement that the Federal Trade Commission enforces the federal act.

The summary shall be sufficient if it appears in substantially the following form: "**State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov**."

(2) A statement that nonprofit credit counseling services may be available in the area.
(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.
(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency, engaged in the debt collection activity.

Insurance Billing:

- For all insured patients, NIHD will bill applicable third-party payers based on information provided by or verified by the patient or their guarantor in a timely manner. Due to the nature of insurance billing, insurance may not process for up to a year after the service date; normally, bills are submitted on the fifth day after service, barring weekends and holidays, but many factors can delay the billing process.
- If a claim is denied (or is not processed) by a payer due to an error by NIHD, NIHD will not bill the patient or their guarantor for any amount in excess of what the patient or their guarantor would have owed had the payer paid the claim.
- If a claim is denied or is not processed by a payer due to factors outside of NIHD's control, staff will follow up with the payer and patient or their guarantor as appropriate to facilitate resolution of the claim. If resolution does not occur after follow-up efforts, Northern Inyo Healthcare District will bill the patient or their guarantor.
- After insurance adjudicates the bill, the appropriate entries will be added to the record.
- If a balance remains on the account, the account will move to Early-out, Self-pay status.
- The general flow of a patient's bill is as follows:
    - Verification of benefits
    - Bill insurance company or companies – this may take up to a year, depending on insurers acceptance of bill;
    - After insurance resolution, bill appropriate amount as determined through contractual arrangements; simultaneously, the account moves to self-pay, early-out status – normally, this may take up to three months from insurance adjudication;

- Patient will receive 5 monthly statements, telephonic communications, or any other reasonable means of communication;
- Patient will receive a "Good Bye" letter on the 6th statement – this will normally occur one hundred seventy-five days after the first statement - informing them, among others, that their balance is transferring to a debt collection agency;
- Up until the time the account is sent to the collection agency, the patient has the opportunity to seek assistance, if assistance is still available due to timing issues, through the Financial Assistance and Charity Care policy.

Patient Billing: Early-out and Self-pay

- Hospital care at NIHD is available to all those who may be in need of necessary services.
- Patient or guarantor may request an itemized statement at any time.
- For uninsured patients, NIHD will bill uninsured patients or guarantors and they will receive a statement as part of the organization's normal billing process.
- NIHD will provide all uninsured patients their Notice of Available Financial Assistance and Charity Care Services**.**
- For insured patients, after claims have been processed by third-party payers, NIHD will bill patient or guarantor the liability amount as determined by their insurer.
- If a patient or guarantor disputes account, has questions or concerns, or requests documentation regarding the bill, NIHD will seek resolution. Patient will be notified of findings.
- NIHD may approve payment plan arrangements for patients or their guarantor who indicate they may have difficulty paying their balance in a single installment.
- Generally, based on income, the balance may be financed for a length up to 60 months. The length of the financing will be based upon the corresponding Federal Poverty Level (FPL), and as follows:
  - When the total income is at or below 100% of the FPL, NIHD will offer financing up to 60 months with a minimum payment of $10.00 per month*;
  - When the total income is above 100% and equal to or lower than 200%, NIHD will offer financing up to 60 months with a minimum payment of $20 per month*;
  - When the total income is above 200% and equal to or lower than 250%, NIHD will offer financing up to 60 months with a minimum payment of $25 per month*;
  - When the total income is above 250% and equal to or lower than 300%, NIHD will offer financing up to 60 months with a minimum payment of $30 per month*;
  - When the total income is above 300% and equal to or lower than 350%, NIHD will offer financing up to 60 months with a minimum payment of $35 per month*;
  - When the total income is above 350%, NIHD will offer long-term financing up to 60 months with a minimum payment of $40 per month*;
  - Under unusual circumstances (e.g. outstanding balance greater than $1,500), the length of financing may exceed 60 months;
    - Approval must be obtained from the CFO for variances;
  - Financing must be offered in 6 month increments until an agreement is made;
  - The minimum amounts can be less than stated with the approval of the CFO.
- * The minimum payment may be less than or more than stated above based on the individual's ability to pay.

NIHD is not required to accept patient or their guarantor initiated payment arrangements and may refer accounts to a collection agency as outlined below if the patient or their guarantor is unwilling to make acceptable payment arrangements or has defaulted on an established payment plan.

Collections Practices

In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, Northern Inyo Healthcare District may engage in collection activities—including outsourcing to outside collection agency to collect outstanding patient balances.

1. General collection activities may include patient statements, follow-up calls, letters, email, messages, or any other authorized form.
2. Northern Inyo Healthcare District will make every effort to identify eligibility for financial assistance programs or charity for uninsured, under insured, or high cost patients.
3. Patient balances may be referred to an outside collection agency for collection for all accounts greater than 180 days if financing arrangements were not reached. The District will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:
   a. There is a reasonable basis to believe the patient or their guarantor owes the debt.
   b. All third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient or their guarantor. NIHD shall not bill a patient or their guarantor for any amount that an insurance company is obligated to pay.
   c. NIHD will not refer accounts for collection while a claim on the account is still pending payer payment. However, the District may classify certain claims as "denied" if such claims are in "pending" mode for an unreasonable length of time despite efforts to facilitate resolution.
   d. NIHD will not refer accounts for collection where the claim was denied due to a District error. However, NIHD may still refer the patient liability portion of such claims for collection if unpaid.
   e. NIHD will not refer accounts for collection where the patient or their guarantor has initially applied for financial assistance, charity care or other District-sponsored program and NIHD has not yet notified the patient or their guarantor of its determination (provided the patient or their guarantor has complied with the timeline and information requests delineated during the application process).

Financial Assistance

NIHD provides all patients or their guarantor the opportunity to apply for financial assistance or charity care for their accounts, payment plan options, and other applicable programs.

NIHD assist patients or their guarantor with access to financial assistance and charity service programs during the collections process.

See Northern Inyo Healthcare District Financial Assistance and Charity Care Program for procedure.

IRS Rule:

26 U.S. Code § 61 - Gross income defined
(a)General definition
Except as otherwise provided in this subtitle, gross income means all income from whatever source derived, including (but not limited to) the following items:
(11)Income from discharge of indebtedness;

NIHD reserves the right to negotiate financing based on applicable IRS Codes and References.

REFERENCES:

1. 26 U.S. Code § 61 - Gross income defined
2. Fair Debt Collection Practices Act (FDCPA)
3. California Fair Debt Collection Practices Act (CFDCPA) - Rosenthal Fair Debt Collection Practices Act
4. Medicare CMS Manual 15: The Provider Reimbursement Manual.

RECORD RETENTION AND DESTRUCTION:
Maintenance of records is for a minimum of fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Financial Assistance and Charity Care Program
2. Bad Debt Policy
3. Pricing Transparency Policy

Supersedes: v.1 Billing and Collections

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Billing Write Off		
Owner: Chief Executive Officer	Department: Administration	
Scope: Revenue Cycle		
Date Last Modified: 01/05/2023	Last Review Date: 01/27/2025	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To ensure compliant coding and billing practices. Maintain and assure the integrity of the hospital's Accounts Receivable activity. Set forth and define protocol and authority for billing adjustments and or write-off activity.

POLICY: Defined Write-Offs are not permitted by any staff other than those provided the authority by this policy. No Write-Off activity is permitted outside the defined Write-Offs listed in this policy unless directed and approved by the Chief Financial Officer or the Chief Executive Officer.

PROCEDURE:

- Non-Billable Item

Items charged to a patient account listed as "non-billable" per Hospital payor contract will be system flagged for Biller to write-off the patient account as claim final bills. Payor Non-Covered items are not submitted to the payor or patient.

- Non-Covered Services - Payor Contract

Non-covered services performed outside payor contract are not billed to patient if District did not inform patient of non-covered service prior to service. Charges are written off by billing staff using the Non-Covered Write-Off code.

- Denials - Payor Contract

Unresolvable account denials for unforeseen non-covered service will be written off by the business office to the code Insurance Contractual. Items above $1,000.00 will be submitted to the business office manager for review and approval. Items above $2,500.00 will be submitted to the Chief Financial Officer for review and approval. Sufficient documentation is required to review and approve the write off.

- Billing Process Related Denials

Unresolvable denials related to "Billing Process" activities for covered services are written off by the business office using the Administrative Write-Off code. Items above $1,000.00 will be submitted to the business office manager for review and approval. Items above $2,500.00 will be submitted to the Chief Financial Officer for review and approval. Sufficient documentation is required to review and approve the write off.

- Administrative Adjustment Write-Off (Discretionary)

When it is determined that reimbursable services should be written off based on factors of unfavorable business outcomes, or other discretionary purposes, balances are adjusted using the administrative

adjustment code. Such discretion may be out of concern for patient relation purposes; billing or clerical error/oversight affecting reimbursement not related to activities covered in other policies.

- Small Balance Write-Off

Small balance write-offs are patient account balances that do not merit the time and cost of sending a bill to the patient. The threshold for small balance write-offs is $9.99 or less.

Monitor all write off activity for unusual activity, trends, accuracy, and adherence to policy.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:
Maintain records for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Charge Reduction or Removal at Department Level

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Conducting Hot Work		
Owner: Maintenance Manager	Department: Maintenance	
Scope:		
Date Last Modified: 01/10/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To establish guidelines and procedures for conducting hot work safely within Northern Inyo Healthcare District (NIHD), ensuring compliance with California state regulations, Joint Commission standards, National Fire Protection Association (NFPA) codes, and Occupational Safety and Health Administration (OSHA) requirements

POLICY STATEMENT:
Hot work, including welding, cutting, grinding, and other activities that produce heat, sparks, or open flames, shall be conducted only under controlled and approved conditions. All hot work must comply with California Code of Regulations (CCR) Title 8, Title 22, Title 24, California Fire Code, NFPA 51B, OSHA standards, and Joint Commission Environment of Care (EC) standards.

SCOPE:
This policy applies to all employees, contractors, and vendors performing hot work activities within Northern Inyo Healthcare District.

DEFINITIONS:
- **Hot Work:** Operations involving open flames, heat, or sparks, including welding, cutting, brazing, soldering, grinding, and torch-applied roofing.
- **Hot Work Permit:** A written authorization allowing hot work to be performed in a specific location under controlled conditions.
- **Fire Watch:** A trained individual assigned to monitor hot work areas for fire hazards during and after work completion.

RESPONSIBILITIES:
- **Facilities/Maintenance Supervisor:** Responsible for oversight, training, permitting, and compliance with hot work procedures.
- **Hot Work Operator:** Responsible for following all safety procedures, obtaining permits, and using proper protective equipment.
- **Fire Watch Personnel:** Responsible for monitoring the hot work area and ensuring no fire hazards persist after work completion.
- **Department Managers:** Ensure compliance with hot work procedures within their departments.

TRAINING REQUIREMENTS:
1. All personnel involved in hot work must complete annual training on hot work safety.
2. Training must cover fire safety, equipment operation, emergency response, and permit requirements.
3. Documentation of training must be maintained in employee records.

PROCEDURE:

A. Hot Work Permit:

1. A Hot Work Permit must be obtained from the Facilities/Maintenance Supervisor before any hot work begins.
2. The permit must include:
    - Description of the work
    - Location
    - Start and end time
    - Fire watch personnel assignment
3. Permits must be displayed in the work area.

B. Pre-Hot Work Inspection:

1. Inspect the work area for flammable materials.
2. Ensure appropriate fire suppression equipment is readily available.
3. Establish a fire-resistant barrier if needed.
4. Ensure proper ventilation in enclosed areas.
5. Verify the presence of fire watch personnel.

C. During Hot Work:

1. Wear appropriate Personal Protective Equipment (PPE), including flame-resistant clothing, goggles, and gloves.
2. Follow all safety guidelines for hot work equipment.
3. Cease operations immediately if unsafe conditions arise.
4. Maintain communication with fire watch personnel.

D. Fire Watch:

1. A fire watch must be maintained during hot work and for at least 30 minutes after work is completed.
2. Fire watch personnel must remain alert and have access to fire suppression equipment.
3. Document the fire watch period.

E. Post-Hot Work Inspection:

1. Inspect the area for potential fire hazards.
2. Ensure hot surfaces have cooled.
3. Remove all flammable materials from the area.
4. Finalize the Hot Work Permit and file it appropriately

F. Emergency Procedures:

1. In case of a fire, follow the hospital's fire response plan.
2. Immediately notify the Facilities Supervisor and emergency services.

RECORDKEEPING:

1. Document all training records.
2. Keep inspection and fire watch logs.

REFERENCES:

1. California Code of Regulations (CCR) Title 8, Title 22, Title 24
2. California Fire Code
3. National Fire Protection Association (NFPA) 51B
4. Joint Commission Environment of Care (EC) Standards
5. OSHA Standards

RECORD RETENTION AND DESTRUCTION:

1. Maintain all Hot Work Permits for a minimum of five (5) years.

CROSS REFERENCE POLICIES AND PROCEDURES: N/A

Supersedes: v.1 Conducting Hot Work

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Decorations, Receptacles & Heating Devices		
Owner: Maintenance Manager	Department: Maintenance	
Scope: District Wide		
Date Last Modified: 01/07/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To establish guidelines and procedures for the safe use of decorations, electrical receptacles, and heating devices within Northern Inyo Healthcare District, ensuring compliance with California state regulations, Joint Commission standards, and applicable fire and safety codes.

POLICY STATEMENT:

The use of decorations, electrical receptacles, and heating devices shall comply with the California Code of Regulations (CCR), Title 8, Title 22, Title 24, California Fire Code, National Fire Protection Association (NFPA) 99 and 101, and Joint Commission Environment of Care (EC) standards. These guidelines are designed to prevent fire hazards, electrical risks, and ensure a safe environment for patients, staff, and visitors.

SCOPE:

This policy applies to all departments, staff, contractors, and vendors operating within the Critical Access Hospital.

DEFINITIONS:

- **Decorations:** Any temporary or permanent ornamental items, including seasonal decor.
- **Receptacles:** Electrical outlets and power strips used for powering devices.
- **Heating Devices:** Portable or fixed devices used to generate heat, such as space heaters.

RESPONSIBILITIES:

- **Facilities/Maintenance Supervisor:** Ensures compliance, conducts inspections, and enforces corrective actions.
- **Department Managers:** Ensure department compliance with this policy.
- **All Staff:** Follow safety guidelines and report non-compliance.

TRAINING REQUIREMENTS:

1. Annual training on fire safety, electrical safety, and proper use of heating devices.

2. Staff must understand reporting procedures for malfunctioning or unsafe equipment.
3. Documentation of training must be maintained.

PROCEDURE:

A. Decorations:

1. Only flame-retardant or non-combustible decorations are permitted.
2. Decorations must not obstruct exits, fire alarms, sprinklers, or emergency lighting.
3. Electrical decorations must be UL-listed and inspected before use.
4. Avoid overloading circuits with multiple decorations.

B. Electrical Receptacles and Power Strips:

1. Only hospital-approved power strips may be used.
2. Power strips must not be daisy-chained.
3. Electrical receptacles must not show signs of damage or wear.
4. Inspect regularly for signs of overheating or frayed cords.

C. Heating Devices:

1. Portable space heaters are prohibited unless approved by the Facilities Supervisor.
2. Approved heaters must have automatic shutoff and tip-over protection.
3. Heating devices must be monitored when in use and turned off when unattended.
4. Heaters must not be placed near combustible materials.

D. Inspections:

1. Routine inspections must be conducted monthly.
2. Document findings and corrective actions.

E. Emergency Procedures:

1. In case of fire or electrical hazards, follow the hospital's fire response plan.
2. Report incidents to the Facilities Supervisor immediately.

REFERENCES:

California Code of Regulations (CCR) Title 8, Title 22, Title 24

California Fire Code

National Fire Protection Association (NFPA) 99, 101

Joint Commission Environment of Care (EC) Standards

OSHA Standards

RECORD RETENTION AND DESTRUCTION:

Training records must be kept for at least five (5) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Decorations, Receptacles & Heating Devices LS.02.01.70 EP 1-9

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL PROCEDURE

Title: Designing Building Systems and Risk Assessment		
Owner: Maintenance Manager	Department: Maintenance	
Scope: District Wide		
Date Last Modified: 01/10/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: Executive Committee	Original Approval Date:	

PURPOSE:
Northern Inyo Healthcare District (NIHD) ensures its' building systems are designed to meet National Fire Protection Association (NFPA) Categories 1-4 requirements. The NIHD building systems are designed to meet the National Fire Protection Association's (NFPA) categories 1-4 requirements as related to gas, vacuum, electrical, and electrical equipment.

DEFINITIONS

Category 1: Facility systems in which failure of such equipment or system is likely to cause major injury or death of patients or caregivers are to be designed to meet system Category 1 requirements.

Category 2: Facility systems in which failure of such equipment is likely to cause minor injury to patients or caregivers are to be designed to meet system Category 2 requirements.

Category 3: Facility systems in which failure of such equipment is not likely to cause injury to patients or caregivers but can cause patient discomfort are to be designed to meet system Category 3 requirements.

Category 4: Facility systems in which failure of such equipment would have no impact on patient care are to be designed to meet system Category 4 requirements.

PROCEDURE
1. At least triennially (once every three years) the organization shall re-evaluate risks
2. Upon installation and before use of a new utility system, the facility evaluated its' risk.

REFERENCES:
1. The Joint Commission CAMCAH Manual (Jan 2021) EC.02.05.01 EP2

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCES POLICIES AND PROCEDURES:
1. Fire Response Plan-Code Red EC.02.03.01 EP0
2. Fire Safety EC.02.03.01 EP1a
3. Fire Safety Management Plan (FSMP) EC.01.01.01 EP7

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Drugs of Abuse Maternal and Infant		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Perinatal		
Date Last Modified: 11/19/2024	Last Review Date: No Review Date	Version: 7
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/2007	

PURPOSE:
To comply with CA Health and Safety Code Section 123605 and to identify protect and treat infants who have been exposed to drugs or alcohol prenatally.

POLICY:
1. A urine drug screen (UDS) will be run on all pregnant patients admitted to the Perinatal Unit per physician/midwife order. The urine will be collected before the patient receives analgesia or sedation.
2. A validated tool will be used to screen for substance use on admission.
3. The patient will be informed that a urine drug screen is routinely run on all patients. If the patient does not refuse the UDS, consent will be implied.
4. If the patient refuses the UDS the obstetrician and pediatrician will be notified. Refusal in the absence of other risk factors is not grounds for a CPS referral.
5. A UDS/ newborn cord sample and/or meconium screening will be run per physician order on neonates whose mother's refused UDS, or have a positive screening score.
6. The first voiding after birth will be collected from the neonate for a UDS if possible..
7. A social service referral will be submitted for all mothers and neonates testing positive for drugs or who are identified with high risk factors.
8. The obstetrician and pediatrician caring for the identified mother and baby will assess the medical status and provide appropriate supportive clinical care.
9. A CPS report and request for evaluation by the Children's Protective Services will be filed by Social Services, the primary care RN, or other Health Care Provider on all mothers and babies testing or screening positive.
10. Follow up services will be arranged for mother and baby prior to discharge.
11. Infants at risk for opiate withdrawal will be assessed using a validated screening tool for opiate withdrawal.

MATERNAL RISK FACTORS:
1. Late or no prenatal care
2. History of substance use
3. Positive results on a standardized screening tool
4. Actively undergoing treatment in a substance abuse program
5. Suspected or confirmed placental abruption
6. Preterm labor
7. Low birth weight

SYMPTOMS OF WITHDRAWAL

1. Excessive crying
2. Fragmented sleep (less than 2-3 hours after feeding)
3. Tremors
4. Increased muscle tone
5. GI dysfunction including:
    a. Hyperphagia
    b. Poor feeding
    c. Feeding intolerance
    d. Loose or watery stools

PROCEDURE:

Collection of Urine

1. Verify the identification of the individual to be tested using the arm band and compare identification to the patient stick, the order, and labeled specimen container
2. If possible, obtain urine directly in the labeled specimen container.
3. Close the lid on the specimen container, and identify specimen with patient label or lab label with the date and time of collection and initials of the collector

Collection of newborn's urine or meconium

1. Verify the identification of the infant to be tested using the armband and compare to the patient sticker, the order, and the labeled specimen container.
2. The infant's urine will be obtained via urine bag or using cotton balls to collect urine in diaper and squeeze urine into specimen container.
3. Meconium will be collected from the diaper using a clean tongue depressor to transfer the sample into the specimen container.
4. Chain of custody process will be followed and the chain of custody paperwork will be completed on all send out specimens.

Notify Social Services of admission of couplet with risk factors for substance use disorder or for positive drug screen. Verify order for a social work consultation has been submitted. The hospital social worker will:

1. Perform an assessment
2. Work with the attending physician/midwife to identify plan of care and referral resources.
3. Make a referral to Child Protective Services in writing. The physicians caring for both mother and baby will be notified of this report. This verbal report to CPS must be made within 24 hours of a positive drug screen result. Drug screen results will be sent to CPS, even if the newborn and mother have been discharged. If the hospital social worker is not available, the RN, LVN, or Physician providing care will file the CPS report.

REFERENCES:

1. California Health and Safety Code Section 123605. Last updated January 1, 2023.
2. Golembeski, et al. (2024). Identify substance-exposed newborns best practice No. 5. CMQCC Mother and Baby Substance Exposure Toolkit**.**
3. Louw, Kerry-Ann (2018). Substance use in pregnancy: The medical challenge. Obstetric Medicine 11(2) 54-66

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Emergency Response Plan-HVAC Failure		
Owner: Maintenance Manager	Department: Maintenance	
Scope:		
Date Last Modified: 01/03/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

I. Purpose

The purpose of this policy is to establish a standardized response plan for HVAC (Heating, Ventilation, and Air Conditioning) system failures to ensure the safety, health, and comfort of patients, staff, and visitors in compliance with **California Code of Regulations (CCR), Title 22**, **Joint Commission Environment of Care (EC) Standards**, and other applicable regulatory requirements.

II. Policy Statement

It is the policy of Northern Inyo Healthcare District to respond swiftly and effectively to any HVAC system failure to maintain appropriate air quality, temperature, and humidity levels in all patient care and critical areas. Contingency measures will be in place to minimize disruption to patient care and ensure compliance with all local, state, and federal regulations.

III. Scope

This policy applies to all hospital departments, staff, and contractors involved in HVAC maintenance, monitoring, and emergency response.

IV. Regulatory References

- **California Code of Regulations (CCR), Title 22**
- **California Department of Public Health (CDPH) Regulations**
- **Joint Commission Environment of Care (EC) Standards**
- **NFPA 99: Health Care Facilities Code**
- **OSHA Standards (29 CFR 1910.37)**
- **ASHRAE Standards (American Society of Heating, Refrigerating, and Air-Conditioning Engineers)**

V. Definitions

- **HVAC System:** Heating, Ventilation, and Air Conditioning system responsible for controlling temperature, humidity, and air quality.

- **Critical Areas:** Areas such as operating rooms, intensive care units, emergency departments, and sterile processing areas.
- **Temporary Cooling/Heating Units:** Portable units deployed during HVAC failures.

VI. Responsibilities

1. **Facilities Management Department:** Responsible for HVAC system maintenance, monitoring, and emergency repairs.
2. **Incident Commander (IC):** Overall responsibility for decision-making during HVAC failures.
3. **Department Managers:** Ensure departmental compliance with emergency procedures.
4. **Staff Members:** Follow instructions provided during an HVAC failure.

VII. Procedure

A. Identification and Notification

1. HVAC failure is identified through monitoring systems, routine inspections, or staff reports.
2. Staff must immediately report HVAC failure to the Facilities Management Department.
3. The Incident Commander activates the HVAC Failure Response Plan.

B. Initial Assessment

1. Facilities staff conduct an initial assessment to identify:
    - Cause of failure
    - Affected areas
    - Estimated repair time
2. Critical patient care areas are prioritized for mitigation.

C. Communication Plan

1. Incident Command communicates status updates to all departments.
2. Staff and patients are informed of expected duration and impact.
3. External agencies (e.g., CDPH) are notified if required.

D. Immediate Response Actions

1. Deploy portable cooling/heating units to critical care areas.
2. Adjust workflow in affected areas, including temporary relocation of patients if necessary.
3. Implement infection prevention protocols.
4. Monitor air quality and temperature.

E. Long-Term Mitigation Measures

1. Coordinate with HVAC contractors for repair or replacement.
2. Document all actions, including repair timelines and contractor activities.

F. Evacuation (if necessary)

1. Follow hospital evacuation procedures if HVAC failure poses a life-threatening risk.

2. Relocate patients to unaffected areas or transfer to other facilities.

VIII. Recovery

1. Verify HVAC system is fully operational.
2. Perform thorough environmental testing for air quality and temperature compliance.
3. Submit incident report to hospital leadership and regulatory bodies as required.
4. Conduct after-action review and revise the HVAC Failure Response Plan as needed.

IX. Training and Drills

1. Conduct annual HVAC failure drills.
2. Staff training includes recognition of HVAC failure signs, emergency roles, and responsibilities.

X. Documentation and Record Keeping

1. Maintain records of all HVAC maintenance, repairs, and incidents.
2. Submit reports to regulatory agencies as required.

REFERENCES:

California Code of Regulations (CCR), Title 22

California Department of Public Health (CDPH) Regulations

Joint Commission Environment of Care (EC) Standards

NFPA 99: Health Care Facilities Code

OSHA Standards (29 CFR 1910.37)

ASHRAE Standards (American Society of Heating, Refrigerating, and Air-Conditioning Engineers)

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Emergency Response Plan-HVAC Failure EC.02.05.01 EP 10d

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Extension Cords		
Owner: Maintenance Manager	Department: Maintenance	
Scope:		
Date Last Modified: 02/06/2025	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
This policy establishes guidelines for the safe and appropriate use of extension cords within Northern Inyo Healthcare District facilities. It ensures compliance with the **California Code of Regulations (CCR), Title 22**, **Joint Commission Environment of Care (EC) Standards**, **NFPA 70 (National Electrical Code)**, **NFPA 99 (Health Care Facilities Code)**, and **OSHA Standards**.

POLICY STATEMENT:
Northern Inyo Healthcare District (NIHD) is committed to minimizing electrical hazards and ensuring the safety of patients, staff, and visitors. Extension cords are not to be used as permanent wiring and must meet specific safety standards for temporary use.

SCOPE
This policy applies to all hospital staff, contractors, and departments where extension cords are used.

DEFINITIONS
- **Extension Cord:** A flexible electrical power cable with a plug on one end and one or more outlets on the other.
- **Power Strip:** A device with multiple electrical outlets, often with surge protection.
- **Temporary Use:** Use of an extension cord for a period not exceeding 90 days.

RESPONSIBILITIES
1. **Facilities Management Department:** Responsible for ensuring compliance with this policy and conducting regular inspections.
2. **Department Managers:** Ensure departmental compliance and address misuse of extension cords.
3. **All Staff:** Adhere to the safe use of extension cords and report any hazards.

PROCEDURE
A. GENERAL GUIDELINES FOR EXTENSION CORD USE
1. Extension cords must only be used for temporary purposes.
2. Extension cords must not replace permanent wiring.
3. All extension cords must be UL (Underwriters Laboratories) listed.
4. Cords must be in good condition, without cracks, frays, or exposed wires.
5. Cords must not run under rugs, doors, or through walls, ceilings, or floors.
6. Extension cords must not be daisy-chained (connected end-to-end).
7. Only hospital-approved power strips with surge protection are permitted.

B. PATIENT CARE AREAS

1. Extension cords must not be used in critical care areas (e.g., operating rooms, ICU) unless approved for specific medical equipment use.
2. Medical-grade power strips must be used in patient care areas.
3. Cords and power strips must be secured to prevent tripping hazards.

C. INSPECTION AND MAINTENANCE

1. Facilities staff will inspect extension cords quarterly for compliance.
2. Non-compliant extension cords must be removed immediately.
3. Damaged cords must be replaced and properly disposed of.

D. TEMPORARY USE APPROVAL PROCESS

1. Department managers must approve temporary extension cord use.
2. A documented plan must outline the purpose, location, and duration of use.
3. Facilities Management must review and approve all temporary use plans.

E. TRAINING AND AWARENESS

1. Staff will receive annual training on the safe use of extension cords.
2. Training will include identification of electrical hazards and proper reporting procedures.

F. EMERGENCY RESPONSE

1. In the event of an electrical hazard, staff must:
   - Disconnect the cord safely (if possible).
   - Notify Facilities Management immediately.
   - Evacuate the area if necessary.
2. Facilities staff will assess and resolve the issue.

PROHIBITED PRACTICES

1. Using extension cords as permanent wiring.
2. Using damaged or non-UL-listed cords.
3. Plugging one extension cord into another.
4. Running cords through doors, walls, or windows.
5. Overloading extension cords beyond their rated capacity.

RECORD KEEPING

1. Records of inspections, approvals, and training will be maintained by Facilities Management.
2. Non-compliance incidents will be documented and addressed promptly.

COMPLIANCE MONITORING

1. Facilities Management will conduct regular audits to ensure compliance.
2. Findings will be reported to the Environment of Care Committee.
3. Corrective action plans will be implemented as needed.

REFERENCES:

1. California Code of Regulations, Title 22
2. NFPA 70: National Electrical Code
3. NFPA 99: Health Care Facilities Code
4. OSHA Standard 29 CFR 1910.303 and 1910.305
5. Joint Commission EC Standards

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES: N/A

Supersedes: v.2 Extension Cords

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Finance and Audit Committee Charter		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope:		
Date Last Modified: 02/06/2025	Last Review Date: No Review Date	Version: 2
Final Approval by:	Original Approval Date:	

Board of Director Bylaws: Finance and Audit Committee:

1. Members of this standing committee shall include a committee of the whole of the Board of Directors, the Chief Financial Officer, the Chief Executive Officer, and others as requested. The Directors shall be the only members of the Committee with voting privileges.
2. The Finance Committee, in consultation with the Chief Executive Officer and Chief Financial Officer, shall be responsible for reviewing and monitoring the annual budget and, as appropriate, its long-term capital expenditure plan. The Finance Committee shall make recommendations to the Board on retention of auditors and approve audits, and business plans pursuant to subsidiary organizations.
3. The Finance and Audit Committee shall meet no less than three times per year

COMMITTEE PURPOSE

1. The Finance and Audit Committee will oversee the management of finances and audit process to ensure that the hospital is financially sustainable, operating within budgetary guidelines, and audit findings are addressed.

COMMITTEE MEMBERSHIP

1. The Finance and Audit Committee shall include a committee of the whole of the Board of Directors, the Chief Executive Officer, the Chief Financial Officer, and others as requested. The Directors shall be the only members of the committee with voting privileges.
2. All Finance and Audit Committee 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 OF MEETINGS

1. The Finance and Audit Committee shall meet in January, June, and August at a minimum unless there is a need for additional meetings. Meetings may be held at irregular intervals.

COMMITTEE RESPONSIBILITIES

1. Analyze financial and audit reports
2. Review capital equipment, construction, and IT project status
3. Review Operational and Capital Budget
4. Review audit results and mitigation plan

5. Review Financial Policies
6. Review Investment status
7. Review cash position
8. Review Bond Covenant and Relationship
9. Review Pension Fund
10. Review approval limitations and signers

FREQUENCY REVIEW/REVISION

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

Supersedes: v.1 Finance and Audit Committee Charter

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Financial Assistance and Charity Care Policy		
Owner: Chief Executive Officer	Department: Administration	
Scope: District Wide		
Date Last Modified: 01/10/2024	Last Review Date: 01/24/2025	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/15/2017	

PURPOSE:

To define the parameters of eligibility, amount of aid possible, and the process of access to the Financial Assistance and Charity Care Program mandated by California **Health and Safety Code Section** (CA HSC) **127400-127446.**

DEFINITIONS:

CA HSC 127400: As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient," means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the District's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level (FPL)" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g).

(2) A patient who has a family income that does not exceed 400 percent of the federal poverty level.

(d) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation. Northern Inyo Healthcare District includes a hospital and clinics, referred to as "the District".

(e) "Department" means the Department of Health Care Access and Information.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital"

(g) “A patient with high medical costs” means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). For these purposes, “high medical costs” means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the Healthcare District that exceed the lesser of 10 percent of the patient’s current family income or family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months.

(3) A lower level determined by NIHD in accordance with the District’s Financial Assistance and Charity Care policy.

(h) “Patient’s family” means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(i) “Reasonable payment plan” means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. “Essential living expenses” means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

POLICY:

Northern Inyo Healthcare District (NIHD) will provide healthcare access to individuals who are uninsured, under insured, or who have high medical costs. This is available for medically necessary service/care. Federal Poverty Level Guidelines (FPL) for income will be the basis of eligibility for NIHD’s Financial Assistance and Charity Care Program. The Notice of Available Charity and Discount Services included in this policy will be updated annually when FPL is released; using 400 percent of the government poverty income level for free, discounted, or financed care. NIHD will offer financing arrangements to ease the burden of healthcare costs. The following criteria will be followed for determining the level and type of assistance:

1. Eligibility criteria will be the applicant’s, applicant’s family, or entire household gross income, including alimony, child support, financial support of absent parent, and all other income from whatever source derived, coupled with household size.
2. Income from whatever source derived will be used to consider the applicant’s level of responsibility. The following indicates the amount and type of assistance available:
    a. When the total income is at or below 100% of the FPL, NIHD will offer free care through the Financial Assistance and Charity Care application and approval process;
    b. When the total income is above 100% and equal to or lower than 200%, NIHD will offer a 25% discount and long-term financing through the Financial Assistance and Charity Care application and approval process;

c. When the total income is above 200% and equal to or lower than 250%, NIHD will offer a 20% discount and long-term financing through the Financial Assistance and Charity Care application and approval process;
d. When the total income is above 250% and equal to or lower than 300%, NIHD will offer a 15% discount and long-term financing through the Financial Assistance and Charity Care application and approval process;
e. When the total income is above 300% and equal to or lower than 350%, NIHD will offer a 10% discount and long-term financing through the Financial Assistance and Charity Care application and approval process;
f. When the income is above 350% and equal to or lower than 400%, NIHD will offer a 5% discount and long-term financing through the Financial Assistance and Charity Care application and approval process;
g. When the total income is above 400%, NIHD will offer long-term financing through the Financial Assistance and Charity Care application and approval process;

3. Monetary assets will be considered in the determination of eligibility. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.
4. Verification of the patient's household income may consist of, but not limited to, the following applicable documents:
    a. Paycheck stubs for current three months;
    b. Unemployment payment stubs;
    c. Disability payment stubs;
    d. Bank statements for current three months;
    e. Copy of current or previous year income tax return;
    f. Copy of currently approved letter or denied letter from the local social service assistance program (Medi-Cal).
5. Should the applicant have no source of income, inquiry will be made as to how the patients supports him or herself**.**
6. All other resources of coverage will first be sought. This includes, but is not limited to, any available local social service assistance program such as Medi-Cal and CCS (California Children's Services); Medicare; Insurance; employer provided or offered health plan; Inyo County Medical Services Program (CMSP); other available third party sources; participation in the Affordable Care Act.
    a. Individuals without insurance will be assisted in following the Affordable Care Act, participating in "Open" Enrollment.
    b. Written denial is required for applicants not eligible for assistance through their local department of social services or Medicaid programs.
    c. Should an applicant be eligible for Medi-Cal or other State's Medicaid programs with a Share of Cost, the applicant may NOT be entitled to the Financial Assistance and Charity Care Program to assist with meeting Share of Cost responsibilities. Once their Share of Cost is satisfied, the applicant's Medi-Cal will be accepted as payment for covered services.
    d. Failure to comply with timely application, (60 days from discharge date) for local social service assistance programs, or failure to complete the application for available local social service assistance programs may be a basis for denial of the NIHD Financial Assistance and Charity Care Program.

7. To sustain eligibility, NIHD Financial Assistance and Charity Care recipients will be required to submit a new Financial Assistance and Charity Care application every twelve months, including new application to available local social service assistance programs.
8. If any information given proves to be untrue, NIHD reserves the right to re-evaluate the application and take whatever action becomes appropriate up to disqualification and revocation of Financial Assistance and Charity Care.
9. Efforts to identify patient's qualification for NIHD Financial Assistance and Charity Care Program will be initiated upon receipt of the completed application and ALL supporting documents not to exceed (6) Six months from self-pay balance first statement.
10. Conditional qualification may be made in cases where eligibility for other available assistance programs has not yet been determined.
11. Individuals who do not respond to notices of Charity or Discount services, who do not respond to billing and collection efforts, and their accounts are subsequently assigned to Bad Debt and an outside collection agency will not be eligible for NIHD's Financial Assistance and Charity Care program adjustments.
12. Financial Assistance and Charity Care denials for patients based upon their income may become subsequently approved should their income change following their original determination based on additional supplied information. Subsequent determinations will not result in a refund of prior payments.
13. Effect of the determination of eligibility will not be open-ended. Charity status may be reviewed at any time during the covered time period, not to exceed one year.
14. Included in the initial billing (patient statement) of the uninsured individuals, will be the NORTHERN INYO HEALTHCARE DISTRICT REQUEST FOR HEALTH COVERAGE INFORMATION / NORTHERN INYO HEALTHCARE DISTRICT NOTICE OF OTHER COVERAGE PROGRAMS / and FINANCIAL ASSISTANCE AND CHARITY CARE SERVICES (included in this policy).
15. Post notices of NIHD's Financial Assistance and Charity Care & Discount Payment Program in all patient care areas, waiting rooms and reception areas as well as the Credit (payment) and Billing Information Office. This will include the Rural Health Clinic and all Northern Inyo Associates Offices.
16. Applications for the NIHD Financial Assistance and Charity Care Services will be available through Northern Inyo Healthcare District Administration, Social Services Department, and the Credit and Billing Information Office.
    a. The application will include the patient's or applicant's complete name; address; telephone number; social security number; employer; family size; income as described above; service rendered/requested; date of service; applicant's signature; and space for eligibility determination.
17. The Credit & Billing Information Staff will process complete applications within ten (10) business days.
18. Send the applicant a final determination by the US mail.
19. https://healthconsumer.org for additional assistance.

REFERENCE:

1. California Health and Safety Code Section 127400-127446.
2. CA AB 1020

RECORD RETENTION AND DESTRUCTION:

Maintain all patient accounting files for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Billing and Collections
2. Price Transparency
3. Credit Balance Refund Processing

4. Prompt Pay Discounts
5. InQuiseek - #600 Financial Policies

Supersedes: v.2 Charity Care Program

REQUEST FOR HEALTH COVERAGE INFORMATION

NOTICE OF OTHER COVERAGE PROGRAMS

OF AVAILABLE FINANCIAL ASSISTANCE AND CHARITY CARE

When you presented for your recent services, it appeared that you may not have health insurance or other coverage. If this is incorrect, please contact our Credit and Billing Information office at (760) 873-2097 at your earliest convenience to provide us with your coverage information.

If you do not have health insurance coverage, or other coverage, you may be eligible for Medicare, MediCal, CMSP, or CCS.

You may contact our Credit and Billing Information office at (760) 873-2190 or your local Social Services office for an application for MediCal.

You may obtain information from the Social Security Office regarding Medicare benefits or your local county Health Department regarding CMSP, CCS benefits.

It is the policy of the Northern Inyo Healthcare District to provide a reasonable amount of care without, or below charge to people who are uninsured, under insured, or with high medical costs. Individuals within the annual income requirements established below may be eligible to receive free or discounted medical care based upon income level and family size.

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$14,580
2	$19,720
3	$24,860

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than 8 persons, add $5,140 for each additional person.	

If you believe, you may be eligible, or if you would like more information or an application, contact the Credit and Billing Information Office, Monday – Friday 8:30a.m. - 4:30p.m. Telephone: (760) 873-2097.

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Fire Drills		
Owner: Maintenance Manager	Department: Maintenance	
Scope: District Wide		
Date Last Modified: 01/02/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE

The purpose of this policy is to ensure compliance with **The Joint Commission (TJC) Standard EC.02.03.03, Elements of Performance (EP) 1-5**, **NFPA 101 (2012 Edition)**, and all **applicable California regulations** regarding fire drills. This policy ensures staff readiness, effective response to fire emergencies, and the safety of patients, staff, and visitors.

POLICY:

It is the policy of Northern Inyo Hospital (NIHD) to conduct fire drills in the hospital and its business occupancies in accordance with NFPA and the Joint Commission's® Environment of Care® (EOC) standards to test fire alarm equipment, fire safety building features, staff knowledge, and response to fire safety.

DEFINITIONS:

- **Fire Drill:** A planned, simulated fire emergency exercise.
- **Life Safety Code:** The NFPA 101 standard governing fire protection and safety.
- **Staff Participation:** Active engagement by employees during fire drills.

RESPONSIBILITY:

- **Facilities Director:** Oversees fire drill scheduling, execution, and documentation.
- **Safety Officer:** Monitors fire drill compliance and evaluates performance.
- **Department Managers:** Ensure staff participation and compliance during drills.
- **All Staff:** Participate actively in fire drills and follow established procedures.
- Licensed independent practitioners

PROCEDURE:

Fire Drill Frequency (TJC EC.02.03.03 EP 1)

1. Fire drills will be conducted **at least once per shift per quarter**.

2. Drills will be unannounced to staff to simulate real emergency scenarios.
3. Outpatient buildings not staffed 24/7 will have fire drills **at least annually**.
4. When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use alternative methods to notify staff instead of activating audible alarms.

Fire Drill Scenarios (TJC EC.02.03.03 EP 2)

1. Each fire drill will simulate different fire emergency scenarios.
2. Scenarios will include blocked exits, equipment failures, and varied points of origin.
3. Staff will be evaluated on their response, including alarm activation, evacuation procedures, and communication.

Staff Participation (TJC EC.02.03.03 EP 3)

1. All staff must participate in scheduled fire drills.
2. Staff will demonstrate knowledge of fire response procedures, including RACE (Rescue, Alarm, Confine, Extinguish) and PASS (Pull, Aim, Squeeze, Sweep) techniques.
3. Non-participating staff must provide justification for absence and may require makeup training.

Evaluation and Documentation (TJC EC.02.03.03 EP 4)

1. Each fire drill will be evaluated for effectiveness and staff responsiveness.
2. Observations will be documented on the **Fire Drill Report Form**.
3. Documentation will include:
    - Date and time of the drill
    - Scenario details
    - Staff participation
    - Observations and corrective actions
4. Records will be maintained for a **minimum of three years**.

Improvement Actions (TJC EC.02.03.03 EP 5)

1. Deficiencies identified during fire drills will be addressed promptly.
2. Corrective action plans will be developed and implemented.
3. Results and improvements will be reviewed during the **Environment of Care Committee meetings**.

Training

- Staff will receive **annual fire safety training**, including procedures for fire drills and emergency response.
- New employees will receive fire drill training as part of their onboarding process.

Compliance Monitoring

- The Safety Officer will perform **quarterly audits** of fire drill records.
- Results will be reported to the **Environment of Care Committee**.
- Non-compliance will result in retraining and possible disciplinary actions.

REFERENCE:

- The Joint Commission (TJC) Standard EC.02.03.03, EP 1-5
- NFPA 101: Life Safety Code (2012 Edition)
- California Code of Regulations (Title 19, Division 1, Chapter 2)

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Fire Drills
2. Exits in Business Occupancy EC.02.03.01 EP 4
3. Fire Response Plan-Code Red EC.02.03.01 EP9
4. Fire Safety EC.02.03.01 EP 1a
5. FIRE SAFETY – Fire Hazards during Surgical Procedures EC.02.03.01 EP 11-12
6. FIRE SAFETY Compliance with NFPA 99-2012: Chapter 15 EC.02.03.01 EP 13
7. Fire Safety Equipment Inspection EC.02.03.05 EP1-28
8. Fire Safety Management Plan (FSMP) EC.01.01.01 EP 7
9. InQuiseek – Fire Safety, Training and Evacuation

Supersedes: v.1 Fire Drills EC.02.03.03 EP 1-5

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Mandated Reporting: Child Abuse/Neglect; Dependent Adult/Elder Abuse; Injury by Firearm or Assault/Abuse		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: District Wide		
Date Last Modified: 12/18/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/21/2022	

PURPOSE:

- To comply with California's Health & Safety, Welfare & Institutions, and state Penal Codes which require specific processes for reporting actual or suspected cases of assault, abuse, and neglect; as well as firearm and other suspicious injuries.
- To promote District-wide awareness of these issues, and accurate recognition/diagnosis of symptoms.
- To help protect, intervene on behalf of, and ensure appropriate post-discharge services/referrals for vulnerable members of some of the District's highest-risk patient populations – including infants who have been prenatally exposed to drugs/alcohol, minor children, dependent adults and elders, battered intimate partners, victims of crimes and survivors of sexual assault.
- To clarify how District staff will handle administrative issues surrounding such cases, including proper documentation, confidentiality, etc.

DEFINITIONS:

Child: Person under age 18 per penal code §11165.

Elder: Person age 65 or older per Welfare & Inst. Code §15610.26.

Dependent Adult: Person between ages 19 and 64 with physical or mental limitation that restricts his or her ability to carry out normal activities or protects his or her rights. Includes all people between ages 18 and 64 who have been admitted as an inpatient to a 24-hour health care facility per Welfare & Inst. Code §15610.23.

Mandated Reporter: Employee who is required by law to report a particular category or type of abuse to the appropriate law enforcement or social service agency.

Mandated Reporters in California, per California Penal Code 11165.7, include the following District job roles:

- An administrator or employee of any organization whose duties require direct contact and supervision of children
- A social worker
- A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker
- A medical examiner or anyone who performs autopsies
- A clergy member or religious practitioner
- An alcohol or drug counselor
- A complete list is available online at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=15630.&lawCode=WIC

A person in a mandated reporter role while at work for the District, when away from work may report as a 'Voluntary Reporter'. Penal Code 11166 (g) permits, but does not require, reporting from any non-mandated

reporter. This includes a mandated reporter who acts in his or her private capacity and not in their professional capacity or within the scope of his or her employment.

CHILD ABUSE/NEGLECT:

1. Reportable Criteria – The following general categories of abuse and neglect of a child must be reported when a mandated reporter knows, or reasonably suspects, such abuse or neglect has occurred:
    A. General neglect including failure to provide basic necessities of life and/or parental absence (absence and deprivation of necessities can be intentional or due to drug/alcohol use, mental health conditions, incarceration, etc.);
    B. Physical injury that results from neglect, willful harm, or excessive corporal punishment;
    C. Endangering of health including failure to provide necessary medical or mental health treatment;
    D. Emotional or psychological abuse including patterns of behavior that could impair a child's development or sense of self-worth (Examples: frequent criticism; intentional humiliation used as punishment; threats of bodily or other serious harm; withholding love, support, or guidance; claiming that the child is bad or evil; not being able to think of any positive qualities about the child.)
    E. Sexual abuse, including the failure to protect against someone else sexually abusing the child;
    F. Infants passively/prenatally exposed to drugs or alcohol, as evidenced by positive universal pre-delivery maternal drug screens given upon admission to the hospital (see exclusions of reporting mandate for additional details);
    G. Minor children who have witnessed domestic violence between parents and/or other caregivers in their households (the existence of violence is not in itself reportable if the children have not been personally exposed to it);
    H. Suspicious or wrongful pediatric deaths.

2. Exclusions of reporting mandate:
    A. Mutual altercations between children;
    B. Injury caused by reasonable and necessary force used by a peace officer acting within the scope of his or her duties.
    C. If a mother tests positive for THC but nursing assessments of her overall social situation suggest no additional risk factors for her children, the THC use does NOT have to be reported per California penal code 11165.13.
    D. High-risk pregnant patients in clinic settings who have not yet delivered prenatally exposed babies.
        i. In deciding whether a drug-related report is/is not necessary, staff should consider whether a high-risk patient is known to have older children at home who may also be negatively affected by the patient's alcohol or drug use – if so, the existing children must still be reported.
        ii. High-risk mothers will also be referred to the hospital's inpatient Social Worker as soon as possible (this includes from clinic settings well before delivery).

PROCEDURE:

1. Reporting process (Penal Code §11166)
    A. Immediately notify the NIHD House Supervisor.
    B. As soon as reasonably possible, Telephone report to county Child Protective Services (CPS) in which the child lives.
    Inyo County CPS Phone number: (866) 806-2461 or (760) 872-1727

Mono County CPS Phone number: (800) 340-5411 or (760) 924-1770
Nye County HHS: (833) 803-1183

These lines serve the community around the clock.

i. Telephone report shall include the following items:
   a. Name of person making report,
   b. Name, current location and identifying information (age, residence address, etc.) of the child
   c. Nature and extent of injury,
   d. Any other information requested by the agency.

ii. Obtain a case number from CPS (if available) and the name of the person taking the report.

C. Within 36 hours, file a written report on 'Suspected Child Abuse Report' (Form SS8572). https://oag.ca.gov/sites/all/files/agweb/pdfs/childabuse/ss_8572.pdf
The state of Nevada does not have a standardized form; therefore reports written using the California SCAR format are still acceptable.

i. Fax (or e-mail) Suspected Child Abuse Report to:
CPS Department of Health and Human Services Inyo County @ 760.872.1749
CPS Department of Health and Human Services Mono County @ 760.924.1721
Nye County (Tonopah, NV): carsondointake@dcfs.nv.gov

ii. **Or** Mail Suspected Child Abuse Report to:
CPS Department of Health and Human Services Inyo County
1360 Main Street
Bishop, CA 93514

CPS Department of Health and Human Services Mono County
PO Box 2969
Mammoth Lakes, CA 93564

iii. Notify hospital Licensed Clinical Social Worker (LCSW) of each Suspected Child Abuse via Report form.
   a. Form is placed into a confidential envelope and delivered to Hospital Social Worker. May be left in the LCSW secured mail box outside of her office, or;
   b. Send report via pre-programed fax to District's LCSW (work) email address.

iv. No Copy of the Suspected Child Abuse Report is maintained at NIHD post notification of CPS and LCSW. Place paper copy into confidential shredding box for destruction.

2. Documentation:
A. Forensic examination documentation is included in the patient medical record. Use of CAL-OES Form 2-900 is recommended for documentation. https://www.ccfmtc.org/wp-content/uploads/2-900-Form-1-1.pdf .
B. Maintain forensic examination documentation done outside of the patient electronic medical record with strict confidentiality.
   i. Place paper records into a sealed envelope, marked confidential.
   ii. Give confidential envelope to the NIHD House Supervisor, who will deliver to Health Information Management Services (HIMS) Manager or Lead.
   iii. During times of unavailability of HIMS Manager or Lead, Lock the confidential document in the HIMS secured mailbox outside of the department.

iv. HIMS will assure coding is completed prior to scanning; document is scanned and made confidential for all forensic documents.

C. Primary Registered Nurse (RN) or workforce member completing the mandated report shall open a confidential note within the patient's medical record.
   i. Document phone report to CPS; including name of person who took the report, date and time report was provide.
   ii. Document written report to CPS; including form number utilized, where the document was sent, how it was sent (fax + number or Mail + address).
   iii. CPS case number, if able to obtain.

DEPENDENT ADULT/ELDER ABUSE:

1. Who musts report at NIHD (Welfare & Inst. Code §15630)
   A. Any NIHD workforce member (direct care job roles, social service, provider or administrator) whose job duties involve interactions or care provision for elders or dependent care services.
   B. Clergy.
2. What must be reported – The following general categories of abuse of an elder or dependent adult must be reported when a mandated reporter has observed, has knowledge of or reasonably suspects the abuse, or is told by the elder or dependent adult that such abuse has occurred:
   A. Physical abuse;
   B. Abandonment;
   C. Abduction;
   D. Isolation;
   E. Financial abuse;
   F. Neglect.

PROCEDURE:

1. Reporting process (Welfare & Inst. Code §15630(c))
   A. The appropriate reporting agency for elder and dependent adult abuse depends on the location in which the abuse occurred, rather than the location in which it was discovered.
   B. Immediately notify the NIHD House Supervisor
   C. Telephone report must happen as soon as reasonably possible.
   D. Written report must occur within two (2) days.
   E. **When the patient is a resident of is a resident of a long term care facility**, such as a skilled nursing facility, or a Swing Bed patient, or attends group care, the **Ombudsman** must be notified as soon as reasonably possible by Telephone:
   Ombudsman Advocacy Services of Inyo and Mono Counties at 1-760.8724128.
   Leave a message if no one answers.
   F. **Report all Elder Abuse Cases to Adult Protective Services (APS).**
      i. Telephone report shall include the following item:
         a. Name of person making report,
         b. Name of the patient,
         c. Present location of the patient,
         d. Nature and extent of injury,
         e. Any other information requested by the Ombudsman.
      ii. Obtain a case number from Ombudsman and APS (if available) and the name of the person taking the report.
      iii. Within two (2) working days, file a written report on 'Report of Suspected Dependent Adult/Elder Abuse" (Form SOC341). This may be used for both Ombudsman and APS

written reporting.
https://cdss.ca.gov/MandatedReporting/story_content/external_files/SOC341.pdf

a. Fax 'Suspected Dependent Adult/Elder Abuse' Report as appropriate to:
Inyo/Mono Ombudsman @ Fax 760.873.4250 and/or
APS Department of Health and Human Services Inyo County @ 760.872.1749
APS Department of Health and Human Services Mono County @ 760.924.1721

b. **Or** Mail to as appropriate:
Suspected Dependent Adult/Elder Abuse Report to Inyo/Mono Ombudsman:
Ombudsman C/O Bishop Senior Center
682 Spruce Street
Bishop, CA 93514

APS Department of Health and Human Services Inyo County
1360 Main Street
Bishop, CA 93514

APS Department of Health and Human Services Mono County
PO Box 2969
Mammoth Lakes, CA 93564

vi. Notify hospital Licensed Clinical Social Worker (LCSW) of each Suspected Elder Adult Abuse or Dependent Adult Abuse via Report form.
   a. Place form into a confidential envelope and delivered to hospital Social Worker. May be left in the LCSW secured mail box outside of his/her office, or;
   b. Send via pre-programed fax to District's LCSW (work) email address.

v. No Copy of the Suspected Dependent Adult/Elder Abuse' is maintained at NIHD post notification of APS and LCSW. Place paper copy into confidential shredding box for destruction.

2. Documentation:
   A. Forensic examination documentation is included in the patient medical record. Consider use of CAL-OES Form 2-602 for documentation. https://www.ccfmtc.org/wp-content/uploads/2-602-Form-1-1.pdf . Instructions for use of the form https://www.ccfmtc.org/wp-content/uploads/2-602-Instructions-1-1.pdf.
   B. Forensic examination documentation done outside of the patient electronic medical record, shall be maintained with strict confidentiality.
      i. Place paper records into a sealed envelope, marked confidential.
      ii. Give confidential envelope to the NIHD House Supervisor, who will deliver to Health Information Management Services (HIMS) Manager or Lead.
      iii. During times of unavailability of HIMS Manager or Lead, lock the confidential document in the HIMS secured mailbox outside of the department.
      iv. HIMS will assure coding is completed prior to scanning; forensic documentation is scanned and made confidential for all forensic documents.
   C. Primary Registered Nurse (RN) or workforce member completing the mandated report shall open a confidential note within the patient's medical record.
      i. Document phone report to Ombudsman or APS; including name of person who took the report, date and time report was provide.

ii. Document written report to Ombudsman or APS; including form number utilized, where the document was sent, how it was sent (fax + number or Mail + address).
iii. Ombudsman or APS case number, if able to obtain.

INJURY BY FIREARM OR ASSAULT/ABUSE POLICY:

1. Who must report at Northern Inyo Healthcare District (NIHD) (Penal Code §11160(a)).
   A. Any NIHD health practitioner providing services in a health facility, clinic or physician's office who knows or reasonably suspects that a patient to whom the practitioner is providing services is the victim of assaultive or abusive conduct or a firearm injury.
   B. NIHD requirement to report suspicious injury, including all firearm or assault/abuse as a part of job responsibility and or care provision on District premises or at NIHD functions.
2. What must be reported – All physical injuries known or reasonably suspected to have resulted from the following general categories of conduct must be reported:
   A. Firearms-whether inflicted by the patient or another;
   B. Murder, manslaughter, mayhem, aggravated mayhem, torture, battery;
   C. Assault – including with intent to commit another crime, with a stun gun or Taser, or with a deadly weapon;
   D. Administration of a controlled substance or anesthetic to aid in commission of a felony;
   E. Sexual battery, incest, rape, spousal rape, procuring a person to have sex with another person, sodomy, oral copulation, sexual penetration;
   F. Throwing chemical substances with the intent to injure or disfigure;
   G. Child abuse or endangerment, lewd or lascivious acts with a child;
   H. Abuse of spouse or cohabitant;
   I. Elder Abuse;
   J. Attempt to commit any crime listed in bullet points above.

PROCEDURE:

1. Reporting Process (Penal Code §11160(b))
   A. Immediately notify the NIHD House Supervisor.
   B. As soon as reasonably possible, Telephone report to local law enforcement agency with jurisdiction over the location where the incident occurred.
      Inyo County Sheriff (Bishop Substation) 760.873.7887 prompt #4
      Bishop Police Department 760.873.5866 prompt #1
      California Highway Patrol 760.872.5900
      i. Obtain the name of the officer taking the report, badge number and case number (if available).
      ii. Obtain the fax number or address for mailing written report to agency.
   C. Within two (2) working days' file a written report on 'Suspicious Injury Report' (Form Cal OES 2-920) must be sent to the Law Enforcement Agency with jurisdiction over the case. https://www.edcgov.us/Government/EMS/forms/Documents/2-920%20Mandated%20Suspicious%20Injury%20Report.pdf
      i. Within two (2) working days' file a written report on 'Report of Suspected Dependent Adult/Elder Abuse" (Form SOC341). https://cdss.ca.gov/MandatedReporting/story_content/external_files/SOC341.pdf
         a. Fax Suspected Adult Abuse Report within two (2) days to appropriate agency:
         Inyo County Sheriff's Fax: 760.872.3485
         Bishop Police Department Fax: 760.873.8956

b. **Or** mail to appropriate agency:

Bishop Police Department (Attn: Records)
207 W. Line Street
Bishop, CA 93514

Inyo County Sheriff Department
PO Box 29691360 N. Main Street Suite 151
Bishop, CA 93514

D. 'Suspicious Injury Report' is not a part of the medical record and is not maintained post completion of mandated reporting. After faxing report to Law Enforcement Agency, place document into a confidential shredding box for destruction.

2. Documentation
   A. Forensic examination documentation is included in the patient medical record.
      i. Consider use of Cal-OES Form 2-950 for documentation of sexual assault suspect examination. https://evawintl.org/wp-content/uploads/2-950-Form.pdf.
      ii. Cal-OES Form 2-923 may be utilized for documentation of Acute (<120 Hours) Adult/Adolescent Sexual Assault Examination. https://www.ccfmtc.org/wp-content/uploads/923-paper-form-July-2018-3.pdf
      iii. Cal-OES Form 2-502 may be utilized for Domestic Violence Examination. https://www.ccfmtc.org/wp-content/uploads/2-950-Form-1-1.pdf
      iv. Multiple other forensic forms may be found @ https://www.ccfmtc.org/forensic-medical-examination-forms/.
   B. Maintain forensic examination documentation done outside of the patient electronic medical record with strict confidentiality.
      i. Place paper records into a sealed envelope, marked confidential.
      ii. Give confidential envelope to the NIHD House Supervisor, who will deliver to Health Information Management Services (HIMS) Manager or Lead.
      iii. During times of unavailability of HIMS Manager or Lead, lock the confidential document in the HIMS secured mailbox outside of the department.
      iv. HIMS will assure coding is completed prior to scanning; forensic documentation is scanned and made confidential for all forensic documents.
   C. Primary Registered Nurse (RN) or workforce member completing the mandated report shall open a confidential note within the patient's medical record.
      i. Document phone report to Law Enforcement Agency; including name and badge number of officer who took the report, date and time report was provide.
      ii. Document sending of written report to Law Enforcement Agency; including form number utilized, where the document was sent, how it was sent (fax + number or Mail + address).
      iii. Case number, if able to obtain.

REFERENCES:

1. 2021 California Code/Penal Code – PEN; Part 4 – Prevention of Crimes and Apprehension of Criminals: Title 1 – Investigation and Control of Crimes and Criminals; Chapter 2 – Control of Crimes and Criminals, Article 2 – Report of Injuries. Section 11160 – 11162
2. California Welfare and Institutions Code-Part 3/Division 9: Article 2, Section 11164 and Chapter 11, Section 15600.
3. Consent Manual, California Hospital Association (2021), Chapter 17 *Assault and Abuse Reporting Requirements.*

RECORD RETENTION AND DESTRUCTION:

Reporting documents sent to outside agencies are not maintained within the medical record and not require maintenance by the District once they are sent to the required agency.
Maintenance of forensic examination documentation within the patient's medical record as a confidential document is mandated by regulations.
The Health Information Management Services (HIMS) Department per California Hospital Association guidelines manages retention and destruction of Medical records.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Lippincott Procedures: Suspected child abuse assessment https://procedures.lww.com/lnp/view.do?pId=3260837&hits=abuse,child,neglect,abusing,abused,abuses&a=false&ad=false&q=child%20abuse%20neglect
2. Lippincott Procedures: Suspected child abuse, recognizing and reporting, ambulatory care https://procedures.lww.com/lnp/view.do?pId=3358961&hits=child,abusing,abuse,abuses&a=false&ad=false&q=child%20abuse
3. Lippincott Procedures: Suspected abuse in a patient with a disability, recognizing and reporting, ambulatory care https://procedures.lww.com/lnp/view.do?pId=3682644&hits=abuse,abused,disabled&a=false&ad=false&q=abuse%20disabled
4. Lippincott Procedures: Suspected elder abuse assessment. https://procedures.lww.com/lnp/view.do?pId=3260835&hits=abuse,elder,abuser,elderly&a=false&ad=false&q=Elder%20abuse
5. Lippincott Procedures: Forensic evidence collection https://procedures.lww.com/lnp/view.do?pId=5644665&hits=forensic,evidence&a=false&ad=false&q=forensic%20evidence
6. Lippincott Procedures: Neonatal abstinence syndrome patient care https://procedures.lww.com/lnp/view.do?pId=3261389&hits=infant,abuse,abused,infants,drugs,maternal,drug&a=false&ad=false&q=drugs%20of%20abuse%20maternal%20and%20infant
7. Sexual Assault Response Team
8. Sexual Assault Exam Procedure
9. Recognizing and Reporting Swing Bed Resident Abuse/Neglect
10. Documentation of Patient Care

Supersedes: Child Abuse or Suspected Abuse or Sexual Assault Guidelines V.3; Elder and Dependent Adult Abuse V.3; Child Abuse Neglect Policy V.1; Ombudsman V.2; Intimate Partner Abuses Guidelines, for Victims of

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Newborn Hearing Screening Program		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Perinatal Staff		
Date Last Modified: 10/03/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/11/2010	

PURPOSE:
To identify those infants at risk for hearing impairment and who require further auditory assessment.

POLICY:
Newborn Hearing Screening will be provided to all infants receiving newborn services at Northern Inyo Hospital and a consent will be signed to allow for this screening.

I. RESPONSIBILITIES

A. The Newborn Hearing Screening Program (NHSP) Director is the Perinatal Nurse Manager. The manager is responsible for management of the newborn hearing-screening program, including training and oversight of the individuals performing the screening, reporting, staff, parent, and physician education and coordination of services and follow-up. The Director shall report changes in Director of the NHSP to Children's Medical Services (CMS) Branch, or its designee, within one week of the change. Perinatal Manager -is responsible for training the screener personnel. The Perinatal Manager will maintain documentation of these competencies
B. A CCS panel audiologist is contracted with NIH and will be overseeing the development, maintenance, equipment, and follow up of the hearing screen program, and ongoing review of the NIH NHSP, at least annually.
C. Screeners - The hearing screenings will be performed by perinatal staff that has completed training in the use of the hearing screen equipment and documented competency according to the Ca. NHSP standards – attachment A. This staff is available to do the screenings 24 hours/day, 7 days/week. The screeners will have individual training, and completed competency annually.
D. Perinatal LVN/Clerk – Provides support for the NIH NHSP. The Perinatal LVN/Clerk will maintain the NIH Newborn Hearing Screening Log, submit data in a format specified by the DHCS, and reports to the CA Department of Health Care Services (DHCS) or its designee South Eastern California Hearing Coordination Center (SECHCC) by the 10th day following the end of each month.
E. The perinatal nurse will give the CA DHCS "Newborn Hearing Screening Program" brochure to all obstetrical patients after admission to the perinatal unit.
The perinatal nurse or primary care physician will provide the appropriate CA DHCS brochure (WAIVE, PASS, REFER) at the time of the hearing screening.

II. FACILITY AND EQUIPMENT:

Infant hearing screening services will be performed using FDA-approved equipment that detects a mild (30-40 dB) hearing loss in infants and newborns. Northern Inyo Hospital uses OAE systems. Please refer to One-Source for each equipment brand used on the unit for hearing screens.

A. The OAE equipment performs a self-calibration with each power-on.
    1. Electrical safety checks are performed twice a year by the Bio-Med Department and logged in their department.
B. The hearing screening tests will be done at the mother's bedside or according to where the environment is best conducive to hearing screening, after agreeing to the plan of care discussed with the newborn's family.
C. The Perinatal Manager is responsible for obtaining loaner equipment as backup within 24 hours following malfunction.
D. The Perinatal LVN/Clerk is responsible for ordering supplies.
E. Nurses performing the hearing screen will document a PASS or REFER according to current state requirements.
F. The equipment will be stored in the nursery.

III. PROCEDURE:

A. Inpatient Hearing Screening

1. Infants should be medically stable and medications should be noted on the EMAR prior to the hearing screening.
2. Hearing screenings are to be done in a quiet environment, and can be done while breastfeeding or skin-to-skin with mom, or the nursery if discussed with parents.
3. The hospital shall inform all parents, in writing and verbally, of the results of the hearing screening prior to hospital discharge.
4. Written material will be given explaining the results of the inpatient hearing screen and the scheduled follow-up appointment, when indicated.
5. The hospital will use DHCS developed brochures, or equivalent materials that have been approved by the CMS Branch or its designee and will include information regarding the stages of development. This information will be reviewed with the patient by the RN prior to discharge.
6. The Perinatal staff will document the results of the hearing screening in the infant's medical record.

B. Hearing Screening Procedure

1. Hearing screener will check chart for admissions hearing screening consent.
2. Parental education is to be performed by a licensed perinatal nurse who has completed newborn hearing screening training. The perinatal nurse is to give CA DHCS education materials to parents including information about the hearing screenings in the language of their preference if possible.
3. Set up the screener according to the manufacturer's specifications.
4. Wash hands.

5. Prepare baby:
   a. Collect supplies:
   b. This includes the scanner with the appropriate size disposable ear tip. The usual for the newborn is the smallest red tip.
   c. The remote probe works best with newborns and will be on the scanner for use.
   d. Inspect the ear canal for excessive cerumen or vernix prior to testing as this may interfere with the test and give invalid or incomplete results.
6. Avoid erroneous referrals, prior to screening by:
   a. Checking the equipment:
   b. Checking the environment:
      - Is there excessive interference (noisy room or nearby electrical sources)?
   c. Checking the baby:
      - Is the baby too active to scan?
      - Is the baby's ear canal compressed or closed?
        - Does the baby have fluid or debris in its ears?
7. Run Screening procedure
   a. Remove the handset from the cradle. The instrument runs on batteries only. They are not rechargeable: placing it on the cradle does not recharge the batteries.
   b. To turn on the EROSCAN instrument, press the DOWN key located below the instrument display screen. Three small lights (red, yellow, and green) will appear briefly just above the display screen. The green ready light will remain on.
   c. A brief display mode will appear and then ←L test R→ screen will appear.
   d. To begin testing, place an ear tip as far down as possible on the probe tip. Select either the right or left key to indicate which ear will be tested.
   e. After the test ear is selected the display will show two horizontal bar graphs representing the environmental noise (NOISE) and the ear canal volume.
   f. If both bars fill the screen then both the environmental noise and the ear canal volume is high. Correct the environmental noise and then make sure that the seal of the ear is complete. You should see a decrease in the bar to the LEFT. Best results are obtained when both are at a minimum.
   g. When a seal is obtained testing will begin automatically. The yellow test light will illuminate throughout the test. The red ERROR LED will illuminate if there is noise in the environment. This flashing is normal and will often occur.
   h. Once the testing is finished, the unit will display "PASS" or "REFER" on the LED screen.
   i. When testing is completed on both ears, turn the printer on by pressing the green button on top and place the handset on the cradle. The most recent test results for both ears will automatically print.
   j. Turn off screener and cleanup.
   k. Notification of parents of screening results:
      PASS condition - A form with screen results is given to parents with Pass results and a CA DHCS PASS brochure filled out on the back.

C. REFER SCREENING RESULTS

1. If the baby refers on either or both ears the screening can be repeated x1 prior to discharge.

2. A referral form and completed CA DHCS REFER brochure will be put on the patient's chart for the physician to review with the parents and provide additional recommendations along with materials and information of community resources.
3. The Perinatal nurse is to notify the primary care physician
4. The primary care provider is required to inform the parents of the REFER condition; give them the CA REFER brochure, and answer questions and concerns. If the PCP does not fill out the REFER brochure, the Perinatal nurse may give and review the brochure only after the PCP has spoken with the parents.
5. The Perinatal nurse will have the LVN/ Clerk fill out the appointment for Out-Patient screening (place, time, date) for a date within 4 weeks of age, verify the parents' information and obtain one additional contact person - 1 copy will be placed in the medical record, and also 1 copy given to the Out-Patient Provider. It will be recorded in DMS by the LVN/Clerk.
    a. Information is to be given to the parent on how to come back as an outpatient.

D. **MISSED SCREENINGS**

1. For infants discharged before hearing screening was performed or scheduled, the RN/LVN/Clerk will contact the parents within 1 week of discharge and schedule an initial hearing screening appointment with a NHSP-certified Outpatient Infant Hearing Screening Provider. The appointment will occur within four weeks of hospital discharge.
2. Attempts to contact the parents will include: Telephone calls, letter written to parents, and letter to infant's primary care provider.
3. After 3 failed attempts, California Newborn Hearing Screening will be notified.
4. The provider and appointment date and time will be documented in the medical record and reported to DHCS, or its designee.

E. **TRANSFERRED INFANTS**

1. All infants transferred out of Northern Inyo Hospital to a hospital with a higher level of care will be given a hearing screening if stable and a candidate for the test to be done, prior to transfer and entered into DMS.
2. The receiving hospital will be notified that the transferred baby is part of the CA NHSP and must be screened before discharge.
3. Results of the hearing screen, if performed, will be included in the transfer paperwork.

F. **WAIVED SCREENING**

1. Family's who choose to not have IP hearing screening done at hospital should have RN/ PCP explain the risk.
2. If family refuses to have baby screened then provide family with a Waiver form to sign.

G. **INFANTS DIAGNOSED WITH ATRESIA OR MICROTIA**

1. Any infant with unilateral or bilateral atresia of the external auditory canal or microtia of the pinna shall be referred to the CCS program for authorization of diagnostic services in lieu of inpatient screening.
2. Simultaneously a referral to the Early Start Program should be made for infants with atresia.
3. For infants referred to or scheduled for a comprehensive diagnostic evaluation with a CCS-approved Type C facility;

- assist the family in completing a CCS program application
- fax the application, completed CCS Service Authorization Request (SAR) form, hearing screening results and supporting documents to the appropriate county CCS program.
- give the Diagnostic Hearing Evaluation Referral brochure to the parents.
- document in the infant's medical record and reported to DHCS, or its designee.

H. **DOCUMENTATION**

1. Place consent/waiver in chart.
2. Test results and follow-up information regarding retesting or anomalies will be recorded.
    a. In the neonates chart
    b. In the Newborn Nursery logbook
    c. On the Patient Teaching Form
    d. In DMS

IV. EQUIMENT CARE AND MAINTENANCE

1. Never reuse disposable equipment
2. Store the screener in the nursery
3. Clean remote probe with antiseptic wipe

For service and maintenance of the hearing screener refer to the user manual

V. SERVICES AND CARE COORDINATION/REFERRAL

A. Medical Record:

a. A copy of the test results shall be placed on the lab report sheet.
b. Any referral letters and appointments for outpatient testing will be a part of the medical record, recorded on the Maternal Teaching form.
c. The perinatal nurse will document patient education in the Postpartum Self-Assessment Checklist Form in the section "Nurse's Notes".

VI. EDUCATION ACTIVITIES

A. Medical and Nursing staff education

a. Physician information will be disseminated by the Director to the medical staff by committee meetings, and written correspondence. This will be done at least annually and more often when indicated.
b. Nurse education will be updated in staff meetings and written correspondence. This will be done at least annually and more often when indicated.

B. Parent Education

a. Literature in the primary care provider offices and on admission to the Perinatal Unit.
b. Informing parents that if they choose not to have the infant's hearing tested, a waiver form must be signed. Provide with diagnostic brochure.
c. RN or MD will inform the parents, in writing, the result, and follow up appointment date/time/location/and contact information if indicated prior to discharge.

C. The Director of the hearing screen program will attend and participate in semi-annual meetings with the SECHCC. If the director is unable to attend information from the meeting will be obtained and reviewed.

VII. DATA MANAGEMENT

The Hearing Screening Coordinator shall report to DHCS, or its designee (the SECHCC), data on all infants receiving neonatal services, into the DMS, specified by DHCS.

A. Qualified licensed perinatal nurses performing hearing screens shall be responsible to:
   a. Enter into the Newborn Nursery log and the DMS, all hearing screening information, which shall contain at a minimum, the following information for every infant:
      - Infant name
      - Date of birth
      - Medical record number
      - Date of screening
      - Screening results
      - Follow-up appointment date, time, and provider (if applicable)
   b. Verify parent contact information (legal guardian) on all infants with a "Refer" result, and obtain one additional contact person, and enter into DMS.
   c. Identify the PCP the infant will see upon discharge if different than the attending Pediatrician or physician, for reporting of "Refer" results and follow-up care notification, and enter information into DMS.
      - An Early Start referral form will be completed and faxed to the state designated Early Start.
      - Referral to CCS will be made by the RN or the LVN/Clerk.
        - Completed CCS Request for Service form
        - Completed CCS family application
        - Documentation of Microtia

B. The LVN/Clerk will be responsible for the following:
   a. Completing the data entry into the DMS on all infants who expired after birth or when screening isn't medically necessary determined by a physician.
   b. Overseeing accuracy and completeness of all DMS data entry.
   c. Verifying that there is a completed DMS entry on all infants
      - Who pass
      - Who refer
      - Who are transferred out to another hospital
      - Who are missed: discharged without a screen
      - Whose parent waives the hearing screen
      - Who expire after birth
      - Or when screening is not medically necessary (i.e. poor prognosis)
   d. Verifying the accuracy of the screening log of newborns/infants admitted to the Well-Baby Nursery. Comparing the OB log with the Nursery Log will do this.
   e. A monthly report shall be sent within ten days after the end of the month to the SECHCC
      - Number of live births

VII. COMPETENCY CRITERIA

Licensed perinatal staff will have individual training in newborn hearing screening, will demonstrate competency through testing, and will be reassessed yearly.

a. The NHSP Coordinator will provide the training.
b. Training of screeners will include watching a hearing screening video, taking an exam, observing a hearing screen and doing a return demonstration successfully in the presence of the instructor. The coordinator will do spot-checking of individuals periodically. Individual refer rates may indicate need for additional training.
c. Annual competency testing will be documented in the employee file.

IX. QUALITY ASSURANCE ACTIVITIES

The coordinator and director will provide quality assurance.

The coordinator and director will monitor quarterly screening rates.

A minimum of 98% of newborns born in the hospital will be provided hearing screening prior to discharge.

The expected REFER rate for the program as a whole and for each individual screener will be <1% or <10% using OAE equipment.

For variances to the above parameters, corrective measures may include:

1. Checking Equipment/Recalibration
2. Observing Screeners by coordinator
3. Checking compliance with policies and procedures.

X. BILLING

a. Inpatient Infant Hearing Screening Providers shall submit claims for reimbursement to DHCS or its fiscal intermediary using only the infant hearing screening codes identified in the NHSP Provider Manual for services provided to Medi-Cal or CCS-eligible beneficiaries, in a format specified by DHCS.
b. All billing for infant hearing screening services shall conform to the requirements specified in the NHSP Provider Manual and in the Medi-Cal Provider Manual.

REFERENCES:

1. Equipment Manufacturer's User Manual
2. California Children's Services Manual of Procedures (CCS), Chapter 3 Provider Standards Infant Hearing Screening Services 3.42.1-11. September 2016
3. Health and Safety Code, division 106, chapter 3, part 2, section 23 article 6.5 (commencing with section 124115).
4. Procedure for hearing screen at NIHD.

RECORD RETENTION AND DESTRUCTION:

Information is maintained within the medical record. The medical record is maintained by the medical records department at Northern Inyo Healthcare District.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Newborn Hearing Screening Program
2. Newborn Hearing Screening Program

Supersedes: v.4 Newborn Hearing Screening Program

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Northern Inyo Hospital Surge Plan		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 09/11/2024	Last Review Date: 05/17/17	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/01/2010	

Definition of Surge: A Surge Event is a significant event or circumstances that impact the healthcare delivery system resulting in excess demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. This definition does not take into consideration the scope of the event or the time between the onset of surge and a local or statewide proclamation of an emergency and/or issuance of gubernatorial executive orders waiving specific licensing and scope of practice requirements. Therefore, Northern Inyo Hospital District (NIHD) planners need to consider the following in surge plan activation:

Local/Regional Surge: No gubernatorial waiver of existing regulations. Local or regional event that may require mutual aid from outside the region. NIHD activates plans to create and expand capacity within existing licensing and other regulatory requirements (e.g., discharge or transfer patients, cancel or delay admissions), or, seeks approval for short-term expansion of capacity through state agencies (e.g., surge tents, Emergency Department (ED) beds, altered/expanded use of inpatient facilities).

Regional/Statewide Surge: Waiver of existing regulations. Multi-area or statewide event(s) that requires mutual aid from outside the region. NIHD activates plans to create and expand capacity and capability using alternative treatment areas, modified/expanded use of licensed facilities, and waiver of selected regulatory requirements (e.g., altered/expanded use of inpatient facilities, nursing ratios, isolation areas, surge tents, clinics, cafeterias, auditoriums, etc.).

Surge Plan: NIHD's Surge Plan is incorporated into the District's Emergency Operations Plan (EOP) and does include a series of policies, procedures and protocols referenced in the EOP. Many of the elements that should be addressed in the Surge Plans are included in the EOP or other hospital plans, policies, procedures or protocols.

1. **COMMAND AND MANAGEMENT**

   Plan identifies triggers and decision-making processes for activating the Emergency Operations Plan (EOP) and surge plan in response to a surge event.

   Initial assessment of the event type, scope and magnitude, estimated influx of patients, real or potential impact on the hospital, and special response needs (e.g., infectious disease, hazardous materials).

   Activation of the Hospital Incident Command System (HICS) and determination of appropriate HICS positions to be activated. Activation of the Hospital Command Center (HCC).

   Notification to appropriate local governmental point of contact (e.g., local health department, local emergency medical services agency, Medical and Health Operational Area Coordinator) of the surge status and activation of the EOP and Surge Plan. The EOP identifies the local government points of contacts and 24/7 contact numbers, alternate contacts and appropriate notification priorities and processes.

   Internal notification/communications (call trees, contact information, etc.).

Processes, procedures and paperwork for contacting local or regional licensing authority (e.g., California Department of Public Health Licensing and Certification) for potential or actual request for temporary permission to exceed staffing ratios or utilize non-traditional patient care delivery areas. Include the licensing authority's contact information in the plan, templates and checklists).
Establish ongoing communications with local governmental point of contact to report patient census, bed capacity, critical issues and resource requests using standardized reporting terminology.
Activation of resource management system including inventory, tracking, prioritizing, procuring and allocating of resources.

2. **CREATING SURGE CAPACITY**

Alternative Triage Sites: Activate and operate additional/alternate triage area(s) during a surge event. Activation triggers for establishing alternate/additional triage areas are defined. NIHD ED will identify primary and alternate triage areas (considering external triage areas, event type, and facility damage. The Operations Chief will assume responsibility and direct the ED staff in the process for set-up and operation of triage areas as defined. The communications plan will address and ensure communications between triage areas, Emergency Department, other key departments and the HCC (e.g., landlines, hand-held radios or cell phones).
Provision of supplies and equipment for the triage area (considering the scope and type of event) will be the responsibility of the Logistics Chief.
NIHD will participate and place a Hospital Liaison in any County Emergency Operations Center (EOC) that is deployed. The hospital will utilize local government points of contact in this document to represent the local health department, local emergency medical services agency, Medical Health Operational Area Coordinator (MHOAC), or other local contact responsible for coordinating disaster medical response in hospital's operational area.
In the absence of gubernatorial orders waiving specific licensing and regulatory requirements, use of facilities outside of existing licensure should trigger notification/requests to appropriate state licensing and regulatory agencies.
Infectious and/or exposed patient triage area(s) and protocols (universal precautions, staff PPE, ventilation, infection control protocols for staff and patients) will be maintained.
NIHD will maintain communication with the HCC to identify available community resources (checklist with level of care capability and contact information).
Decontamination: Plan to activate and perform decontamination, as necessary with coordination with the local Fire department. Plan for segregation and prioritization of contaminated individuals for decontamination. Methods for directing patients to decontamination area(s) (e.g., signage, stations, cones, etc.). Primary and alternative decontamination areas (consider external areas, event/agent, and facility damage potential). Establish communication protocols within the decontamination area(s) and between other units.
Holding Areas: Will be established per the EOC. Plan for activation and operation of holding areas for patients awaiting triage, decontamination, treatment, admission, discharge, or transport to lower levels of care. Responsibility for set-up and operation of holding area(s) (identify by area) will be established by the Operations Chief. Primary and alternate holding area(s) (consider event type, capacity, and level of care, infectious disease, and facility status).
Treatment Areas: Plan for activation and operation of additional treatment areas (to include identification of sites, signage, capacity, responsibility, communications, staffing, equipment and supplies, patient tracking/medical records, etc.) to allow the ED to focus on higher acuity patients.
Security: Facility Access Plan(s) for securing and limiting facility access during a surge event. Security assessment with plans to address vulnerabilities. Plan for initiating facility lock-down and/or limited access and entry. Identification/diagram of all access points in facility. Identification of limited access points for entry and procedures for monitoring/managing (staff). Criteria and protocols for facilities

entry and exit, including staff, volunteers, patients, family and other individuals (e.g., identification requirements). Special considerations following a terrorist attack (e.g. creating a secure perimeter, restricting access to adjacent parking areas, etc.). Plan and mutual aid agreements for assistance with hospital security (hospital staffing pool, local law enforcement, outside agencies).

Traffic Control: Plan for activating traffic control measures for access to facility (pre-planned traffic control measures, tools, etc.). Road map outlining ingress, egress and traffic controls during surge event (coordinated with law enforcement). Specific staffing assignments and instructions for traffic control (who, what, how) during surge event.

Training for staff who may be utilized in security roles (including protocols, handling abusive behavior, etc.).

Direct Patient Care Areas: Specific protocols for creating surge capacity to care for a significant surge of both ambulatory care and inpatient disaster patients. Agreements with area hospitals, long term care facilities and other health providers to accept or receive patients and share resources as appropriate and possible. Plan for immediate cancellation/delay of scheduled/non-emergent admissions, procedures and diagnostic testing inpatient admissions (scheduled surgeries/procedures). Develop protocols for rapid and periodic review of patients for admission, discharge or transfer by teams of physicians, nurses and discharge planners.

For potential/actual terrorist or criminal event, chain-of-evidence for law enforcement is addressed.

Communication and coordination with HCC regarding activated and available community resources to triage, discharge or transfer to (plan should include checklist with location, level of care and contact information).

Capacity Plan Contents: Specific protocols for expanding ambulatory and inpatient capacity beyond licensed capacity.

Identify how ED, inpatient units, clinics, clinical areas and other hospital areas (e.g., cafeteria, conference rooms, open spaces, etc.), will be utilized to expand surge capacity. Address all key elements for use (form and protocols for each area.), develop capacity and use, and consider cohorts of patients (e.g., inpatient, minor care, holding).

Operations will manage special needs patients (hearing impaired, blind, wheelchair dependent, other).

Inpatient Capacity: Specific plans for increase bed capacity to care for surge of inpatients, including expanding beyond licensed capacity on inpatient units and use of alternative care areas (dialysis, outpatient surgery, recovery, etc.) while maintaining continuity of operations and care for current patients who cannot be discharged or transferred.

Trauma: Assume NIHD will receive all trauma cases when trauma center capabilities are exceeded.

Critical Care: Expand bed capacity in existing units, use of other areas/units.

Burn: Assume NIHD will receive burn patients when burn center capabilities are exceeded.

Isolation: Identify specific hospital unit(s) or areas for negative pressure or isolation through independent ventilation if event involves contagious/infectious disease.

Pediatric: Assume NIHD will receive pediatric cases when pediatric center capabilities are exceeded.

Maternity: Assume continuity of operations.

Ambulatory Care Capacity: Specific plans for expanding capacity to care for surge of emergency/ambulatory patients, including use of ambulatory care centers, and opening alternative treatment areas (e.g., surge tents, clinics, other hospital areas and facilities).

Ancillary Services: Specific plans have been established for increasing capacity and capability for ancillary/diagnostic services during a surge event.

Laboratory Services: Maintain services including communication and reporting to and from the County Laboratory.

Imaging Services: Imaging services including MRI, CT, Ultrasound, etc. will be maintained.

Fatality Management: Coordinate with the County of Inyo plans that have been established for management and disposition of deceased patients. Plans are consistent and coordinated with Operational

Area Fatality Management plan (ME/Coroner Plans). Includes mortality estimates by type of event to anticipate and secure supply needs (e.g., body bags, shroud packs). Plan for expanding morgue capacity, including alternative areas (identify capacity). Agreements with external agencies for refrigerated trucks or mortuary support (contacts and capacity).
Medical Waste: Plans have been established for storage and/or disposition of increased medical waste during a surge event.

3. **PERSONNEL**
Staffing: NIHD has developed a specific plan for staffing during a significant surge event using hospital staff, contracted pools, and mutual aid resources taking into consideration type and scope of event. Identification of staffing needs by staff type, service area, and status of regulatory waivers regarding staffing ratios, licensure and scope of practice. Contingency staffing plan identifies minimum staffing needs and prioritizes critical and non-essential services. Staff contact information (updated) available to HCC and individuals responsible for contacts (redundant).
Staff disaster response assignments/roles (labor pool, specific units/areas, etc. considering event type) will be established during the initiation of the HICS Plan.
Staff notification and call-back protocols, including responsibilities (multiple methods, automated if possible).
Agreements with staffing agencies (assume multiple organizations have agreement with the same agencies). Protocols for requesting and for receiving staff resources (volunteers, special needs/teams, etc.) through HCC to local government point of contact).
NIHD will consider movement of select critical care patients to step-down areas, high/low rate alarms on pulse oximetry in lieu of cardiac monitors, increased reliance on ventilator alarms for ventilated patients and portable monitors in ward rooms to upgrade capability. Consider and plan for conversion of single rooms to double, double to triple, etc. Consider use of corridors, classrooms, open space, etc. Cross-training, and reassignment, of staff to support critical/essential services. Establish Just In Time (JIT) training for key areas to allow staff to be assigned where most needed (e.g., Pediatrics, Burns, Respiratory, Security, Critical Care).
Address shift change, rotation, rest areas and feeding of staff. Protocols for shift changes and rotation of staff (consider type of event). Specific areas designated for staff respite and sleeping (identify areas, responsibilities). Supplies to ensure food and water for staff and volunteers (for a minimum of 96 hours self-sufficiency).
Volunteers: Plan includes utilization of non-facility volunteers including policies and procedures for accepting, credentialing, orienting, training and using volunteers during a surge event. Volunteer check-in protocols including staffing of check-in location (single entry). Issuance of identification badge and other means of identification (e.g., colored/printed armband). Protocols for assignments and roles by type of volunteer (consider buddy systems as appropriate). Just-in-Time (JIT) training as appropriate to volunteer role(s).
Staff/Family Needs: Specific plans for addressing staff needs, family and domestic concerns during a surge event. Internal or external arrangements for dependent care to include, if necessary, boarding, food, and special needs to remove barriers that may prevent staff from coming to work (encourage staff to have family disaster plan and to pre-arrange, if possible). Internal or external arrangements for pet care (encourage staff to pre-arrange). Protocols and specific assignment of appropriately trained professionals to monitor and assess staff for both stress related and physical health concerns. Plan for providing staff and family with psychological support and resources.

4. **SUPPLIES, PHARMACEUTICALS AND EQUIPMENT**
The NIHD Surge Plan addresses supplies, pharmaceuticals and equipment for patients and staff for a 96 hour period of self-sufficiency for a significant surge event. This includes Personal Protective

Equipment(PPE), equipment (beds, ventilators, IV pumps, etc.), Pharmaceuticals including prophylaxis for in-patients, staff and staff families, and supplies required to run the facility on a daily basis such as food, paper supplies, etc. NIHD will use its existing Emergency Management Plan to ensure there are sufficient supplies and that the required paperwork and agreements are met to accomplish this. All hospital disaster/cashed items will be used as deemed required by the Incident command per EOP. The current EOP includes a process to report real time information regarding status of resources to the local government and the Inyo County Office of Public Health.

5. **COMMUNICATION**
   The NIHD Surge Plan describes primary and back up internal and external communication systems, assigned frequencies and uses, maintenance and equipment locations (e.g., internet, telephone, cell, satellite, EMS Radio System, WebEOC, CAHAN). It includes media communication using the current EOP, (an EOP spokesperson will be identified), and communication with other county agencies, as well as other area hospitals will be the decision of the incident command.
6. **DOCUMENTATION** – The NIHD Surge Plan includes patient documentation requirements for use during a surge event and protocols for patient tracking and reporting to appropriate agencies per the EOP.

7. **ALTERED STANDARDS OF CARE** The hospital will continue to provide critical/essential services, non-essential services and protocols for staff assignments during the surge. The hospital does have a disaster backup system (downtime procedure packets) if unable to use the electronic medical record. Protocols for transfer of patient to a facility with appropriate capabilities, when available. Prophylaxis/Vaccination plan in place to prophylactically treat or vaccinate staff, staff family members, volunteers, and patients if available.

8. **TOOLS AND RESOURCES**
   See EOP for tools

9. **AMBULANCE PATIENT OFFLOAD TIME REDUCTION PROTOCOL**
   To ensure high quality patient centered care and mitigate ambulance patient offload delay instances, NIHD personnel and Emergency Medical Services (EMS) personnel shall collaboratively work to ensure a safe, efficient, timely, and seamless ambulance transfer of care. In addition, establishing standards and best practices to mitigate ambulance patient offload delays, ensures critical emergency service resource availability for the community.
   In support of high quality, patient-centered care, EMS personnel and NIHD medical personnel shall ensure there is no interruptions in patient care while awaiting transfer of care.
   All patient care by EMS shall be documented according to the Inland Counties Emergency Medical Agency (ICEMA) policies.
   The EMS-to-ED transfer requires a patient-centered approach by patient caregivers, including collaboration on key assignments and quality communication. The responsibilities of NIHD hospital personnel and EMS personnel to mitigate extended ambulance patient off load times is critical for safe patient care.

Procedure:
If EMS personnel is unable to promptly transfer care and offload patients in less than 30 minutes, ED medical personnel shall:
Provide a safe area inside the ED within direct visualization of ED staff where the EMS personnel can temporarily wait while a patient remains on the ambulance gurney.

Deploy streamline triage process where the triage/charge nurse work to quickly prioritize and direct EMS to appropriate care areas based on acuity, current census, and the waiting room if appropriate. Patient's on the EMS gurney may be directed to a different care area and then moved by EMS personnel to a specific location, e.g. immediate lab draw for a code stroke patient then directed to diagnostic imaging to the open CT table. Additionally, critical patient's assessments may be needed to be performed on the EMS gurney to route patients appropriately, e.g. EKG for chest pain or time sensitive labs drawn for a Code Stroke or STEMI patient.

Offload to waiting room can be deployed in instances that the ED triage and or Charge nurse has received a full report from EMS and have assessed the patient's chief complaint, level of acuity and have deemed it safe to offload the patient to the ED waiting room.

Early notification of the Nursing Supervisor that the ED is experiencing ambulance patient offload delay with request for assistance with patient throughput challenges. Request for additional staffing resources if needed.

Assess if activation of NIHD surge plan is warranted with ED leadership, House Supervisor or Administrator on call (AOC).

EMS personnel shall not be required to monitor patients with known or suspected care and monitoring needs outside of the individual EMS provider's credentialed scope of practice.

NIHD will file this protocol with ICEMA as the governing authority and any revision will be updated annually to ICEMA.

REFERENCES:

1. HICS Guidebooks, tools and website, including Hospital Overload Incident Planning and Response Guides https://emsa.ca.gov/wp-content/uploads/sites/71/2017/09/HICS_Guidebook_2014_11.pdf
2. Operational Area Medical-Health Emergency Management/Surge Plan https://www.cdph.ca.gov/Programs/EPO/CDPH%20Document%20Library/FinalEOM712011.pdf
3. The Joint Commission, Environment of Care Standards, June 2024. https://www.jointcommission.org/standards/
4. Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employees (OSHA 2023). https://www.osha.gov/sites/default/files/publications/OSHA_pandemic_health.pdf
5. Standing Together: An Emergency Planning Guide for America's Communities (The Joint Commission 2005). https://asprtracie.hhs.gov/technical-resources/resource/1082/standing-together-an-emncy-planning-guide-for-americas-communities
6. Surge Hospitals: Providing Safe Care in Emergencies (The Joint Commission 2006). https://asprtracie.hhs.gov/technical-resources/resource/3923/surge-hospitals-providing-safe-care-in-emncies
7. Healthcare at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems (The Joint Commission 2003). https://nhchc.org/wp-content/uploads/2019/08/emergency_preparedness.pdf

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Capacity Management: Patient Surge
2. Credentialing Health Care Practitioners in the Event of a Disaster
3. Emergency Room Overcrowding
4. Emergency Management Plan
5. Evacuation Policy
6. Lockdown Plan

RECORD RETENTION AND DESTRUCTION: Northern Inyo Hospital District Surge Plan documents need to be retained for 15 years.

Supersedes: v.1 Northern Inyo Hospital Surge Plan

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Patient Restraints (Behavioral & Non-Behavioral)		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: NIHD		
Date Last Modified: 12/11/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/23/2016	

PURPOSE:
To delineate standards of care for the patient who is restrained which promotes an environment conducive to maintaining patient dignity, while protecting patient safety.

POLICY:

A. It is the policy of Northern Inyo Hospital (NIHD) to create a physical, social and cultural environment that limits the use of restraint to appropriate and justified situations, and, to reduce restraint use through preventive or alternative methods which focus on the patient's rights, dignity and well-being. Patients have the right to be free from restraints of any form that are not medically necessary. Restraint may only be imposed to ensure the immediate physical safety of the patient, staff, or others and must be discontinued at the earliest possible time.

B. The decision to use a restraint is not driven by diagnosis. Comprehensive assessment of the patient and environment, in conjunction with individualized patient care planning, should be used to determine those interventions that will best ensure the patient's safety and well-being with the least risk. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient. Restraint may only be used if needed to improve the patient's well-being when less restrictive interventions have been determined to be ineffective in protecting the patient and others from harm. Restraints, if deemed appropriate, are implemented using safe techniques identified in this policy and reinforced during annual staff education. The restraint shall be discontinued at the earliest possible time, regardless of the scheduled expiration of the order.

C. Patient's rights, dignity and well-being are protected during restraint use to assure the following:
   1. Respect for the patient as an individual
   2. Safe and clean environment
   3. Protection of the patient's modesty, visibility and body temperature

D. The hospital does not permit restraint for management of violent or self-destructive behavior to be used for the purpose of coercion, discipline, convenience, or staff retaliation. Restraints are never a substitute for adequate staffing.

E. The patient and family will be informed of the organization's policy/procedure on the use of restraints.

   1. Staff will explain the need for the use of restraint to the patient/family/ significant other to increase their understanding and decrease their fears about the use of restraint.
   2. Patient and/or family will be encouraged to be involved in decision-making. Incorporating patient/family preferences in the care process may help minimize restraint use.

3. The patient/family/significant other are assured that the least restrictive device will be utilized, that restraints are discontinued as soon as possible, and that the patient's basic needs for nutrition, personal care, and exercise are met during the use of the restraint.
4. In the event that the patient chooses not to include the family/significant other, or that participation would have a detrimental effect on the patient, family/significant other involvement would not be applicable.
5. Staff will attempt to promptly contact the family to notify them when restraints are used as appropriate.

F. The use of restraints must be in accordance with the telephone order or written order of a physician.

G. A Registered Nurse (RN) may make the decision to initiate a restraint in an emergent situation when the risk to the patient is such that an order from a physician cannot be obtained before restraining the patient.

H. Per the restraint orders, the RN may discontinue restraints prior to the expiration of the order when the action/behavior leading to the need for restraints is no longer evident. If the restraints must be re-initiated, another order must be obtained.

DEFINITIONS:

A. Physical Restraints: Physical restraint is any manual or physical method or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, or head freely.

1. Bed side rails: Side rails present an inherent safety risk, particularly when the patient is elderly or disoriented. Even when they are not used intentionally as a restraint, patients may become trapped between the mattress or bed frame and the side rail.

   a. Side rails used to physically restrict a person's freedom of movement or physical activity in order to protect the patient or others from injury is considered restraint. Therefore, when all four side rails of a four rail system are raised, it is considered a restraint.
   b. Individual patient needs are assessed for the use of side rails.
   c. Infants and children will have crib rails and side rails up at all times which are not considered restraint.
   d. The upper two side rails of a four rail system may be placed in the up position to provide patient access to bed control, the nurse call system, or to assist the patient in turning in bed and are not considered restraint.
   e. The upper two side rails and one lower side rail of a four-rail system or one side of a two-rail system may be up for patient protection and comfort as long as the patient's ability to get out of bed is not restricted and are not considered restraint.
   f. The upper and lower two side rails of a four rail system on specialty beds (i.e. lateral rotation beds) may be up for patient protection and in order for the bed to properly operate and are not considered restraint.

2. Devices and Immobilization

   a. Devices, which serve multiple purposes when they have the effect of restricting a patient's movement and cannot be easily removed by the patient, constitute a restraint. (e.g. Geri chair, elbow immobilizers to prevent the patient from reaching tubes, etc.)

b. Patient assessment for the use of the device should be based on the least risk for the patient and the risk of what might happen if the device is not used versus the risk it poses as a restraint.

B. Drugs used as a restraint: Chemical restraint is defined as medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not standard treatment for the patient's medical or psychological condition. These are medications used in addition to or in replacement of the patient's regular drug regimen to control aggressive and/or violent behavior during an emergency.

1. A standard treatment for a medication used to address a patient's condition would include all of the following:
   a. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization.
   b. The use of the medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's knowledge of that patient's expected and actual response to the medication.
   c. If the overall effect of a medication is to reduce the patient's ability to effectively or appropriately interact with others, then the medication is not being used as a standard treatment for the patient's condition.
   d. Whether or not the use of a medication is voluntary, or even whether the drug is administered as a one-time dose or PRN are not factors in determining if a drug is being used as a standard treatment. The use of PRN medications is only prohibited if the drug is being used as restraint.

2. NIHD does not use chemical restraints as a means of coercion, discipline, convenience or retaliation by staff. Medications that comprise the patient's regular medical regimen (including PRN medications) are not considered drug restraints, even if their purpose is to control ongoing behavior.

C. Seclusion: Seclusion of an individual is involuntarily confining an individual alone in a room or area where he/she is physically prevented from leaving. NIHD's policy and practice prohibits the use of seclusion.

D. NIHD prohibits the use of restraints when the patient is in a prone position.

E. Exceptions: Therapeutic or protective interventions that, although they may restrict activity, are ***not*** considered restraint interventions include:

1. A restraint does not include devices, such as prescribed orthopedic devices, surgical dressings or bandages, protective helmets, or methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests.
2. A restraint does not include methods that protect the patient from falling out of bed.
   a. Examples include raising the side rails when a patient is on a stretcher; recovering from anesthesia; sedated; on seizure precautions, experiencing involuntary movement; or on certain types of therapeutic beds to prevent the patient from falling out of the bed.
3. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, highchair lap belts, raised crib rails and crib covers) that a safety-conscious child care provider outside a healthcare setting would utilize to protect an infant, toddler or preschool-aged child would not be considered restraint or seclusion for the purposes of this regulation.
4. A physical escort would include a "light" grasp to escort the patient to a desired location

a. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint and all the requirements would apply.

5. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint (e.g. knee immobilizers for medical clinical purposes, abductor pillow, postural support, or orthopedic devices).
6. A position or securing device used to maintain the position, limit mobility or temporarily immobilize the patient during medical, dental, diagnostic or surgical procedures.
7. The use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons is not considered restraint.
8. Placing hand mitts on a patient to prevent the patient from pulling on tubes or scratching him or herself is not considered a restraint unless any of the following criteria is met:
   a. The mitts are pinned or otherwise attached to the bed/bedding or are used in conjunction with wrist restraints and/or
   b. The mitts are applied so tightly that the patient's hands or fingers are immobilized, and/or
   c. The mitts are so bulky that the patient's ability to use their hands is significantly reduced, and/or
   d. The mitts cannot be easily removed intentionally by the patient in the same manner they were applied by staff considering the patient's physical condition and ability to accomplish the objective.
9. A medication used to control a patient's behavior that is standard treatment for the patient's medical or psychiatric conditions (i.e. drug or alcohol withdrawal, psychiatric diagnosis) is not considered chemical restraint.
10. If the patient is on a stretcher, there is an increased risk of falling from a stretcher without raised side rails due to its narrow width and high center of gravity. Additionally, since stretchers are elevated platforms, the risk of patient injury due to a fall is significant. Therefore, the use of raised side rail is not considered restraint but a prudent safety intervention.

F. The following functional guidelines should be considered when defining an intervention as a physical restraint:

1. Does the patient have the ability and skill to easily remove the intervention? (If the answer is no, then intervention is a restraint).
2. Is the patient's freedom to move when the intervention is in place less than their freedom to move without the intervention, or is the patient's access to their body when the intervention is in place less than their access to their body without the interventions? (If the answer is yes, then intervention is a restraint).
3. Utilization of a functional assessment allows for individual assessment of each device and situation that could potentially be used to inhibit an individual's movement. Therefore, if the effect of using an object fits the definition of restraint for a patient at a specific point in time, then for that patient, the device is a restraint.

APPROVED TYPES OF RESTRAINTS

A. Soft limb restraints
B. Four (4) side rails up (See definitions)
C. Safety vest
D. Hand Mitts

ALTERNATIVES TO RESTRAINTS/LEAST RESTRICTIVE DEVICE

A. Alternatives to restraints do not always need to be tried, but prior to the use of restraints; alternative interventions must be determined to be ineffective to protect the patient or others from harm.

B. Alternatives attempted or rationale for not attempting alternatives must be documented.

C. Efforts are taken to develop and promote preventive strategies and use safe and effective alternatives when appropriate as follows:
   1. Identify and treat the cause of the behavior (e.g. medical re-evaluation, reposition, put to bed if fatigued, change environmental noise level, lighting, furnishings, or equipment, or if possible, change or eliminate bothersome treatments).
   2. Increase observation/supervision.
   3. Involve the family and significant others.
   4. Provide diversionary measures (e.g. formal activities, visitors, exercise, reorganize the ADLs).
   5. Consider and eliminate barriers; manipulate the environment (e.g. increase the lighting, leave side rails down, decrease noise, call bell accessible).
   6. Re-orient patients/provide reality orientation.
   7. Evaluate medication regimen (e.g. pain, agitation, and initiation).

D. The use of restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.

Examples of Alternatives to Physical Restraints

All behaviors can be viewed as a symptom and each may arise from a variety of causes or be indicative of an array of unmet needs. Medical re-evaluation is always appropriate. Involvement of the interdisciplinary team (i.e. OT/PT assessment) may identify additional alternatives.
Observe the patient's behavior, investigate its meaning, and develop creative and individualized alternatives. Educate the patient and family to reduce the use of physical restraints.

Behavior Exhibited	Suggested Options, if available
Falls	Bathroom rounds Grab rails and raised toilet seats Side rails kept down Bed in low position Increase the light in the room Eliminate hazards, clear a path Ambulate frequently / supervised ambulation Bed Alarm / Chair Alarm Family supervision Call bell within reach Wear supportive shoes Gripping rubber mats / nonslip surface in chairs Keep patient in view of staff Wedge cushions Adequate pain medication Place commode at bedside Provide glasses, hearing aid, dentures, purse, etc.

Behavior Exhibited	Suggested Options, if available
	If fatigued and in the chair, transfer to the bed Place pillow or rolled blanket under mattress to create lip at edge Evaluate meds to decrease the possibility of side effects Make sure clothing, tubing, etc. not interfering with walking Consult with PT for alternatives
Scratching	Eliminate itch and treat the cause Diversional activities
Pulling at Tubes	Wear Briefs over Foley catheter Hide or camouflage IV tubing Get tubes out as soon as possible Provide patient something else to "fiddle" with Consider alternatives for NG tubes
Pulling at wounds or dressings	Overdress wounds Hide or camouflage dressings Medicate for pain Supervise confused patients carefully Use abdominal binders when possible Evaluate to see if tape or dressing is itching Try calming music / distract the patient with TV, activities, etc. Consult with school program for learning activities If active play activities are not available, provide stimulation with music, audio books, and mobiles. colorful surroundings, etc.
Wandering	Determine where the patient is going and why Anticipate needs; learn past patterns and coping styles Have hearing aid and glasses available Use STOP signs Decrease stimuli (ex. light, noise, interruptions) Exercise patient or walk them frequently Reminisce and validation Use alarms Family / friend / volunteer supervision Test for urinary tract infections (UTI) and treat as indicated and ordered Assess pain level. Treat as indicated and ordered Place bed in lowest position Reality orientation / psychosocial intervention Offer interesting TV program, game or activity Consult with OT / PT for alternatives
Rummaging and Scavenging	Busy boxes Reorientation Family / friend / volunteer supervision
Combative	Control for visual and auditory stimuli Music therapy and relaxation tapes Assess pain level or medication side effects

Behavior Exhibited	Suggested Options, if available
	Explain slowly what you are trying to do and move slowly Rest periods Contracting, when appropriate Consistent personnel Family / friend / volunteer involvement Provide reality links: TV, radio, calendar, clock Explain procedures to reduce fear and convey a sense of calm Involve the patient in conversation, don't talk over them Use active listening to elicit the patient's perspective Allow patient I family as much control over daily routine as possible

E. When an individual patient's assessed needs indicate the use of restraint, the least restrictive means should be chosen. For example, hand mittens for a patient who is scratching an irritated skin rash may be effective instead of the more restrictive soft wrist restraints.

F. Less restrictive measures may still constitute a restraint for which an order must be obtained if the patient cannot readily remove the device.

RESTRAINTS TO PREVENT INTERFERENCE WITH MEDICAL AND SURGICAL CARE

A. Definition of Restraints used for non-behavioral health patients (Non-violent and non-self destructive behavior) purposes

1. The patient is performing some action that interferes or has the potential to interfere with medical and /or surgical healing.

a. The patient pulls at, attempts to remove, actually removes, or dislodges IVs, drains, tubes, surgical dressings or other therapies or treatments.

b. The patient gets out of bed unassisted when assessed as unstable or when activity may be detrimental to the patient.

B. Clinical Justification

1. After assessing/evaluating a patient's physical or emotional condition, and despite attempts at alternative solutions, the documented continuance of a patient activity that will interfere with medical therapy justifies initiation or continued use of restraints.

2. If, based on a complete nursing assessment/evaluation, an RN assesses a patient to need a restraint to prevent interference with medical and surgical care, then that RN shall notify the patient's treating physician who may give an order for restraints.

C. Initiation of Restraints

1. If the patient is not in immediate danger, the RN may obtain an order for the restraint prior to applying restraints.

2. The RN may only apply restraints to prevent interference with medical and surgical care without receiving a physician's order if the patient's safety will be jeopardized without immediate use. The RN, after appropriate assessment, may make the decision to initiate and apply a restraint if the physician is not immediately available.

   a. The RN who determines that the patient requires restraints will notify the physician and obtain a telephone order or written order. The order must be obtained immediately (within 1 hour) after the initiation of restraints. If the episode that led to restraints is a significant change for the patient, the physician will be notified immediately.

   b. A physician will examine the patient within 24 hours of initiation of restraint used to prevent interference with medical or surgical care, and will enter a written order into the patient's medical record.

D. Physician's Order

1. A physician's order for the management of non-behavioral health patients (Non-violent and non-self-destructive behavior) must be obtained for each restraint episode.
2. Restraint orders must include:
   a. Date and time order was written
   b. Restraint category: Non-behavioral health patients (Non-violent and non-self destructive behavior)
   c. The type of restraint to be used
   d. Time specific
   e. The reason for restraint (i.e. patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint).
   f. Signature of a physician
   g. Cannot be written as “PRN."
3. Each written order for a physical restraint to prevent interference with medical and surgical care is to be renewed no less often than every twenty-four (24) hours.
4. Example of Physician order
   a. Restrain wrists for up to twenty-four hours using soft wrist restraints to prevent dislodging IV tubes.

E. Physician Assessment and Continuation of Restraint orders

Continued use of restraints beyond the first 24 hours is authorized by a physician renewing the original order or issuing a new order if restraint continues to be clinically justified.

1. Such renewal or new order is issued no less often than every 24 hours and is based on a documented face-to-face examination of the patient by the physician. The physician reevaluates the efficacy of

the patient's treatment plan and works with the patient to identify ways to help him or her regain control.
2. If the patient's attending physician is not the physician who has ordered the restraint, then the patient's attending physician should be notified of the initiation of the restraint order as soon as possible.

F. Early Termination
1. The restraint will be terminated as soon as possible when the initial action is no longer evident or alternatives are effective.
2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(e)

G. Re-application

1. If a patient was recently released from interference with medical and surgical care restraint due to non-behavioral health (Non-violent and non-self-destructive behavior) and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.
2. Staff cannot discontinue an order and re-start it under the same order because that would constitute a PRN order. Each episode of restraint use must be initiated in accordance with the order of a physician.
3. A temporary release that occurs for the purpose of caring for a patient's needs-for example toileting, feeding, and range of motion or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/ Ongoing Assessment of the Patient

1. An RN/LVN/CNA who has demonstrated competency in the application and monitoring of restraints may apply and monitor the restraints.
2. The RN is responsible to assess the patient on an ongoing basis and determine whether restraints should be continued or terminated.
3. After applying restraints, immediately perform an initial assessment to ensure the well-being of the patient, safe and proper application, , and that there is no evidence of injury. If the patient's response is negative, make immediate changes.
4. During the period of restraint, the patient must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction with the patient, or direct assessment and will be done at a minimum of every 2 hours. Documentation of assessment will include relevant orders for use, results of patient monitoring, reassessment, and significant changes in patient's condition.
    a. Assessment for patients who are restrained with soft limb restraints, mitts, or side rails, will be documented at least every 2 hours.
5. The RN assessment includes the following:
    a. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)
    b. Circulation/sensation/movement (CSM) of affected extremities
    c. Well-being - the patient's physical and emotional well-being is addressed
    d. Application: the restraint is safely and properly applied
    e. Signs of injury associated with applying restraint
    f. Vital Signs: Done if per patient physical/emotional status the RN assesses the need for vital signs

g. Release and ROM to restrained extremity every 2 hours
h. Whether less restrictive methods are possible
i. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible.
j. Dignity and rights are maintained. Attention is given and interventions are provided to meet the patient's physical needs including but not limited to:
   1) Hydration
   2) Nutrition
   3) Elimination
   4) Hygiene

RESTRAINTS FOR MANAGEMENT OF VIOLENT AND/OR SELF-DESTRUCTIVE BEHAVIOR

A. Definition: Behavioral health (Violent and/or self destructive behavior) Restraint
   1. The patient is displaying assaultive/ aggressive behavior that poses imminent risk of physical harm to him/her, the staff and/or others.
   2. Restraints for management of violent or self-destructive behavior is an emergency measure that should be reserved for those occasions when unanticipated aggressive or destructive behavior places the patient or others in imminent danger and nonphysical intervention would not be effective.

   3. The use of restraints for the management of violent or self-destructive behavior is not based on a patient's restraint history or solely on a history of dangerous behavior.
   4. Whenever possible, non-physical interventions are used to avoid the use of restraints for the management of violent or self-destructive behavior through de-escalation techniques. when there is an imminent risk of physical harm, physical interventions will need to be applied.

B. Clinical Justification

   1. After assessing/evaluating a patient's emotional condition, and after consideration or trial of alternative solutions, the documented continuance of a patient behavior that gives reasonable probability of harm to self or others justifies the initiation or continued use of restraints.
   2. The RN must justify the use of the restraint in the patient's medical record. This includes the specific behavior that placed the patient or others at risk and the alternatives attempted.

C. Initiation of Restraints

   1. In an emergent condition when the RN has assessed the patient and evaluates that the behavior is aggressive/assaultive then the RN may make the decision to restrain the patient.
   2. The RN must inform the physician for the need for restraints for the management of violent or self-destructive behavior, obtain a telephone order or written order, and consult with the physician about the patient's physical and psychological condition immediately (within 1 hour) after initiation of the restraint.
   3. The in-person evaluation and documentation by the physician, conducted within 1 hour of the initiation of restraint for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff or others, includes the following:
      a. An evaluation of the patient's immediate situation.
      b. The patient's condition or symptom(s) that warranted the use of the restraint.
      c. Alternatives or less restrictive interventions attempted (as applicable).
      d. The patient's medical and behavioral condition.
      e. A description of the intervention used.

f. The patient’s response to the intervention used, including the need to continue or terminate use of restraint.

D. Physician Order

1. A physician's order for a restraint for management of behavioral health restraints (violent and/or self-destructive behavior) must be obtained for each restraint episode.
2. Restraint orders must include:
   a. Date and time order was written.
   b. Restraint category: Behavioral Health (Management of Violent and/or Self-Destructive Behavior).
   c. Type of restraint to be used.
   d. Time specific.
   e. Reason for restraint; description of the patient's behavior'
   f. Signature of a physician.
   g. Cannot be written as "PRN."

3. Verbal and written orders for restraints used for the management of behavioral health (violent and/or self-destructive behavior) are time-limited as indicated below. Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.
   a. 4 hours for adults ages 18 and older
   b. 2 hours for children and adolescents ages 9-17
   c. 1 hour for children under 9 years of age.

E. Physician Assessment and Continuation of Restraints

1. The physician must complete a face-to-face evaluation of the patient and evaluate the need for restraint within one hour after the initiation of the restraint. A telephone call is not adequate.
2. Upon initiation of restraints for management of violent or self-destructive behavior and on an ongoing basis, the physician will provide the following:
   a. Reviews with staff the physical and psychological status of the patient and supplies staff with guidance in identifying ways to help the patient regain control so that restraints can be discontinued.
   b. Reevaluates the efficacy of the patient's plan of care, treatment, and services and determines whether restraints should be continued.
   c. Works with the patient to identify ways to help regain control.
   d. Supplies the order.
3. When restraint is continued for management of violent or self-destructive behavior and the individual providing the order is someone other than the patient's physician, the patient's responsible physician is notified of the patient's status.
4. The physician reevaluates the efficacy of the patient's treatment plan and works with the patient to identify ways to help him or her regain control.
5. Every 24 hours, the physician primarily responsible for the patient's ongoing care evaluates the patient in person before writing a new restraint order for management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.
6. If the patient is released from restraint used for management of violent or self-destructive behavior prior to the expiration of the original order, the physician still has to conduct an in-person evaluation of the patient within 24 hours of the initiation of restraint and original order.

F. Early Termination
   1. The use of physical restraint must be limited to the duration of the emergency safety situation regardless of the length of the order. The physician has the discretion to decide that the order should be written for a shorter period of time. Staff should assess, monitor, and assist the patient to regain control, and re-evaluate the patient so that he or she is released from the restraints at the earliest possible time.
   2. The physician may make the decision to discontinue the restraint based on current assessment and evaluation of the patient's condition. CMS 482.13(F)

G. Reapplication of Restraints
   1. If the patient was recently released from restraints for the management of violent or self-destructive behavior and exhibits behavior that can only be handled by the reapplication of restraint, a new order is required.
   2. Staff cannot discontinue an order and re-start it under the same order if the patient's behavior escalates again after he or she has been released. Each episode of restraint use must be initiated in accordance with the order of a physician; PRN orders are prohibited

   3. A temporary release that occurs for the purpose of caring for a patient's needs - for example toileting, feeding, and range of motion - or assessing whether restraints can be discontinued is not considered a discontinuation of restraint.

H. Observation/Ongoing Assessment of Patients
   1. During the time of restraint use for the management of violent or self-destructive behavior, there will be continuous in-person observation by an assigned staff member who is competent in the use of restraints.
   2. During the period of restraint use for management of violent and/or self-destructive behavior, all patients must be monitored and assessed at a frequency that is determined by the needs of the patient, his/her condition, and the type of restraint used. This can be accomplished by observation, interaction, or direct assessment.
   3. After applying restraints, the RN will immediately perform an initial assessment to ensure the well-being of the patient, safe and proper application, and that there is no evidence of injury. If the patient's response is negative, make immediate changes.
      a. Assessment of the patient in restraints for management of violent or self-destructive behavior is performed at the initiation of restraints and minimally every 15 minutes thereafter. This assessment includes the following:
      b. Skin Integrity (e.g. dry & intact, redness or swelling, abrasions)
      c. Circulation/sensation/movement (CSM) of affected extremities
      d. Well-being. The patient's physical and emotional well-being is addressed
      e. Application: the restraint is safely and properly applied
      f. Signs of injury associated with applying restraint
      g. Vital Signs: Completed if the RN’s assessment warrants the need for vital signs
      h. Release and range of motion (ROM) to restrained extremity every 2 hours
      i. Whether less restrictive methods are possible
      j. If the patient's behavior or clinical condition is appropriate to need continuation of restraints or if termination is possible
      k. Dignity and rights are maintained. Attention is given to the patient's needs including but not limited to:
         1) Hydration

2) Nutrition
3) Elimination
4) Hygiene
5) Physical or psychological status and comfort.

4. If the patient is in a physical hold for management of violent or self-destructive behavior, another staff person who is competent in the use of restraint and who is not involved in the physical hold is assigned to observe the patient.
5. Staff members help patients meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior by attempting alternatives and providing for less restrictive measures whenever possible.
   a. Assisting to meet behavior criteria for discontinuing restraints for management of violent or self-destructive behavior can include the following interventions:

      1) Appropriate implementation of medical plan of care to stabilize the disease process causing the aggressive/assaultive behavior
      2) Decrease environmental stimuli to a minimum
      3) Set clear, consistent, and enforceable limits on behavior
      4) Attend and respond positively to patient anxiety or anger with active listening and validation of patient distress
      5) Work with patient to identify the internal and interpersonal factors that provoke violence/aggression
      6) Work with patient to identify what supports are lacking and problem-solve ways to achieve needed support
      7) Role-play alternative behaviors with patient that they can use in stressful and overwhelming situations
      8) Work with patient to set goals for their behavior
      9) Provide patient with other outlets for stress and anxiety
      10) Provide patient and family/significant other with community resources that teach anger management and stress reduction techniques
      11) Utilize de-escalation techniques for staff who are trained in this

RESTRAINT APPLICATION

A. Competent staff applies restraint correctly and appropriately to protect patient safety.

B. Please reference Lippincott for limb and vest restraint application.

C. If a patient must be restrained in the supine position, ensure that the head is free to rotate to the side and, when possible, the head of the bed is elevated to minimize the risk of aspiration.

D. Secure Restraint so that it may be released immediately in emergency situations.

E. Verify that the order for restraint includes rationale for restraint, length of time and type of restraints to be used, and extremity or body part(s) to be restrained

F. All limb restraints are to be kept in full view and not covered with sheet or bedspread.

DOCUMENTATION

A. Documentation of restraint application for non-behavioral health (non-violent, non-self-destructive behavior), or for behavioral health (violent and/or self-destructive behavior) includes the following:
   1. In the Electronic Health Record (EHR)
      a. Initial assessment/clinical justification that includes the patient's behavior or actions that led to the use of the restraint.
      b. Alternatives/Interventions attempted before use of restraint or rationale on why these were not appropriate with this patient.
      c. Choice of less restrictive means as applicable.
      d. Time of application and termination.
      e. Family notification of restraint application, if appropriate
      f. When the patient no longer needs to be restrained, documentation must include the time and rationale for removal from restraints

      g. Physician's order, which includes type of restraint, time limit and reason for restraint.
   2. Patient family teaching is documented on the Restraint Education section.

CARE PLANNING

A. A modification to the patient's plan of care must accompany the use of restraints for either Non-behavioral health (Non-violent, non-self destructive behavior) or management of behavioral health (violent and/or self-destructive behavior)

B. Nursing documentation will reflect assessment intervention, evaluation, and re-intervention process with a focus on utilizing the restraint for the shortest period of time and the least restrictive measures

C. Care plan modifications may include but are not limited to the following:
   1. Patient care problem
   2. Outcome-oriented goal
   3. Restraint intervention used
   4. The Nursing documentation will reflect the date the restraint was initiated and discontinued and appropriate interventions taken to ensure patient safety

EDUCATION

A. Physicians and other licensed independent practitioners authorized to order restraints are educated on the policy during their orientation. Education on policy changes occurs during policy review and approval at medical department meetings

B. Education and training in the proper and safe use of restraints shall be provided as part of the employee's initial orientation and before participating in the use of restraints. Competency will be evaluated during orientation and annually. The nursing department education plan will include annual restraint education.

C. Education and training of staff with direct patient contact shall include but not be limited to:
   1. Hospital policy on restraints
   2. Understanding that behaviors are sometimes related to the patient's medical condition
   3. The use of alternative interventions and least restrictive measures

4. The initiation, safe application, and removal of all types of restraints used including monitoring and reassessment criteria. Training includes how to recognize and respond to signs of physical and psychological distress, and patient monitoring/observation/assessment and reassessment parameters.
5. Monitoring the physical and psychological well-being of the patient who is restrained, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person physician evaluation conducted within one hour of initiation of behavioral health (Violent and/or self-destructive behavior) restraints.
6. Patient comfort, modesty, wellbeing, dignity, rights and respect, hygiene, psychological status, elimination, nutrition, hydration needs and to recognize signs of physical distress in restrained patients.
7. Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of behavioral restraints.
8. Determination of underlying causes of behavior that may be related to a medical condition. (i.e. hypoglycemia, DTs, delirium and how that may be related to the patient's emotional condition).
9. Recognition of how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way an individual reacts to physical contact and restraints.
10. Use of nonphysical intervention skills
11. Methods for choosing the least restrictive interventions based on an assessment of the patient's medical or behavioral status or condition
12. Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
13. Clinical justification of specific behavioral changes that indicate that restraints are no longer necessary

REPORTING OF PATIENT DEATHS ASSOCIATED WITH RESTRAINT

NIHD must report deaths associated with restraint to its CMS regional office no later than the close of business the next business day following knowledge of the patient's death. [CMS 482.13(f)(7)]

NIHD must report to its CMS Regional Office each death that occurs:

1. While a patient is in restraint, except when no seclusion has been used and the only restraint used was a soft, cloth-like 2-point wrist restraint.
   a. Deaths occurring during or within 24 hours of discontinuation of 2-point soft, cloth-like non-rigid wrist restraints used in combination with any other restraint device must be reported to CMS.
   b. Death associated with the use of other types of wrist restraints, such as 2-point rigid or leather wrist restraints must be reported to CMS.
2. Within 24 hours after the patient has been removed from restraint or seclusion, except when no seclusion has been used and the only restraint used was a soft, 2-point wrist restraint
3. Within one (1) week after use of restraint or seclusion where the death is known to the hospital and it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to the patient's death, regardless of the type(s) of restraint used on the patient during this time

Patient Death Reporting- Only in 2-Point Soft Wrist Restraints and no seclusion:

NIHD must maintain an internal log or other type of tracking system for recording information within seven (7) days of a patient's death that occurs.

1. While a patient is only in 2-point soft, cloth-like non-rigid wrist restraints and there is no use of seclusion; and
2. Within 24 hours of the patient being removed from 2-point soft, cloth-like non-rigid wrist restraints where there was no use of any other type of restraint or seclusion

This log must be made readily available to CMS immediately upon request.

It is the responsibility of the Chief Executive Officer, or his/her designee, to report the incident to CMS after notification of hospital group administration and document in the patient's medical record the date and time the death was reported to CMS.

REFERENCES:

1. Centers for Medicare and Medicaid Services (CMS). Federal Register Part IV: Department of Health and Human Services. Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient's Rights; Final Rule. December 8, 2006. 42 CFR Part 482: (pp.71378-
    a. 71428).
2. Centers for Medicare and Medicaid Services (CMS). Restraint Rate per 1000 LTCH Days Measure Specifications*. June 11, 2012. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/ltch-quality-reporting/downloads/restraintrateper1000-ltchdaysmeasurespecifications.pdf
3. Centers for Medicare and Medicaid Services (CMS), State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, 04-01-2015
4. California Department of Public Health, Licensing and Certification Program, General Acute
    a. Care Hospital Memorandum, Subject: Centers for Medicare and Medicaid (CMS) Death
    b. Reporting Requirements, August 3, 2009.
5. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive
    a. Accreditation Manual for Hospitals Update 1, June 2010(pp. PC.03.02.01-PC.03.02.11)
    b. Oakbrook Terrace, IL: Joint Commission Resources, Inc.
6. Management of Aggressive Behavior. MOAB Training International, Inc. 2007. Kulpsville,
    a. PA: Cricket Press, Inc.
7. Title 22, California Code of Regulations, Division 5. Licensing and Certification of Health
    a. Facilities, Home Health Agencies, Clinics, and Referral Agencies, section 73095, 73403-
    b. 73409.2005. State of California, Office of Administrative Law.
8. Varcarolis, EM. Manual of Psychiatric Nursing Care Plans: Diagnoses, Clinical Tools, and
9. Psychopharmacology, 3rd edition. 2006. (pp. 497-517). St Louis, MO: Saunder Elsevier.
10. The Joint Commission Standards FAQs. https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/provision-of-care-treatment-and-services-pc/000001668/

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Lippincott limb restraint application
2. Lippincott vest restraint application
3. Management of the Behavioral Health Patient (5150 and non-5150)

Supersedes: v.3 Patient Restraints (Behavioral & Non-Behavioral)

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Policy on Transfilling of Medical Gas Cylinders		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Maintenance Department		
Date Last Modified: 01/10/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To establish guidelines and procedures for the safe and compliant transfilling of medical gas cylinders within Northern Inyo Healthcare District, ensuring adherence to California state regulations, Joint Commission standards, and applicable federal laws.

POLICY STATEMENT:
The transfilling of medical gas cylinders shall be performed in strict compliance with the California Code of Regulations (CCR), Title 8, Title 22, Title 24, California Health and Safety Code, National Fire Protection Association (NFPA) 99, and Joint Commission Environment of Care (EC) standards. Only trained and authorized personnel are permitted to transfill medical gases.

SCOPE:
This policy applies to all personnel involved in the handling, storage, and transfilling of medical gas cylinders within the Critical Access Hospital.

DEFINITIONS:
- **Medical Gas:** A gas intended for medical purposes, such as oxygen or nitrous oxide.
- **Transfilling:** The process of transferring medical gas from a larger bulk container into smaller cylinders.

RESPONSIBILITIES:
- **Facilities/Maintenance Supervisor:** Responsible for oversight, training, and ensuring compliance with applicable regulations.
- **Qualified Personnel:** Responsible for performing transfilling activities safely and reporting any irregularities.

TRAINING REQUIREMENTS:
1. Personnel must complete annual training on medical gas transfilling procedures.
2. Training must include safety protocols, equipment operation, emergency response, and regulatory compliance.
3. Documentation of training must be maintained in the employee's file.

PROCEDURE:
A. Pre-Transfilling Inspection:
1. Verify cylinder labels, expiration dates, and structural integrity.

2. Inspect transfilling equipment for leaks, damage, and proper function.
3. Ensure the transfilling area is properly ventilated and marked as a restricted zone.

B. Transfilling Process:

1. Wear appropriate Personal Protective Equipment (PPE) including gloves, safety goggles, and fire-resistant clothing.
2. Follow the manufacturer's instructions for the transfilling equipment.
3. Open valves slowly to prevent rapid pressurization.
4. Monitor cylinder pressure to prevent overfilling.
5. Log all transfilling activities, including date, time, cylinder ID, gas type, and personnel initials.

C. Post-Transfilling Inspection:

1. Check for leaks using an approved leak-detection method.
2. Verify that valves are securely closed and caps are in place.
3. Properly label cylinders with transfilling date and responsible personnel.

D. Storage and Transport:

1. Store filled cylinders in designated, ventilated storage areas.
2. Secure cylinders during transport to prevent tipping or damage.

E. Emergency Procedures:

1. In case of a gas leak, evacuate the area and notify emergency services.
2. Report incidents to the Facilities Supervisor immediately.

RECORDKEEPING:

1. Maintain records of transfilling logs for a minimum of five (5) years.
2. Document employee training and certifications.

REFERENCES:

1. California Code of Regulations (CCR) Title 8, Title 22, Title 24
2. California Health and Safety Code
3. National Fire Protection Association (NFPA) 99
4. Joint Commission Environment of Care (EC) Standards
5. OSHA Standards
6. FDA Compressed Medical Gases Guidelines

RECORD RETENTION AND DESTRUCTION:

1. Minimum of five (5) years

CROSS REFERENCE POLICIES AND PROCEDURES: N/A

Supersedes: v.1 Policy on Transfilling EC.02.05.09 EP13

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 01/29/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/01/2018	

PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of adult health maintenance (specific chronic diseases – protocols i.e. hypertension, diabetes).

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Function: management of adult health maintenance.
3. Circumstances:
    a. Patient Population: adult patients
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
4. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:
1. Definition: health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults.
    a. Includes health assessment and disease prevention utilizing:
        i. physical exam
        ii. diagnostic testing
        iii. immunizations
        iv. developmental screening
        v. health education
2. Data base:
    a. Subjective:
        i. Obtain complete histories on all first-time patients; interval histories on subsequent visits.
    b. Objective:
        i. At each visit obtain vital signs, weight, allergy history and pain assessment.
        ii. Risk assessment when establishing care and as indicated.
        iii. Perform complete physical examinations as indicated.
        iv. Perform appropriate psychosocial assessment.
        v. Laboratory/diagnostic testing as needed.
        vi. Initiate and modify orders for home health services as needed

3. Plan:
    a. Diagnosis established utilizing current coding standards in CPOE format.
        i. Health maintenance
        ii. Acute illness
        iii. Current assessment of chronic illness
    b. Therapeutic regimen
        i. Diet as appropriate for age/nutritional status
        ii. Medications
            1. Vitamins/mineral supplements
            2. Immunizations as indicated
            3. Hormonal replacement as indicated
            4. Medications appropriate to address acute and chronic health problems.
                a. For contraindications and precautions to immunization as stated in the vaccine package insert, consult with a physician before administration of vaccine.
        iii. Activity/exercise as appropriate for age/health status
        iv. Health education related to age/health status, preventative health behaviors.
        v. Interventions appropriate to address acute and chronic health problems.
        vi. Refer to specialist or other community resource indicated
    c. Physician consultation is to be obtained under the following circumstances
        i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
        ii. Acute decompensation of patient situation.
        iii. Problem which is not resolving as anticipated.
        iv. History, physical, or lab finding inconsistent with the clinical picture.
        v. Upon request of patient, nurse, or supervising physician.
        vi. Conditions for which diagnosis and/or treatment are beyond the scope of the NP's or CNM's knowledge and/or skills.
    d. Follow-up
        i. According to adult health maintenance schedule, sooner as indicated.
    e. Record keeping
        i. Appropriate documentation to be maintained in patient's chart.
        ii. Allergic reaction to vaccine/medication

REFERENCES:

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

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.4 Standardized Procedure - Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

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

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

1. _____ _____
   NAME DATE

2. _____ _____
   NAME DATE

3. _____ _____
   NAME DATE

4. _____ _____
   NAME DATE

5. _____ _____
   NAME DATE

6. _____ _____
   NAME DATE

7. _____ _____
   NAME DATE

8. _____ _____
   NAME DATE

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Well Child Care Policy for the Nurse Practitioner		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioners		
Date Last Modified: 01/07/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/20/2020	

PURPOSE:

1. This standardized procedure developed for the use by the Family Nurse Practitioner (FNP) or Pediatric Nurse Practitioner (PNP) is designed to establish guidelines that will allow the FNP or PNP to manage well child care.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure is designed to establish guidelines that will allow the PNP or FNP to perform health maintenance, health promotion and disease prevention activities which promote the physical, psychosocial and developmental well-being of children.
3. Circumstances:
    a. Patient population: neonatal and pediatric patients
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP

PROCEDURE:

1. Data Base
    a. Subjective
        i. Obtain complete histories on all first time patients; interval histories on subsequent visits.
    b. Objective
        i. See schedule of well child care. Gather and review information as indicated on periodicity schedule.
2. Plan
    a. Diagnosis
        i. Well child
        ii. Acute illness
        iii. Current assessment of chronic illness
    b. Therapeutic regimen
        i. Diet as appropriate for age/nutritional status
        ii. Medications

1. Vitamins/mineral supplements
2. Immunizations as indicated
3. Medication as indicated for chronic or acute illness

iii. Activity/exercise as appropriate for age
iv. Health education and anticipatory guidance related to developmental level
v. Treatment of acute illness as indicated (see *Management of Acute Illness Standardized Procedure*).

c. Consultation/referral
   i. Physician consult to be obtained under the following circumstances:
      1. Unexplained history, physical or laboratory finding
      2. Problem which is not resolving as anticipated
      3. Emergency conditions requiring prompt medical intervention
      4. Upon request of patient/family or supervising physician
      5. Conditions for which diagnosis and/or treatment are beyond the scope of the NP's knowledge and/or skills
   ii. Refer to specialist or other community resource as indicated.
d. Follow-up
   i. According to well child schedule or sooner as indicated
e. Record keeping
   i. Appropriate documentation to be maintained in patient's chart.
   ii. Allergic reaction to vaccine

3. For contraindications and precautions to immunization as stated in the vaccine package insert, consult with a physician before administration of vaccine.

REFERENCES:

1. California Code of Regulations. Title 16, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.4 Standardized Procedure – Well Child Care Policy for the Nurse Practitioner

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure for Registered Nurse First Assistant		
Owner: Perioperative Manager	Department: Surgery	
Scope: RNFA		
Date Last Modified: 10/16/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The RN First Assistant (RNFA) assists the attending surgeon during a surgical procedure by providing aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.

POLICY

The RNFA practices within the appropriate limitations and may choose not to perform those functions for which she has not been prepared or for which she does not feel capable of performing.
The activities outlined are determined based on the experience and education of the RNFA. The performance of other activities in the role of RNFA is dependent on the ability of the RNFA to safely perform the activities under the direction of the surgeon in a competent manner.

PROCEDURE

1. Experience
    a. Current California RN licensure
    b. Demonstrated proficiency in perioperative nursing practice as both scrub and circulator for at least two years, and currently effectively fulfilling the role of Surgery RN at NIH.
    c. Successful completion of a course in RN First Assisting through an accredited program; one which uses the AORN Core Curriculum for the RNFA as a foundation. (A copy of the certificate of completion will be aced in the RNFA's personnel file.)
    d. Current CNOR (Certified Nurse in the Operating Room), or obtains this within the first year of employment as RNFA.
    e. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that is unique to functioning as an RNFA.
    f. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the RNFA assists.
    g. Demonstrated ability to function effectively and harmoniously as a team member and in stressful and emergency situations.
    h. Able to perform CPR; ACLS/PALS completion.
    i. Effective January 1, 2020, the education level for entry into an RNFA program and, subsequently, RNFA practice will be the baccalaureate degree. AORN recommends that RNs who were practicing as RNFAs prior to January 1, 2020, who do not have a baccalaureate degree be permitted to continue to practice as RNFAs.

2. Method of Initial and Continued Evaluation of Competence
    a. The attending surgeon has determined that the RNFA can provide the type of assistance needed during the specific surgery.
    b. The RNFA will be evaluated for continued competency 90 days after assuming this position and yearly thereafter.
    c. The evaluation will be done by means of a written performance evaluation based on the RNFA job description, will be done by the Surgery Nurse Manager, and will contain input from the appropriate attending surgeons based on the protocol section of this standardized procedure, chart review and their observations.

3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RNFAs competent to perform this standardized procedure is maintained with the Chief Nursing Officer and with the Surgery Manager and is updated annually

4. Settings where Standardized Procedure may be performed
    a. The Standardized Procedure for RNFA may take place in the OR

5. Standardized Procedure
   The RNFA will:
    a. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
    b. Provide retraction by:
        - Closely observing the operative field at all times.
        - Demonstrating stamina for sustained retraction.
        - Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
        - Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
        - Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
    c. Provide hemostasis by:
        - Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
        - Sponging and utilizing pressure, as necessary.
        - Utilizing suctioning techniques.
        - Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
        - Placing suture ligatures in the muscle, subcutaneous and skin layer.
        - Placing hemoclips on bleeders, ad directed by the surgeon.
    d. Perform knot tying by:
        - Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
        - Tying knots firmly to avoid slipping.
        - Avoid undue friction to prevent fraying of suture.
        - "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
        - Approximating tissue rather than pulling tightly to prevent tissue necrosis.

    e. Perform dissection as directed by the surgeon by:

- Having knowledge of the anatomy
- Demonstrating the ability to use the appropriate instrumentation
- For abdominal surgery: dissection includes all layers to, but not, the peritoneum

f. Provide closure of layers by:
- Correctly approximating the layers, under direction of the surgeon
- Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs. continuous; skin sutures vs. staples; subcuticular closure; horizontal mattress
- Correctly approximating skin edges when utilizing skin staples or suture

g. Assist the surgeon at the completion of the surgical procedure by:
- Affixing and stabilizing all drains
- Cleaning the wound and applying the dressing
- Assist with applying casts; splints, bulky dressings, abduction devices

6. Other specialized circumstances requiring RN to contact physician
   a. None (physician always supervising)

7. Review of Standardized Procedure
   a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

REFERENCES:

1. Westlaw California Code of Regulations. (2021). Barclays Official California Code of Regulations 17 CA ADC § 35055. Retrieved from https://govt.westlaw.com/calregs/Document/I2599B8C0D60711DE88AEDDE29ED1DC0A?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
2. AORN standards for RN first assistant education programs. https://www.aorn.org/guidelines/clinical-resources/rn-first-assistant-resources. Published 2014. Accessed September 29, 2022.

Supersedes: v.1 Standardized Procedure for Registered Nurse First Assistant

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol – Well Child Care Policy for the Physician Assistant		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 01/07/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/20/2020	

PURPOSE:

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to manage well child care.

POLICY:

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

PROTOCOL:

1. Definition: health maintenance, health promotion and disease prevention activities which promote the physical, psychosocial and developmental well-being of children. Includes health assessments, appropriate laboratory tests, and disease prevention through immunizations, developmental screening, and health education.
2. Data Base:
    a. Subjective:
        i. Obtain complete histories on all first time patients; interval histories on subsequent visits.
    b. Objective:
        i. See schedule of well child care. Gather and review information as indicated on periodicity schedule.
3. Plan:
    a. Diagnosis:
        i. Well child
        ii. Acute illness
        iii. Current assessment of chronic illness
    b. Therapeutic regimen:
        i. Diet as appropriate for age/nutritional status
        ii. Medications

1. Vitamins/mineral supplements
2. Immunizations as indicated
3. Medication as indicated for chronic or acute illness

iii. Activity/ exercise as appropriate for age
iv. Health education and anticipatory guidance related to developmental level
v. Treatment of acute illness as indicated (see Acute Illness Protocol).

c. Physician consultation is to be obtained under the following circumstances:
   i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
   ii. Acute decompensation of patient situation.
   iii. Problem which is not resolving as anticipated.
   iv. History, physical, or lab finding inconsistent with the clinical picture.
   v. Upon request of patient, family, nurse, or supervising physician.
   vi. Conditions for which diagnosis and/or treatment are beyond the scope of the PA's knowledge and/or skills
d. Referral
   i. Refer to specialist or other community resource as indicated
e. Follow-up
   i. According to well child schedule or sooner as indicated
f. Record keeping
   i. Appropriate documentation to be maintained in patient's chart.
   ii. Allergic reaction to vaccine

4. For contraindications and precautions to immunization as stated in the vaccine package insert, consult with a physician before administration of vaccine.

REFERENCES:

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

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Protocol – Well Child Care Policy for the Physician Assistant

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Value Analysis Committee		
Owner: Chief Executive Officer	Department: Administration	
Scope: District-wide		
Date Last Modified: 01/31/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
The Value Analysis Committee (VAC) provides a framework and structure for the introduction, evaluation, standardization and utilization of products and new equipment at Northern Inyo Healthcare District (NIHD).

POLICY:
To assure patient safety, reduce risk, encourage standardization of patient care products and equipment optimize cost savings opportunities, and support innovative and quality patient care at NIHD.

Decisions made through the VAC process will include:

- Clinical and operational problem evaluation and product criteria identification.
    - Managing product and equipment conflicts related to simultaneous utilization and Operating Room turnover time.
        - Impact to volume of cases.
        - Impact to case duration.
    - Assess clinical need(s).
    - Assess training needs.
- Analysis of new products prior to adoption.
    - Assess conflicts with existing contracts.
    - Duplication of existing products.
    - Assess proposed pricing.
- Documentation of clinical soundness for new products.
- Analysis of cost reduction opportunities achieved through supply standardization, utilization, and process improvement.
    - Impact to inventory management.
        - Charge Master.
        - Materials Master
- Cost impact/return on investment analysis recommendation to the Return on Investment Committee (ROI).
    - Complete financial analysis to include impact of expense on cost per case and resulting contribution margin for both professional and technical aspects.

Key areas that use the VAC process include, but are not limited to:

- Cardiopulmonary
- Diagnostic Imaging

- Surgery
- Laboratory
- Emergency Department
- Nursing
- Support Services
- Clinics

The VAC function is to review and evaluate products and equipment for utilization that will best meet the needs of patients, providers and staff at NIHD. Major components of the process include:

1. Selection of products/equipment that meet or exceed requirements of performance, quality, safety, and cost effectiveness.
2. Reduction of cost through contract negotiations, standardization and proper utilization of products and equipment.
3. Measurement of clinical and financial outcomes as appropriate for selected items.

PROCEDURE:

New Initiative or Product Request

1. All new product and equipment requests must go through the VAC process prior to use at NIHD.
2. Exceptions to this policy will be:
   Replacement products or parts for existing equipment
3. All new initiative, product and equipment requests should be routed directly to the VAC Chair or designee to initiate the initial review process.

Product and Equipment Value Analysis Evaluation

- The VAC will evaluate and document the following in the course of its deliberations:
  - Identification of Clinical need or problem.
  - Documentation of current product related to issue or consideration.
  - Reason for request.
  - Stakeholder input.
  - Objective clinical requirements.
  - Evaluation/validation documentation (see detail below)
  - Pre and post clinical measurements for the evaluation/validation to ensure predicted outcomes.
  - Related regulatory requirements.
  - Education needs related to validation and/or implementation.
  - All communication
  - Referral to ROI Committee for financial impact review/analysis and approval
- Use of the approved VAC documents is required to assist with documentation. If an area of documentation is not relevant to the particular initiative or request for evaluation, the VAC team should indicate that the area does not apply.
- Add attachments to the VAC documentation as needed for any given evaluation.
- Complete a full evaluation, then VAC will develop a recommendation related to the request; this can include a full or limited adoption, postponement, decline, etc. and present it to the appropriate NIHD committee for final approval.

Evaluation/Validation

- In the event that a product or equipment validation is needed, the following will be in place prior to initiation of the validation:
  - All appropriate staff and providers have been properly trained and in-serviced.
  - Vendors will not participate in the validations.
  - An evaluation form containing objective non-financial criteria will be developed, evaluation time-frame defined, and methodology approved by the VAC.
  - Appropriate safety checks will be conducted by individual departments.

Final Decision Process

- The recommendation from the VAC will be sent to the appropriate NIHD committee for a final decision.
- The VAC Chair or designee will communicate the outcome to the original requestor.

Initiative Implementation

- The Director of Purchasing will note and coordinate changes as follows:
  - Negotiate and obtain best possible pricing and service based upon a bid and/or group purchasing contract and/or benchmark data to be obtained by Purchasing.
  - Place item in Item Master per policy and procedure.
  - Place item into other databases as required.
- The VAC Chair will coordinate acquisition of item or service in collaboration with VAC.
  - VAC will document savings on appropriate reports to District leadership and key stakeholders.
- The VAC Chair or designee will coordinate the following:
  - Conduct follow-up utilization measurement to validate actual versus predicted use.
  - Report out usage, savings and other findings at next regularly scheduled VAC meeting for inclusion into minutes.
  - Manage conversion checklist to ensure a full and timely conversion of products and equipment.

Emergency Product Approval for One Time Use

- Notify the Director of Purchasing for a one-time use or emergency need products.
- Consider emergency use for consumable and or clinic products for an urgent patient need with possible adverse clinical outcomes if not made available.
- The use of Emergency product can also be approved by a member of the executive leadership team prior to use.
- Maintain a record for each request to include the vendor, product, physician, rationale for use, and approving executive leader.
- Any product used within NIHD for an emergency situation will be automatically submitted to the VAC for evaluation.
- Products that are introduced through the Emergency product process will be considered a donation to the organization and will not be billed to the patient or their insurance provider unless the product is ordered by Purchasing in advance (one week or more) of the procedure.
- Emergency use will not be utilized to “try” a product prior to submitting to the VAC process.

VAC Membership

Membership will consist of representatives from nursing, operations, purchasing, clinical engineering, project management, executive leadership and finance.

Role	Representative
Chair	Chief Nursing Officer?
Co-Chair	Director of Purchasing
Clinical Engineering	Clinical Engineering Manager
Nursing	Director of PACU
Finance	Director of Revenue Cycle
Operations	Chief Operating Officer
Executive Leader	Chief Medical Officer
Project Management	Project Management Manager

VAC Meetings

The VAC will meet at least monthly or as required based on the volume of product and equipment requests.

- The VAC Chair facilitates the meetings.
- Meeting agendas will be set by the VAC Chair
  - Old business
    - Review of outstanding requests (i.e. incomplete)
  - New business
    - Review of new product and equipment requests
  - Analysis results
  - Action items
    - Product and equipment recommendations for approval/denial
- NIHD committee submission follow-up and finalization
- Next meeting

REFERENCES:

1.

CROSS-REFERENCE POLICY & PROCEDURE:

1. Purchasing and Signature Authority
2. New Product Review Emergency Purchases
3. Emergency Purchases

Supersedes: Not Set

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

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: February 4, 2025
RE: Medical Executive Committee Report

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

A. Medical Staff Reappointments (*action item*)

1. Christopher Quijano, DO (general surgery) – Courtesy Staff, 2024-2025
2. Lisa Manzanares, DO (family medicine) – Active Staff, 2025-2026
3. Jake Ichino, MD (cardiovascular disease) – Telehealth Staff, 2025-2026

B. Request for Additional Privileges (*action item*)

1. William Pace, MD (*diagnostic radiology/interventional radiology*) – additional privileges in Mammography recommended for approval
2. Lindsey Ricci, MD (*pediatrics*) – additional privileges in lingual frenotomy recommended for approval

C. Medical Staff Initial Appointments (*action item*)

1. Michael Doyle, MD (*pediatrics*) – Courtesy Staff
2. Bartlett White, PA-C (*physician assistant*) – Advanced Practice Provider Staff

D. Medical Staff Initial Appointments – Proxy Credentialing (*action item*)

As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Sevaro's credentialing and privileging decisions.

1. Hami Ramani, DO (*neurology*) – Telemedicine Staff (Sevaro Group)

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

Date: February 6, 2025

Title: 2024 Annual Compliance Report

Synopsis: The Compliance Department Annual 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 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.

I recommend that the Board of Directors accept this report.

Prepared by: Patty Dickson, Compliance Officer

FOR EXECUTIVE TEAM USE ONLY:

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

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

Northern Inyo Healthcare District

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

Annual Compliance Report –CY 2024
February 5, 2025

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**—The District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment is completed annually and as needed by Compliance and Information Technology (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, our local Medicare Administrative Contractor (MAC) Noridian, and other regulatory agency 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. Enforcement and discipline are among the seven essential elements of an effective compliance program, as is reporting as required to regulatory agencies and the Board.
8. **Compliance Committees—**This section provides a brief overview of the work of the Compliance committees and subcommittees.
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. Education and training, along with response and prevention, are two of the seven essential elements of an effective compliance program.
10. **California Public Records Act (CPRA) Requests**—The Compliance Officer is responsible for receiving and reviewing public records requests and researching, investigating, redacting, and fulfilling them.
11. **Policies and Procedures—**Policies and procedures are vital to the organization as they outline expectations and processes for 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 quality data to leadership and teams for monitoring and trending. Compliance also manages the software, reporting, user configuration, and resolution of all UORs.
13. **Regulatory Updates—**Compliance requires knowledge of updates and changes to state and federal regulations. The Compliance Department has implemented regulatory monitoring software to ensure we are aware of and plan for upcoming effective dates for new and changing regulations.

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

The Compliance Reports help the Board of Directors and Executives fulfill their governance and oversight roles. Governing board and executive oversight of compliance is one of the seven essential elements of an effective compliance program.

Report

1. Audits

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

i. Cerner semi-automated audit software tracks all workforce interactions and provides a summary dashboard for the Compliance Team. The dashboard provides "flags" for unusual activity, which require further investigation and review by the Compliance Team. The majority of access audits are a manual process involving reviewing hundreds of thousands of lines of data in Excel spreadsheets.

ii. With assistance from ITS and Project Management, the Compliance Department is currently performing the due diligence necessary to implement a fully automated auditing solution, Protenus. Once implemented, this software will save the Compliance Department over 1300 hours per year, allowing the Compliance Team to use those hours to improve other areas of District regulatory compliance. See sample report from Protenus, attachment 1.

ii. The following is the CY24 activity:

a. New Employee Audits (30 days): 35
   I. Flags: 1
   II. Flags resulting in policy violations: 1
   III. The 30-day audit for new employees was added to the access audit plan in 2024 as a part of a Protected Health Information (PHI) breach corrective action plan.

b. New Employee Audits (90 days): 126
   I. Flags: 1
   II. Flags resulting in policy violations: 0

c. For-Cause Audits: 39
   I. Flags: 8
   II. Flags resulting in policy violations: 0
   III. Flags resulting in disciplinary action: 6

d. In "own" chart flags: 43
    I. Flags resulting in policy violations: 17
        i. Provided education and training: 17
        ii. Repeat violations: 0
e. Same Last Name Search Flags: 890
    I. Resulted in follow-up with the employee: 10
    II. Flags resulting in policy violations: 0
f. Third-Party Vendors (ex. Our billing or coding company): 66
    I. Flags: 1
    II. Flags resulting in policy violations: 0
g. High Profile Persons: 26
    I. Flags: 0
    II. Flags resulting in policy violations: 0
h. Random Employee Audits: 28
    I. Flags: 0
    II. Flags resulting in policy violations: 0

B. Business Associates Agreements (BAA) audit
    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 is accountable to the strict governmental regulations regarding using, transmitting, and storing protected information to protect NIHD and NIHD patient information.
    ii. In 2025, compliance will vet high-risk business associates to ensure compliance with BAAs and privacy and security laws.
    iii. NIHD has nearly 100 BAAs.
C. Compliance Department Contract and Agreement reviews/audit
    i. Documents processed for CY 24
        a. Approximately 250 agreements, amendments, or termination notices were reviewed and completed.
        b. ~10 are currently in progress
D. HIMs (Health Information Management) scanning audit
    i. To be conducted by HIMS, and summary reports will be sent to Compliance
    ii. No reports have been received 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, it results in reminder emails to use email encryption sent to workforce members.
        b. Occasionally, this results in full investigations of potential privacy violations.
F. Language Access Services Audits and Reviews
    i. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line.
        a. NIHD has provided 88,429 minutes of interpreting services to our patients at a cost to the District of $97,667.62. See attachment 2.

ii. Translation services (written word) services are provided via Language Line Translation Services. NIHD spent $6,707.64 on translation services in 2024.
iii. NIHD provided services in the following languages in 2024:
    a. Spanish (21 countries claim Spanish as an official language)
    b. American Sign Language
    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
iv. Laws require providing language access services to all patients with limited English proficiency at no cost to the patient.
v. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.
vi. Compliance has vetted and selected Pocketalk's HIPAA-compliant handheld AI interpreting device. We will update Language Access Services Policies and Procedures and roll the product out throughout the District. See attachment 3.

G. 340B program audits
    i. The 340B drug program is designed to provide rural and underserved communities with access to discount drug prices, allowing the facility to save several hundred thousand dollars annually. The district uses those funds to improve services provided to the community.
    ii. Annual 340B audit has been scheduled for 2025 with SpendMend (formerly TurnKey)
        a. The Compliance Department recognizes Becky Wanamaker and Jeff Kneip for their excellent work maintaining the compliance of our 340B program.

H. Narcotic Administration/Reconciliation Audit
    i. Compliance works with Pharmacy to review narcotic administration and compliance with professional standards and regulations.

I. Vendor Diversity Audit – NIHD has approximately 1200 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 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. There are changes to this state regulation in 2025. Compliance is reviewing the changes and updating our policies as needed.

J. Provider Verification Audits
    i. Compliance verified over 400 providers for state and federal exclusions in CY 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. UASI has provided coding quality reports.
    a. UASI has provided education to providers.
ii. Charge Master Audit
    a. The audit conducted by CliftonLarsonAllen identified opportunities in multiple areas of the chargemaster. These are the focus of multiple revenue cycle committees.

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

2. **HIPAA Security Risk Assessment (SRA)** – Completed in December 2024.
   A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG. See attachment 4 for an overview of the 2024 results.
   B. The Compliance Officer (Patty Dickson) and Security Officer (Bryan Harper) work on this risk assessment together. We are moving the process of a once-per-year review to a software-driven continuous process. See ComplyAssistant information in attachment 5.
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 (Merit-based Incentive Payment System) data submission.
   C. MIPS data is the quality-of-care data submitted by the Quality Team. MIPS documents improvements in patient care measures and outcomes and is worth millions of dollars for NIHD.
4. **Compliance Work Plan** – Updated for Calendar Year (CY) 2025. See attachment 6.
5. **Conflicts of Interest**
   A. All new employees complete and return COI questionnaire forms.
   B. We sent all current employees the new format COI questionnaire form in July 2024.
      i. We have received over 350 completed forms.
      ii. We have reduced the time the Compliance Department spends on this process by approximately 85%, which saves the District 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, for special consideration, or for political contribution.
      vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.
6. **Privacy Investigations**- See attachment 7.
   A. Privacy investigations/potential breaches for 2024:
      i. Reported to Compliance – 29
      ii. Reported to CDPH/OCR – 7
      iii. Investigations (2024) still active in the Compliance Department - 0
      iv. Investigations closed by the Compliance Department with no reporting required - 22
   B. Outstanding breach cases reported to CDPH
      i. CDPH has notified NIHD that the Medical Breach Enforcement Section (MBES) will begin investigating its backlog of breaches. MBES can review and investigate breaches for

seven years. The MBES team was reassigned to contact tracing during the pandemic and is now working to resolve the oldest reported potential breaches first.

a. Privacy investigations from 2023
    I. Reported – 10
        i. 4 are closed
b. Privacy investigations from 2022
    I. Reported – 6
        i. 3 are closed
        ii. NIHD received notice that CDPH assigned a $45,000 administrative penalty for a breach in 2022.
            1. This was an intentional breach by the former employee.
            2. Compliance was able to negotiate a $30,000 Settlement Stipulation. NIHD has paid this administrative penalty.
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 an 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. CDPH is still investigating 1

ii. CDPH Status definitions
    a. Closed – CDPH investigation was completed, and a determination was made.
    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 corrective actions to ensure any harm has been mitigated and reduced the risk for recurrence.
    c. Substantiated with deficiencies—CDPH has found that a violation of the privacy laws occurred and determined that further action by NIHD is needed to reduce the risk of 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 approximately 45 investigations during 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 Civil Rights (OCR)
         a. Business Associate Data Breach – Keenan
            I. OCR reviewed the 700-page response submitted by NIHD for this breach by a business associate.
            II. OCR provided recommendations for improvement.
            III. The case was closed without further action on December 30, 2024. See attachment 8
            IV. The recommendations will be completed with the implementation and completion of tasks in the ComplyAssistant software.
      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 required vendor diversity information due by July 1, 2024. NIHD had three certified diverse vendors. NIHD spent ~$66k with certified diverse vendors, approximately 0.08% of its total procurement. These reports are due before July 1 annually.
         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. We are required to update this information any time the policies are updated, which most recently occurred in December 2024.
         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. Project Manager Lynda Vance led an NIHD team assembled to assess, create, and execute a corrective action plan.
            II. On November 8, 2024, NIHD received notification that the reviewed section complies with Hospital Price Transparency regulations. See attachment 9.
            III. Thanks to Lynda's continuous follow-up and pressure on internal and external teams, NIHD avoided tens of thousands of dollars in fines.
            IV. NIHD Business Office still performs weekly follow-up calls with Cerner and other vendors to ensure the process works well and complies with the regulations.
   C. Subpoenas

i. The Compliance Department also accepts and completes subpoena service for cases related to District business. This includes subpoenas for NIHD business records and appearances. Subpoenas for Medical Records are processed by the Health Information Department (HIM).
ii. The Compliance Team has facilitated 59 subpoenas for records or appearances in CY 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 and coding issues, chargemaster changes, and policies that affect billing, coding, and accounting. The Manager of the Business Office chairs this committee.
C. Business Compliance Team (BCT) reports to the CBEC Committee.
   i. This group reviews all Conflict of Interest questionnaires that list potential conflicts to determine the appropriate and consistent method of addressing the conflict. The Compliance Officer chairs this subcommittee, which meets ad hoc 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. Standardized templates, designated fonts, official translations, mandatory non-discrimination and language access information create compliant and consistent documentation for the District.
   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 form development and approval process.
   iv. The Forms Committee is transitioning to serial meetings via Smartsheet to facilitate faster form approvals.

9. Issues and Prevention

A. Compliance researched over 100 issues for the District in 2024. They include adolescent privacy regulations, billing issues, consent, and regulatory reporting. The Compliance Team proactively approaches all matters brought to our attention.

10. CPRA (California Public Records Act) Requests

A. Compliance has received thirteen (13) CPRA requests in CY 2024.
   i. All thirteen were completed timely, per regulatory standards.

11. Policy and Procedures

A. Clear and current policies are the basis of an effective and efficient organization.
B. The Board must review and approve policies every two years, and the Executive Team or the Medical Executive Committee must review and approve procedures every two years.
C. Written policies and procedures are one of the seven essential elements of an effective Compliance Program, per the Health and Human Services Office of Inspector General. The compliance officer manages user set-up, policy administration, and other software optimization.
A. Policy and Procedure Audits:
   i. NIHD has approximately 1155 policies and procedures.
   ii. NIHD leadership teams consistently work on regulatory compliance through policy updates and reviews.

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

12. Unusual Occurrence Reports (UOR)

A. UOR data for Calendar Year 2024. See attachment 10
   i. Notable trends out of 515 UORs received in CY 2024:
      a. Complaints and requests to review billing and care are the most frequent UORs. These two areas represent 138 of the 515 UORs (27%).
         I. We are addressing some trending issues:
            i. Billing complaints
            ii. Communication and customer service concerns
      b. NIHD had nine reports of workplace violence.
      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 attachment 11.
      d. Attachment 11 includes a list of systemic changes implemented based on action plans developed during the UOR review and investigation process.
         I. Five systemic changes were the result of patient complaints.
         II. Three systemic changes resulted from safety and security occurrence reports.

B. The current review process for UORs.
   i. The Compliance Team currently receives all UORs in Complytrack.
      a. Many patient complaints and concerns calls are transferred to the Compliance Team for intake and assistance.
      b. The Compliance Team provides response letters for patient complaints. Per District policy and regulatory guidance from CMS, the average response time for complaint letters should be no more than 7 days.
   ii. UORs are triaged and assigned to appropriate department leaders for review. Leaders are contacted via email and phone 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 responding promptly and attempts to assist them with a resolution.
   v. The Compliance Team ensures that UORs are closed after a thorough review, corrective actions, and, in most cases, resolution.

13. Regulatory Updates

A. An introduction to another Compliance Department Project is included in attachment 12.
B. The Board will receive regulatory changes with recent or near-future effective dates in each Compliance Report.
C. Currently, the software has only been rolled out to the Revenue Cycle Director, Compliance Department, and the Director of Inpatient Nursing. We will roll out to additional leaders in the future.

D. To ensure no significant changes were missed during 2024, the Compliance Officer reviewed approximately 350 regulatory updates with effective dates in 2024. Relevant regulations were accepted and assigned to verify compliance.

Attachment 1

PROTENUS

Report Generated **November 26, 2024**

Not real information

Case Information

Case 545

Rylee Q Grant accessed Ashley Barrows on 6/27/2020

EMR User	Patient	Case Created
Rylee Q Grant	Ashley Barrows	July 2, 2024 9:04 AM PDT by Nicholas Culbertson
Case Owner	**Resolution**	**Case Type**
Tom Chelchowski	VIOLATION	VIP

Caseflow

Case Created

Nicholas Culbertson Jul 2, 2024 9:04 AM PDT

Privacy Assessment Added Activity from 06/26/2020 through 06/27/2020

Added by Protenus Jul 2, 2024 9:04 AM PDT based on data available

Assessments

A Nurse in the NICU questionably accessed a VIP's medical record

This user accessed 14 patients on this day.

This user accessed 13 NICU patients and 1 pediatric patient.

This user searched for this patient by name (search query: "Ashley Barrows").

This user searched for 1 (out of 14) patients by name on this day.

This user spent 14 minutes and 26 seconds in this patient's medical record.

This user did not chart or document in this patient's medical record.

This user has never accessed this patient before.

This user's others patients share departments that this patient does not share: NICU (100%).

This user has violated privacy in the past.

This patient was recently mentioned in the news (https://www.10tv.com/article/child-prodigy-needs-a-heart-transplant).

Suspicion Score: 93

Assessments and suspicion score generated based on data available: 11/12/2023

Case escalated to Nursing Leadership, 11/25/2024

Not real information

eiopiroeuq

Note Added

Workforce member Rylee Q Grant accessed Ashley Barrows as a result of searching this patient by name. This access is suspicious because the workforce member is not part of the patients care team and the patient has no upcoming appointments with this workforce member.

Case escalated to HR, 11/25/2024

Case Resolved as Violation - Privacy

User & Patient Details

EMR Record Epic Teresamouth

Rylee Q Grant

Desiree E Cook 5/3/24 – 9/10/24

Details

NP
via **Lawson**

RGrant1

10/8/1988 : 36 years old

5/4/2024

08989 Buckley Islands Suite 376
Breannaburgh, Tennessee 79801
via **ADP**

Medical Record Epic New Denise

Ashley Barrows

★ VIP

Details

1/25/2024 4:34 PM PST

Office Visit, Heart Center

9/26/2016 : 8 years old

Female

SB911448397652415
IK291274884947147
VR286498952356833

869 Jefferson Mills
Lake Daniel, Arkansas 22014
via Salesforce

None

NICU
via Epic

Specialties	Intensive Care
Service Area Type	Nursing Home
Service Area	Richie Center for Rehabilitation
Facility	SHIRE UNIT/DONOR FACILITY

NICU
via Lawson

Associated Roles

NP
via Lawson

Start Date	None Provided
End Date	None Provided
Work Email	RGrant1@northside.org
Organization	NICU
Title	Nurse Practitioner

Admin
via Workday

Start Date	None Provided
End Date	None Provided
Work Email	rylee.grant@gmail.com
Organization	Community Hospital
Title	Volunteer

Contacts

Emily J Morgan
via Meditech

Relationship	Manager
Home Phone	(565)852-4156x64447

70139815

Student

Unknown

4430 Blue Spruce Lane
Baltimore, MD 21212
via Epic

443-416-9693
via Epic

Contacts

Will Barrows
via Epic

Relationship	Father
Home Phone	1-426-659-9298

Encounters

Future Encounters

No Future Encounters

Past Encounters

Office Visit, Heart Center
via Epic

Date/Time	1/25/2024 4:34 PM PST – 6:34 PM PST
Viewed By	Sara B Golden
Providers	Valerie D Coffey
Financial Num.	20098442586039

Office Visit, Heart Center
via Epic

Date/Time	6/15/2020 10:00 AM PDT – 12:15 PM PDT
Providers	Nancy D Davis
Financial Num.	96989874490804

Vacation Address 8663 Moore Shores Apt. 171
West Gina, Minnesota 03563

Not real information

Language Acess Services

Attachment 2

Interpreting	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	999	345	273	330	436	141	277	
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	$133.95	$263.15	
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	2,625	3,189	
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	$3,937.50	$4,783.50	
Cyracom - Phone - minutes provided	1,415	1,201	1,754	959	719	2,294	3,186	4,577	3,329	4,014	2,908	3,019	
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	$2,051.04	$2,161.85	
Cyracom - Video - minutes provided	154	142	232	77	243	1,692	1,689	1,844	775	823	689	314	
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	$516.75	$298.45	
Total Minutes of interpretive services provided	**6479**	**5748**	**7859**	**7689**	**8453**	**7532**	**7317**	**8982**	**6658**	**8550**	**6363**	**6799**	**88429**
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**	**$6,639.24**	**$7,506.95**	**$97,667.62**
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**

In California healthcare facilities, the use of handheld AI interpreting devices is generally allowed, but with some important legal and ethical considerations.

Key Legal Considerations:

1. **Compliance with Language Access Laws** – California law (e.g., the Dymally-Alatorre Bilingual Services Act) and federal regulations (e.g., Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act) require healthcare providers to offer qualified interpreters for Limited English Proficiency (LEP) patients. AI devices may not always meet the requirement of a *qualified interpreter* unless they are proven to be highly accurate.
2. **HIPAA & Patient Privacy** – Any AI interpreting device used must comply with HIPAA (Health Insurance Portability and Accountability Act) regulations to protect patient information. If the device transmits data over the internet or stores information, it must have strong security measures.
3. **Accuracy & Medical Risk** – AI translation tools can sometimes misinterpret medical terminology, leading to errors in patient care. Pocketalk displays the spoken words on the screen to verify the "AI" heard what the speaker said correctly.
4. **Acceptability by Healthcare Facilities** - Hospitals or clinics should develop internal policies for the use of AI interpreting devices.

POCKETALK

Pocketalk offers instant, accessible translation, giving every patient a chance to be heard and understood and improving the healthcare experience for all.

- HIPAA and GDPR compliant.
- Reduce reliance on language lines without slowing down your staff.
- Provide security and confidentiality for the most sensitive conversations.
- Easily export translations to patient files, spending less time charting and documenting.

Image and camera translation

The Pocketalk camera takes a photo and the large touchscreen displays translated text directly on top of the image. Pocketalk can provide an optional audio translation for the camera-translated text as well.

NIHD anticipates a savings of $50-70K in year one, and a $60-8k savings in years two and three following implementation.

We expect improved patient and workforce satisfaction and a decrease in delays in care compared with access times for phone and video interpreting.

Phone and video interpreting will still be available for certain critical conversations and American Sign Language patients.

Security Risk Analysis Tool

Application Version: 3.5

Risk Report

12-20-2024

DISCLAIMER
The Security Risk Assessment Tool at http://HealthIT.gov is provided for informational purposes only. Use of this tool is neither required by nor guarantees compliance with federal, state or local laws. Please note that the information presented may not be applicable or appropriate for all health care providers and professionals. The Security Risk Assessment Tool is not intended to be an exhaustive or definitive source on safeguarding health information from privacy and security risks. For more information about the HIPAA Privacy and Security Rules, please visit the HHS Office for Civil Rights (OCR) Health Information Privacy website at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

NOTE: The NIST Standards provided in this tool are for informational purposes only as they may reflect current best practices in information technology and are not required for compliance with the HIPAA Security Rule's requirements for risk assessment and risk management. This tool is not intended to serve as legal advice or as recommendations based on a provider or professional's specific circumstances. We encourage providers, and professionals to seek expert advice when evaluating the use of this tool. Updated: August 18, 2023

Section 1, SRA Basics		
Threats & Vulnerabilities		
Inadequate Asset Tracking		
	Information disclosure (ePHI, proprietary, intellectual, or confidential)	Critical
	Disruption of business processes, information system function, and/or prolonged adversarial presence within information systems	High
	Unauthorized use of assets or changes to data within information systems	High
	Unauthorized installation of software or applications	Critical
	Loss, theft, or disruption of assets	Medium
	Improper operation/configuration of assets	High

Section 2, Security Policies
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 2.

Section 3, Security & Workforce		
Threats & Vulnerabilities		
Failure to hold workforce members accountable for undesired actions		
	Insider carelessness causing disruption to computer systems	Medium
	Insider carelessness exposing ePHI to unauthorized persons or entities	Medium
	Lack of interest for protecting sensitive information	Medium

Section 4, Security & Data
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 4.

Section 5, Security and the Practice		
Threats & Vulnerabilities		
Undocumented location of equipment or assets		
	Unconfirmed identity of connected physical devices/ equipment	Medium
	Unauthorized devices gaining access to the network	Medium
	Unconfirmed identity of connected devices/equipment	Low
	Exploitation of unsecured computer systems	High

Section 6, Security and Business Associates		
Threats & Vulnerabilities		
Failure to update or review business associate contracts		
	Contract termination due to expiration	Medium
	Provide sensitive information and ePHI without authorization	Medium
	Disruption of access to data due to contract dispute or lapse	Medium
	Inability to determine the criticality of access granted to third parties	Low
	Fines, litigation, and financial penalties from non-compliance	Medium

Section 7, Contingency Planning
Threats & Vulnerabilities
No Threats and Vulnerabilities were selected or rated in Section 7.

Areas for Review

Section 1, Q3. How often do you review and update your SRA?	
Answer	Periodically but not in response to operational changes and/or security incidents.
Education	An accurate and thorough security risk assessment should be reviewed and updated periodically, or in response to operational changes, or security incidents.
References	HIPAA: §164.308(a)(1)(ii)(A) NIST CSF: ID.RA, ID.AM, GV.OC, PR.DS, PR.PS, RS.MI HPH CPG: 1 HICP: TV1 - Practice #10

Section 3, Q18. Do you have a sanction policy to enforce security procedures?	
Answer	I don't know.
Education	Consider looking into whether your practice has a sanction policy. It is required that your practice be able to apply appropriate sanctions against workforce members who fail to comply with your practice's security policies and procedures.
References	HIPAA: §164.308(a)(1)(ii)(C) NIST CSF: PR.PS HPH CPG: N/A HICP: N/A

Section 4, Q2. How do you manage and control personnel access to ePHI, systems, and facilities?	
Answer	Other.

Education	Make sure your access control measures are effective and up-to-date. Implement a procedure for updating your log upon changes in the workforce to include access levels based on role within your practice. To meet the standard, any updates based on changes in the workforce should be verified by the security officer. Implement single sign-on systems that automatically manage access to all software and tools once users have signed onto the network. Such systems allow the organization to centrally maintain and monitor access.
References	HIPAA: §164.308(a)(3)(i) NIST CSF: PR.AT, PR.PS, PR.AA, PR.IRHPH CPG: 3, 6 HICP: TV1 - Practice #2, 3

Section 4, Q7. How do you make sure that your workforce's designated access to ePHI is logical, consistent, and appropriate?

Answer	Workforce members have a default level of access for their role, but exceptions are commonly granted.
Education	Review role-based access to determine how specific you can designate access for users, based on their roles. Implement and document procedures to ensure minimum necessary access is in place across the board to the extent reasonable and appropriate. If access exceptions are commonly granted, they should be documented and policies should be in place outlining the procedure for access exceptions. Tailor access for each user based on the user's specific workplace requirements. Most users require access to common systems, such as e-mail and file servers. Implementing tailored access is usually called provisioning.
References	HIPAA: §164.308(a)(3)(i) NIST CSF: PR.AT, PR.PS, DE.CMHPH CPG: 3, 8, 9 HICP: TV1 - Practice # 3,4

Section 4, Q24. Do you protect ePHI from unauthorized modification or destruction?

Answer	Yes. We have some procedures to protect the integrity of our ePHI but these may not be totally comprehensive.
Education	Implement policies and procedures to protect ePHI from unauthorized modification or destruction, such as user activity monitoring or data validation tools. Organizational policies should address all user interactions with sensitive data and reinforce the consequences of lost or compromised data.
References	HIPAA: §164.312(c)(1) NIST CSF: PR.DS HPH CPG: N/A HICP: TV1 - Practice # 4

Section 5, Q8. Do you have an authorized user who approves access levels within information systems and locations that use ePHI?

Answer	Yes. We have written procedures in place describing determination of user access levels to information systems, locations, and ePHI, but not detailing all of the variables described above.
Education	Consider assigning an authorized user to approve access levels with information systems and locations that contain and use ePHI. If this is determined to not be reasonable and appropriate, document the reason why and implement a compensating control. Describe cybersecurity roles and responsibilities throughout the organization, including who is responsible for implementing security practices and setting and establishing policy.

References	HIPAA: §164.308(a)(3)(ii)(A) NIST CSF: ID.AM, PR.MA, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 2, 10

Section 5, Q22. Do you ensure access to ePHI is terminated when employment or other arrangements with the workforce member ends?

Answer	Yes. We have written procedures documenting termination or change of access to ePHI upon termination or change of employment, but not detailing all of the variables listed above.
Education	Changes to access to ePHI should be documented in the event of device recovery, deactivation of user access, and changes in access levels or privileges. Policy documentation should include details on how the process is completed. When an employee leaves your organization, ensure that procedures are executed to terminate the employee's access immediately. Prompt user termination prevents former employees from accessing patient data and other sensitive information after they have left the organization. This is very important for organizations that use cloud-based systems where access is based on credentials, rather than physical presence at a particular computer. Similarly, if an employee changes jobs within the organization, it is important to terminate access related to the employee's former position before granting access based on the requirements for the new position.
References	HIPAA: §164.308(a)(3)(ii)(C) NIST CSF: PR.AA, PR.IR, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 3

Section 6, Q14. Does the organization require business associates and third-party vendors to implement security requirements more stringent than required in the HIPAA Rules?

Answer	No, contracts with vendors or BAs outline requirements to follow the HIPAA Rules as applicable to BAs without additional cybersecurity protocols.
Education	The HIPAA Rules require a covered entity to obtain satisfactory assurances from its business associate that it will appropriately safeguard PHI it receives or creates on behalf of the covered entity. Organizations could consider protocols within their business practice to include enhanced cybersecurity and supply chain requirements beyond those required by the HIPAA Rules that third parties can follow and how compliance with the requirements may be verified. Rules and protocols for information sharing between the organization and suppliers are detailed and included in contracts between the two.
References	HIPAA: N/A NIST CSF: GV.SC HPH CPG: 13 HICP: N/A

Section 6, Q15. How do you track and verify business associate and third-party vendor compliance to security policies and where are these policies documented?

Answer	The organization verifies business associate and third-party vendor status each year but does not perform evaluations.
Education	The organization could require business associates and third-party vendors to disclose cybersecurity features, functions, and known vulnerabilities of their products and services for the life of the product or the term of service. Contracts could require evidence of performing acceptable security practices through self-attestation, conformance to known standards, certifications, or inspections. Business associates and third-party vendors could be monitored to ensure they are fulfilling their security obligations throughout the relationship lifecycle.

References HIPAA: N/A NIST CSF: GV.SC HPH CPG: 13 HICP: N/A

Security Risk Analysis Tool

Application Version: 3.5

Remediation Report

12-24-2024

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Section 1, SRA Basics

Q3. How often do you review and update your SRA?

Answer: Periodically but not in response to operational changes and/or security incidents.
Education: An accurate and thorough security risk assessment should be reviewed and updated periodically, or in response to operational changes, or security incidents.

References
HIPAA: §164.308(a)(1)(ii)(A) NIST CSF: ID.RA, ID.AM, GV.OC, PR.DS, PR.PS, RS.MI HPH CPG: 1 HICP: TV1 - Practice #10

Remediation Activities:
Owner: Bryan Harper **Due Date:** 04-30-2025 **Date Completed:**

Section 2, Security Policies

Section 3, Security & Workforce

Q18. Do you have a sanction policy to enforce security procedures?

Answer: I don't know.
Education: Consider looking into whether your practice has a sanction policy. It is required that your practice be able to apply appropriate sanctions against workforce members who fail to comply with your practice's security policies and procedures.

References
HIPAA: §164.308(a)(1)(ii)(C) NIST CSF: PR.PS HPH CPG: N/A HICP: N/A

Remediation Activities:
Owner: Patty Dickson **Due Date:** 04-30-2025 **Date Completed:**

Section 4, Security & Data

Q2. How do you manage and control personnel access to ePHI, systems, and facilities?

Answer: Other.
Education: Make sure your access control measures are effective and up-to-date. Implement a procedure for updating your log upon changes in the workforce to include access levels based on role within your practice. To meet the standard, any updates based on changes in the workforce should be verified by the security officer. Implement single sign-on systems that automatically manage access to all software and tools once users have signed onto the network. Such systems allow the organization to centrally maintain and monitor access.

References
HIPAA: §164.308(a)(3)(i) NIST CSF: PR.AT, PR.PS, PR.AA, PR.IRHPH CPG: 3, 6 HICP: TV1 - Practice #2, 3

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q7. How do you make sure that your workforce's designated access to ePHI is logical, consistent, and appropriate?

Answer: Workforce members have a default level of access for their role, but exceptions are commonly granted.
Education: Review role-based access to determine how specific you can designate access for users, based on their roles. Implement and document procedures to ensure minimum necessary access is in place across the board to the extent reasonable and appropriate. If access exceptions are commonly granted, they should be documented and policies should be in place outlining the procedure for access exceptions. Tailor access for each user based on the user's specific workplace requirements. Most users require access to common systems, such as e-mail and file servers. Implementing tailored access is usually called provisioning.

References
HIPAA: §164.308(a)(3)(i)
NIST CSF: PR.AT, PR.PS, DE.CMHPH CPG: 3, 8, 9 HICP: TV1 - Practice # 3,4

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q24. Do you protect ePHI from unauthorized modification or destruction?

Answer: Yes. We have some procedures to protect the integrity of our ePHI but these may not be totally comprehensive.
Education: Implement policies and procedures to protect ePHI from unauthorized modification or destruction, such as user activity monitoring or data validation tools. Organizational policies should address all user interactions with sensitive data and reinforce the consequences of lost or compromised data.

References
HIPAA: §164.312(c)(1) NIST CSF: PR.DS HPH CPG: N/A HICP: TV1 - Practice # 4

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Section 5, Security and the Practice

Q8. Do you have an authorized user who approves access levels within information systems and locations that use ePHI?

Answer: Yes. We have written procedures in place describing determination of user access levels to information systems, locations, and ePHI, but not detailing all of the variables described above.
Education: Consider assigning an authorized user to approve access levels with information systems and locations that contain and use ePHI. If this is determined to not be reasonable and appropriate, document the reason why and implement a compensating control. Describe cybersecurity roles and responsibilities throughout the organization, including who is responsible for implementing security practices and setting and establishing policy.

References
HIPAA: §164.308(a)(3)(ii)(A)
NIST CSF: ID.AM, PR.MA, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 2, 10

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q22. Do you ensure access to ePHI is terminated when employment or other arrangements with the workforce member ends?

Answer: Yes. We have written procedures documenting termination or change of access to ePHI upon termination or change of employment, but not detailing all of the variables listed above.
Education: Changes to access to ePHI should be documented in the event of device recovery, deactivation of user access, and changes in access levels or privileges. Policy documentation should include details on how the process is completed. When an employee leaves your organization, ensure that procedures are executed to terminate the employee's access immediately. Prompt user termination prevents former employees from accessing patient data and other sensitive information after they have left the organization. This is very important for organizations that use cloud-based systems where access is based on credentials, rather than physical presence at a particular computer. Similarly, if an employee changes jobs within the organization, it is important to terminate access related to the employee's former position before granting access based on the requirements for the new position.

References
HIPAA: §164.308(a)(3)(ii)(C)
NIST CSF: PR.AA, PR.IR, PR.PS HPH CPG: 6 HICP: TV1 - Practice # 3

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Section 6, Security and Business Associates

Q14. Does the organization require business associates and third-party vendors to implement security requirements more stringent than required in the HIPAA Rules?

Answer: No, contracts with vendors or BAs outline requirements to follow the HIPAA Rules as applicable to BAs without additional cybersecurity protocols.
Education: The HIPAA Rules require a covered entity to obtain satisfactory assurances from its business associate that it will appropriately safeguard PHI it receives or creates on behalf of the covered entity. Organizations could consider protocols within their business practice to include enhanced cybersecurity and supply chain requirements beyond those required by the HIPAA Rules that third parties can follow and how compliance with the requirements may be verified. Rules and protocols for information sharing between the organization and suppliers are detailed and included in contracts between the two.

References
HIPAA: N/A NIST CSF: GV.SC
HPH CPG: 13 HICP: N/A

Remediation Activities:

Owner: **Due Date:** **Date Completed:**

Q15. How do you track and verify business associate and third-party vendor compliance to security policies and where are these policies documented?

Answer: The organization verifies business associate and third-party vendor status each year but does not perform evaluations.
Education: The organization could require business associates and third-party vendors to disclose cybersecurity features, functions, and known vulnerabilities of their products and services for the life of the product or the term of service. Contracts could require evidence of performing acceptable security practices through self-attestation, conformance to known standards, certifications, or inspections. Business associates and third-party vendors could be monitored to ensure they are fulfilling their security obligations throughout the relationship lifecycle.

References
HIPAA: N/A NIST CSF: GV.SC
HPH CPG: 13 HICP: N/A

Remediation Activities:

Owner:	Due Date:	Date Completed:

Section 7, Contingency Planning

ComplyAssistant

In early January 2025, Northern Inyo Healthcare District Compliance Department began the process of implementing ComplyAssistant.

The software allows for direct documentation of compliance with each standard in major compliance regulations. It provides the regulation, standards assessments, and areas to store documentation (policies, penetration testing, audits, etc.) that support our assessments. Additionally, this allows us to determine risk based on standardized metrics and create plans for risk mitigation. The current compliance percentages listed are based on the average of the completed metrics and not currently a reflection of overall compliance with the regulations during the implementation process.

The following pages contain four reports that demonstrate our starting point of data entry for each regulation. They also contain a list of all standards required to comply fully with each set of regulations.

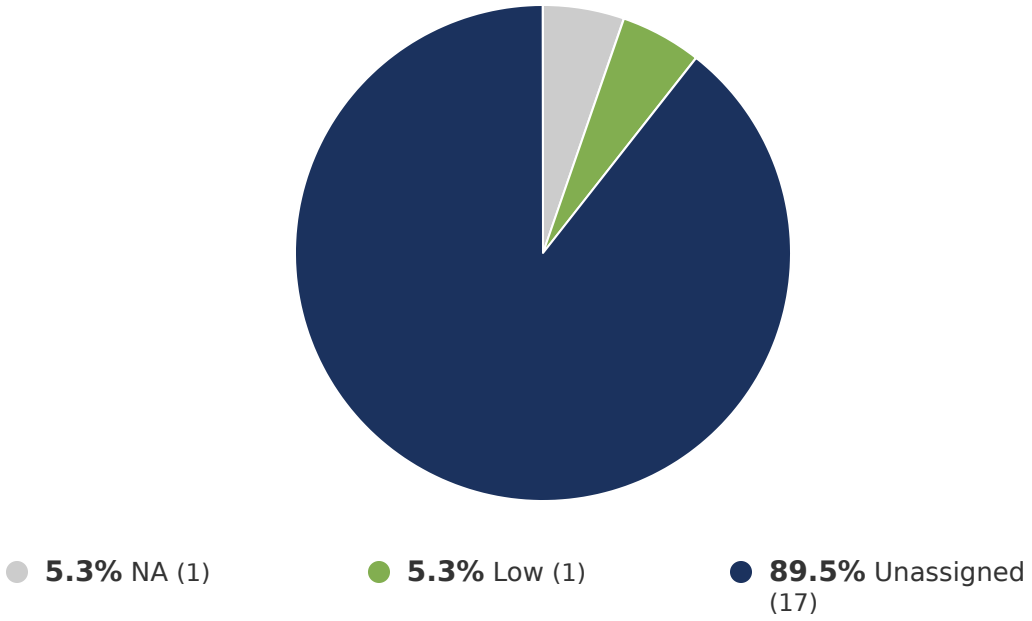
1. Federal Compliance Programs for Hospitals
2. Health Industry Cybersecurity Practices
3. HIPAA HITECH Security
4. HIPAA Privacy

HIPAA – Health Information Portability and Accountability Act of 1996
HITECH – Health Information Technology for Economic and Clinical Health Act of 2009

Regulation Management: Federal Compliance Program for Hospitals at Northern Inyo Healthcare District

Federal Compliance Program for Hospitals at Northern Inyo Healthcare District

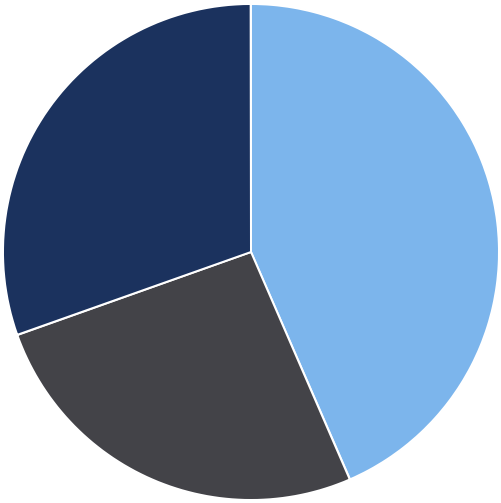
Average Risk: **Low (1)**



Risk Progress:

(2/19)

Average Compliance Level: 75%



- **52.6%** Established: Formal processes that are standardized across the organization have been established. The organization continuously evaluates risks and adapts processes in response to changes in its cybersecurity environment. (10)
- **31.6%** Developing: Formal processes are in development. The organization is evaluating risks and identifying appropriate protocols that are informed by the risk evaluation. (6)
- **36.8%** Unassigned (7)

Compliance Level Progress:

(12/19)

Federal Compliance Program for Hospitals - Rule Hierarchy: Scope

- **A. - Written Policies and Procedures**
  - **A.1. - Standards of Conduct**
  - **A.2. - Risk Areas**
  - **A.3 - Claim Development and Submission Process**
  - **A.4 - Test**
- **B -** Designation of a Compliance Officer
  - **B.1. - Designation of a Compliance Officer**

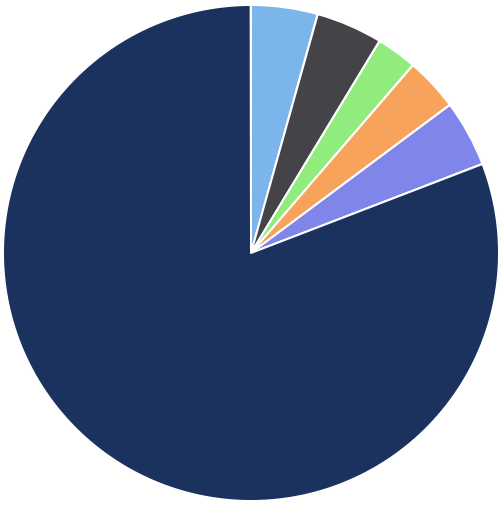
- **B.2 -** Designation of a Compliance Committee
- **C. - C. Conducting Effective Training and Education**
- **D. -** Developing Effective Lines of Communication
  - **D.1. -** Access to the Compliance Officer
  - **D.2. - Hotlines and Other forms of Communication**
- **E - Enforcing Standards Through Well Publicized Disciplinary Guidelines**
  - **E.1 -** Discipline Policy and Actions
  - **E.2. -** New Employee Policy
- **F. -** Auditing and Monitoring
- **G. -** Responding to Detected Offenses and Developing Corrective Action Initatives
  - **G.1. -** Violations and Investigations
  - **G.2. -** Reporting

Regulation Management: Health Industry Cybersecurity Practices 2023 (HICP) at Northern Inyo Healthcare District

Health Industry Cybersecurity Practices 2023 (HICP) at Northern Inyo Healthcare District

Average Risk: No Risk Assigned

Average Compliance Level: 88%



- **5.1%** Evaluated (5)
- **5.1%** Process in place (not documented) (5)
- **3.1%** Documented policies implemented (3)
- **4.1%** Documented procedures implemented (4)
- **5.1%** Implemented with Evidence (5)
- **94.9%** Unassigned (93)

Compliance Level Progress:

(5/98)

Health Industry Cybersecurity Practices 2023 (HICP) - Rule Hierarchy:

Scope

- **S -** Small
  - **1.S - Email Protection Systems**
    - **1.S.A - Email System Configuration**
    - **1.S.B - Education**

- **1.S.C -** Phishing Simulations

2.S - Endpoint Protection Systems

- **2.S.A - Basic Endpoint Protection Controls**

3.S - Access Management

- **3.S.A - Basic Access Management**

4.S - Data Protection and Loss Prevention

- **4.S.A -** Policies
- **4.S.B -** Procedures
- **4.S.C -** Education

5.S - Asset Management

- **5.S.A -** Inventory
- **5.S.B -** Procurement
- **5.S.C -** Decommissioning

6.S - Network Management

- **6.S.A -** Network Segmentation
- **6.S.B -** Physical Security and Guest Access
- **6.S.C -** Intrusion Prevention

7.S - Vulnerability Management

- **7.S.A -** Vulnerability Management

8.S - Incident Response

- **8.S.A -** Incident Response
- **8.S.B -** ISAC/ISAO Participation

9.S - Network Connected Medical Devices

- **9.S.A -** Medical Device Security

10.S - Cybersecurity Oversight and Governance

- **10.S.A -** Policies
- **10.S.B -** Cybersecurity Risk Assessment and Management
- **10.S.C -** Security Awareness and Training
- **10.S.D -** Cyber Insurance

M - Medium

1.M - Email Protection Systems

- **1.M.A -** Basic Email Protection Controls
- **1.M.B -** MFA for Remote Email Access

1.M.C - Email Encryption

1.M.D - Workforce Education

2.M - Endpoint Protection Systems

2.M.A - Basic Endpoint Protection Controls

3.M - Access Management

3.M.A - Identity

3.M.B - Provisioning, Transfers, and De-provisioning Procedures

3.M.C - Authentication

3.M.D - Multi-Factor Authentication for Remote Access

4.M - Data Protection and Loss Prevention

4.M.A - Classification of Data

4.M.B - Data Use Procedures

4.M.C - Data Security

4.M.D - Backup Strategies

4.M.E - Data Loss Prevention (DLP)

5.M - Asset Management

5.M.A - Inventory of Endpoints and Servers

5.M.B - Procurement

5.M.C - Secure Storage for Inactive Devices

5.M.D - Decommissioning Assets

6.M - Network Management

6.M.A - Network Profiles and Firewalls

6.M.B - Network Segmentation

6.M.C - Intrusion Prevention Systems

6.M.D - Web Proxy Protection

6.M.E - Physical Security of Network Devices

7.M - Vulnerability Management

7.M.A - Host/Server Based Scanning

7.M.B - Web Application Scanning

7.M.C - System Placement and Data Classification

7.M.D - Patch Management, Configuration Management, Change Management

8.M - Incident Response

8.M.A - Security Operations Center

8.M.B - Incident Response

8.M.C - Information Sharing and ISACs/ISAOs

9.M - Network Connected Medical Devices

9.M.A - Asset Management

9.M.B - Endpoint Protections

9.M.C - Identity and Access Management

9.M.D - Network Management

9.M.E - Vulnerability Management

9.M.F - Contacting the FDA

10.M - Cybersecurity Oversight and Governance

10.M.A - Policies

10.M.B - Cybersecurity Risk Assessment and Management

10.M.C - Security Awareness and Training

L - Large

1.L - Email Protection Systems

1.L.A - Advanced and Next Generation Tooling

1.L.B - Digital Signatures

1.L.C - Analytics Driven Education

2.L - Endpoint Protection Systems

2.L.A - Automate the Provisioning of Endpoints

2.L.B - Mobile Device Management

2.L.C - Host Based Intrusion Detection/Prevention Systems

2.L.D - Endpoint Detection Response

2.L.E - Application Whitelisting

2.L.F - Micro-segmentation/virtualization strategies

3.L - Access Management

3.L.A - Federated Identity Management

3.L.B - Authorization

3.L.C - Access Governance

3.L.D - Single-Sign On (SSO)

4.L - Data Protection and Loss Prevention

4.L.A - Advanced Data Loss Prevention

4.L.B - Mapping of Data Flows

5.L - Asset Management

- **5.L.A -** Automated Discovery and Maintenance
- **5.L.B -** Integration with Network Access Control

6.L - Network Management

- **6.L.A -** Additional Network Segmentation
- **6.L.B -** Command and Control Monitoring of Perimeter
- **6.L.C -** Anomalous Network Monitoring and Analytics
- **6.L.D -** Network Based Sandboxing/Malware Execution
- **6.L.E -** Network Access Control (NAC)

7.L - Vulnerability Management

- **7.L.A -** Penetration Testing
- **7.L.B -** Remediation Planning
- **7.L.C -** Attack Simulation

8.L - Incident Response

- **8.L.A -** Advanced Security Operations Center
- **8.L.B -** Advanced Information Sharing
- **8.L.C -** Incident Response Orchestration
- **8.L.D -** Baseline Network Traffic
- **8.L.E -** User Behavior Analytics
- **8.L.F -** Deception Technologies

9.L - Medical Device Security

- **9.L.A -** Security Operations and Incident Response
- **9.L.B -** Procurement and Security Evaluations

10.L - Cybersecurity Oversight and Governance

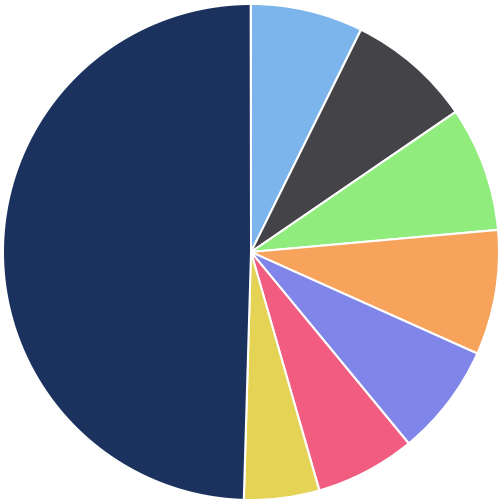
- **10.L.A - Cyber Insurance**

Regulation Management: HIPAA / HITECH Security at Northern Inyo Healthcare District

HIPAA / HITECH Security at Northern Inyo Healthcare District

Average Risk: No Risk Assigned

Average Compliance Level: 89%



- **12.7%** Operational controls and processes indicate a reasonable level of due diligence for this standard/implementation specification. (9)
- **14.1%** Policies are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (10)
- **14.1%** Procedures are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (10)
- **14.1%** Policy(ies) and procedure(s) are reviewed and updated (if necessary) on a reasonable periodic basis (e.g. annual, organization, technical and/or regulatory changes). (10)
- **12.7%** Periodic audits are performed (if appropriate) as specified in the policy(ies) and procedure(s). (9)
- **11.3%** This standard / implementation specification is included in the security management workforce training program. (8)
- **8.5%** Evidence of operational compliance is available to support the documented controls and processes; policies and procedures; and overall requirements of this standard/implementation specification. (6)
- **85.9%** Unassigned (61)

Compliance Level Progress:

(10/71)

HIPAA / HITECH Security - Rule Hierarchy: Scope

- **Part 164 - Security and Privacy**
  - **164 - Subpart C -** Security Standards for the Protection of Electronic Protected Health Information
    - **164.308 -** Administrative safeguards.
      - **164.308(a)(1)(i) -** Security Management Process
        - **164.308(a)(1)(ii)(A) - Risk Analysis (Required)**
        - **164.308(a)(1)(ii)(B) - Risk Management (Required)**
        - **164.308(a)(1)(ii)(C) - Sanction Policy (Required)**
        - **164.308(a)(1)(ii)(D) - Information System Activity Review (Required)**
      - **164.308(a)(2) - Assigned security responsibility.**
      - **164.308(a)(3)(i) - Workforce security**
        - **164.308(a)(3)(ii)(A) - Authorization and/or supervision(Addressable)**
        - **164.308(a)(3)(ii)(B) - Workforce clearance procedure (Addressable)**
        - **164.308(a)(3)(ii)(C) - Termination procedures (Addressable)**
      - **164.308(a)(4)(i) -** Information access management.
        - **164.308(a)(4)(ii)(A) -** Isolating health care clearinghouse functions (Required)
        - **164.308(a)(4)(ii)(B) - Access authorization (Addressable)**
        - **164.308(a)(4)(ii)(C) -** Access establishment and modification (Addressable)
      - **164.308(a)(5)(i) - Security awareness and training.**
        - **164.308(a)(5)(ii)(A) - Security reminders (Addressable)**
        - **164.308(a)(5)(ii)(B) - Protection from malicious software (Addressable)**
        - **164.308(a)(5)(ii)(C) - Log-in monitoring (Addressable)**
        - **164.308(a)(5)(ii)(D) - Password management (Addressable)**
      - **164.308(a)(6)(i) - Security incident procedures.**
        - **164.308(a)(6)(ii) - Response and Reporting (Required)**
      - **164.308(a)(7)(i) - Contingency plan.**
        - **164.308(a)(7)(ii)(A) - Data backup plan (Required)**
        - **164.308(a)(7)(ii)(B) -** Disaster recovery plan (Required)
        - **164.308(a)(7)(ii)(C) - Emergency mode operation plan (Required)**
        - **164.308(a)(7)(ii)(D) - Testing and revision procedures (Addressable)**

- **164.308(a)(7)(ii)(E) -** Applications and data criticality analysis (Addressable)
- **164.308(a)(8) - Evaluation.**
- **164.308(b)(1) - Business associate contracts and other arrangements.**
- **164.308(b)(3) - Written contract or other arrangement (Required)**
- **164.310 -** Physical safeguards.
- **164.310(a)(1) - Facility access controls.**
- **164.310(a)(2)(i) - Contingency operations (Addressable)**
- **164.310(a)(2)(ii) - Facility security plan (Addressable)**
- **164.310(a)(2)(iii) - Access control and validation procedures (Addressable)**
- **164.310(a)(2)(iv) - Maintenance records (Addressable)**
- **164.310(b) - Workstation use.**
- **164.310(c) - Workstation security.**
- **164.310(d)(1) - Device and media controls.**
- **164.310(d)(2)(i) -** Disposal (Required)
- **164.310(d)(2)(ii) - Media re-use (Required)**
- **164.310(d)(2)(iii) - Accountability (Addressable)**
- **164.310(d)(2)(iv) - Data backup and storage (Addressable)**
- **164.312 - Technical safeguards.**
- **164.312(a)(1) - Access control.**
- **164.312(a)(2)(i) - Unique user identification (Required)**
- **164.312(a)(2)(ii) - Emergency access procedure (Required)**
- **164.312(a)(2)(iii) - Automatic logoff (Addressable)**
- **164.312(a)(2)(iv) - Encryption and decryption (Addressable)**
- **164.312(b) - Audit controls.**
- **164.312(c)(1) - Integrity.**
- **164.312(c)(2) - Mechanism to authenticate electronic protected health information (Addressable)**
- **164.312(d) - Person or entity authentication.**
- **164.312(e)(1) - Transmission security.**
- **164.312(e)(2)(i) -** Integrity controls (Addressable)
- **164.312(e)(2)(ii) - Encryption (Addressable)**
- **164.314 -** Organizational requirements.
- **164.314(a)(1) -** Business associate contracts or other arrangements.

164.314(a)(2)(i) - Business associate contracts (Required)

164.314(a)(2)(ii) - Other arrangements (Required)

164.314(a)(2)(iii) - Business associate contracts with subcontractors. (Required)

164.314(b)(1) - Requirements for group health plans.

164.314(b)(2)(i)-(iv) - Requirements for group health plans. (Required)

164.316 - Policies and procedures and documentation requirements.

164.316(a) - Policies and Procedures.

164.316(b)(1) - Documentation.

164.316(b)(2)(i) - Time limit (Required)

164.316(b)(2)(ii) - Availability (Required)

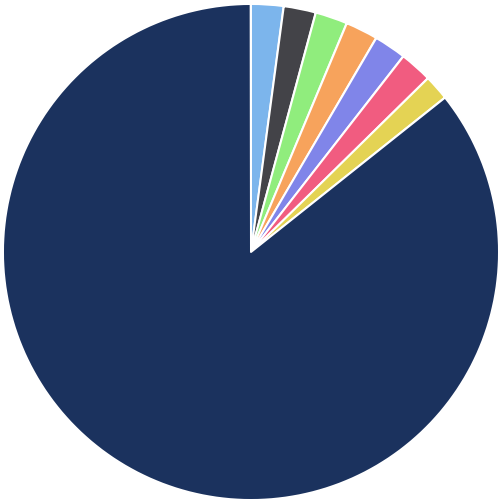
164.316(b)(2)(iii) - Updates (Required)

Regulation Management: HIPAA Privacy at Northern Inyo Healthcare District

HIPAA Privacy at Northern Inyo Healthcare District

Average Risk: No Risk Assigned

Average Compliance Level: 97%



- **2.4%** Operational controls and processes indicate a reasonable level of due diligence for this standard/implementation specification. (5)
- **2.4%** Policies are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (5)
- **2.4%** Procedures are in place to support the documented operational controls and processes, and overall requirements of this standard/implementation specification. (5)
- **2.4%** Policy(ies) and procedure(s) are reviewed and updated (if necessary) on a reasonable periodic basis (e.g. annual, organization, technical and/or regulatory changes). (5)
- **2.4%** Periodic audits are performed (if appropriate) as specified in the policy(ies) and procedure(s). (5)
- **2.4%** Evidence of operational compliance is available to support the documented controls and processes; policies and procedures; and overall requirements of this standard/implementation specification. (5)
- **1.9%** This standard / implementation specification is included in the security management workforce training program. (4)
- **97.6%** Unassigned (207)

Compliance Level Progress:

(5/212)

HIPAA Privacy - Rule Hierarchy:	Scope
164 - Security and Privacy	
164 - Subpart E - Standards for Privacy of Individually Identifiable Health Information	
§ 164.501 - Definitions	
§ 164.500 - Applicability	
§ 164.502 - Uses and Disclosures of Protected Health Information: General Rules.	
§ 164.502(a) - Permitted Uses and Disclosures	
§ 164.502(a)(1) - Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information	
§ 164.502(a)(2) - Required disclosures. A covered entity is required to disclose protected health information	
§ 164.502(b) - Minimum Necessary	
§ 164.502(c) - Uses and Disclosures Subject to Restrictions	
§ 164.502(d) - Uses and Disclosures of De-identified PHI	
§ 164.502(e)(1) - Disclosures to Business Associates	
§ 164.502(e)(2) - Implementation Specifications: Documentation	
§ 164.502(f) - Deceased Individuals	
§ 164.502(g)(1) - Personal Representatives	
§ 164.502(g)(2) - Implementation Specification: Adults and Emancipated Minors	
§ 164.502(g)(3) - Implementation Specification: Unemancipated Minors	
§ 164.502(g)(4) - Implementation Specification: Deceased Individuals	
§ 164.502(g)(5) - Implementation Specification: Abuse, Neglect and Endangerment	
§ 164.502(h) - Confidential Communications	
§ 164.502(i) - Uses and Disclosures Consistent with Notice	
§ 164.502(j) - Disclosures by Whistleblowers and Workforce Member Crime Victims	
§ 164.502(j)(1) - Implementation Specification: Disclosures by Whistleblowers	
§ 164.502(j)(2) - Implementation Specification: Disclosures by Workforce Members Who are Victims of a Crime	
§ 164.504 - Uses and Disclosures: Organizational Requirements	
§ 164.504(a) - Definitions	
§ 164.504(b)-(d) - Reserved	
§ 164.504(e)(1) - Business Associate Contracts	
§ 164.504(e)(2) - Implementation Specifications: Business Associate Contracts	

- **§ 164.504(e)(3) -** Implementation Specifications: Other Arrangements
- **§ 164.504(e)(4) -** Implementation Specifications: Other Requirements for Contracts and Other Arrangements
- **§ 164.504(e)(5) -** Implementation Specifications: Business Associate Contracts with Subcontractors
- **§ 164.504(f)(1) -** Requirements for Group Health Plans
- **§ 164.504(f)(2) -** Implementation Specifications: Plan Documents
- **§ 164.504(f)(3) -** Implementation Specifications: Uses and Disclosures by Group Health Plans
- **§ 164.504(g) -** Requirements for a Covered Entity with Multiple Covered Functions
- **§ 164.504(g)(1) -** Implementation Specification: Standards and Requirements
- **§ 164.504(g)(2) -** Implementation Specification: Uses and Disclosures
- **§ 164.506 -** Uses and Disclosures to Carry Out Treatment, Payment or Health Care Operations
- **§ 164.506(a) -** Permitted Uses and Disclosures
- **§ 164.506(b) -** Consent for Uses and Disclosures Permitted
- **§ 164.506(b)(1) -** Implementation Specification: Consent for Uses
- **§ 164.506(b)(2) -** Implementation Specification: Disclosures Permitted
- **§ 164.506(c) -** Implementation Specifications: Treatment, Payment or Health Care Operations
- **§ 164.508 -** Uses and Dislosures for which an Authorization is Required
- **§ 164.508(a) -** Authorizations for Uses and Disclosures
- **§ 164.508(a)(1) -** Implementation Specification: Authorization Required: General Rule
- **§ 164.508(a)(2) -** Implementation Specification: Authorization Required: Psychotherapy Notes
- **§ 164.508(a)(3) -** Implementation Specification: Authorization Required: Marketing
- **§ 164.508(a)(4) -** Implementation Specification: Authorization Required: Sale of Protected Health Information
- **§ 164.508(a)(5) -** Implementation Specification: Reproductive health care
  - **§ 164.508(a)(5)(A) -** Prohibition.
  - **§ 164.508(a)(5)(B) -** Rule of applicability.
  - **§ 164.508(a)(5)(C) -** Presumption.
  - **§ 164.508(a)(5)(D) -** Scope.
- **§ 164.508(b) -** Implementation Specifications: General Authorization Requirements
  - **§ 164.508(b)(1) -** Sub Implementation Specification: Valid Authorizations
  - **§ 164.508(b)(2) -** Sub Implementation Specification: Defective Authorizations
  - **§ 164.508(b)(3) -** Sub Implementation Specification: Compound Authorizations

- **§ 164.508(b)(4) -** Sub Implementation Specification: Prohibition on Conditioning of Authorizations
- **§ 164.508(b)(5) -** Sub Implementation Specification: Revocation of Authorizations
- **§ 164.508(b)(6) -** Sub Implementation Specification: Documentation
- **§ 164.508(c) -** Implementation Specifications: Core Elements and Requirements
- **§ 164.508(c)(1) -** Sub Implementation Specification: Core Elements
- **§ 164.510 -** Uses and Disclosures Requiring Opportunity to Agree or Object
- **§ 164.510(a) -** Use and Disclosure for Facility Directories
- **§ 164.510(a)(1) -** Implementation Specification: Permitted Uses and Disclosure
- **§ 164.510(a)(2) -** Implementation Specification: Opportunity to Object
- **§ 164.510(a)(3) -** Implementation Specification: Emergency Circumstances
- **§ 164.510(b) -** Uses and Disclosures for Involvement in Individual's Care and for Notification Purposes
- **§ 164.510(b)(1) -** Implementation Specification: Permitted Uses and Disclosures
- **§ 164.510(b)(2) -** Implementation Specification: Uses and Disclosures With the Individual Present
- **§ 164.510(b)(3) -** Implementation Specification: Limited Uses and Disclosures When the Individual is Not Present
- **§ 164.510(b)(4) -** Implementation Specification: Use and Disclosures for Disaster Relief Purposes
- **§ 164.510(b)(5) -** Implementation Specification: Uses and Disclosures When the Individual is Deceased
- **§ 164.509 -** Uses and Disclosures for Which an Attestation is Required.
- **§ 164.509(a) -** Attestations for certain uses and disclosures of protected health information to persons other than covered entities or business associates.
- **§ 164.509(b) -** Implementation specification: General requirements
- **§ 164.509(b)(1) -** Valid attestations.
- **§ 164.509(b)(2) -** Defective attestations.
- **§ 164.509(b)(3) -** Compound attestation.
- **§ 164.509(c) -** Implementation specifications: Content requirements and other obligations
- **§ 164.509(c)(1) -** Required elements.
- **§ 164.509(c)(2) -** Plain language requirement.
- **§ 164.509(d) -** Implementation Specification: Material misrepresentations
- **§ 164.512 -** Uses and Disclosures for which an Authorization Or Opportunity to Agree/Object is not Required

- **§ 164.512(a) -** Uses and Disclosures Required by Law
  - **§ 164.512(a)(1) -** Implementation Specification: Uses and Disclosures
- **§ 164.512(b) -** Uses and Disclosures for Public Health Activities
  - **§ 164.512(b)(1) -** Implementation Specification: Permitted Disclosures
- **§ 164.512(c) -** Disclosures about Victims of Abuse, Neglect or Domestic Violence
  - **§ 164.512(c)(1) -** Implementation Specification: Permitted Disclosures
  - **§ 164.512(c)(2) -** Implementation Specification: Informing the Individual
- **§ 164.512(d) -** Uses and Disclosures for Health Oversight Activities
  - **§ 164.512(d)(1) -** Implementation Specification: Permitted Disclosures
  - **§ 164.512(d)(2) -** Implementation Specification: Exception to Health Oversight Activities
- **§ 164.512(e) -** Disclosures for Judicial and Administrative Proceedings
  - **§ 164.512(e)(1) -** Implementation Specification: Permitted Disclosures
- **§ 164.512(f) -** Disclosures for Law Enforcement Purposes
  - **§ 164.512(f)(1) -** Implementation Specification: Permitted Disclosures: Pursuant to Process and as Otherwise Required by Law
  - **§ 164.512(f)(2) -** Implementation Specification: Permitted Disclosures: Limited Information for Identification and Location Purposes
  - **§ 164.512(f)(3) -** Implementation Specification: Permitted Disclosure: Victims of a Crime
  - **§ 164.512(f)(4) -** Implementation Specification: Permitted Disclosure: Decedents
  - **§ 164.512(f)(5) -** Implementation Specification: Permitted Disclosure: Crime on Premises
  - **§ 164.512(f)(6) -** Implementation Specification: Permitted Disclosure: Reporting Crime in Emergencies
- **§ 164.512(g) -** Uses and Disclosures about Decedents
- **§ 164.512(h) -** Uses and Disclosures for Organ, Eye and Tissue Donation Purposes
- **§ 164.512(i) -** Uses and Disclosures for Research Purposes
  - **§ 164.512(i)(1) -** Implementation Specification: Permitted Uses and Disclosures
  - **§ 164.512(i)(2) -** Implementation Specification: Documentation of Waiver Approval
- **§ 164.512(j) -** Uses and Disclosures to Avert a Serious Threat to Health or Safety
  - **§ 164.512(j)(1) -** Implementation Specification: Permitted Disclosures
- **§ 164.512(k) -** Uses and Disclosures for Specialized Government Functions
  - **§ 164.512(k)(1) -** Implementation Specification: Military and Veterans Activities
  - **§ 164.512(k)(2) -** Implementation Specification: National Security and Intelligence Activities
  - **§ 164.512(k)(3) -** Implementation Specification: Protective Services for the President and Others

- **§ 164.512(k)(4) -** Implementation Specification: Medical Suitability Determinations
- **§ 164.512(k)(5) -** Implementation Specification: Correctional Institutions and Other Law Enforcement Custodial Situations
- **§ 164.512(l) -** Disclosures for Workers' Compensation
- **§ 164.514 -** Other Requirements Relating to Uses and Disclosures of Protected Health Information
- **§ 164.514(a) -** De-Identification of Protected Health Information
- **§ 164.514(b) -** Implementation Specifications: Requirements for De-identification of Protected Health Information
  - **§ 164.514(b)(1) -** Sub Implementation Specification: Determining and Documenting Risk
  - **§ 164.514(b)(2) -** Sub Implementation Specification: Identifiers of the Individual
- **§ 164.514(c) -** Implementation Specifications: Re-Identification
- **§ 164.514(d)(1) -** Minimum Necessary Requirements
- **§ 164.514(d)(2) -** Implementation Specifications: Minimum Necessary Uses of Protected Health Information
- **§ 164.514(d)(3) -** Implementation Specification: MInimum Necessary Disclosures of Protected Health Information
- **§ 164.514(d)(4) -** Implementation Specifications: Minimum Necessary Requests for Protected Health Information
- **§ 164.514(d)(5) -** Implementation Specification: Other Content Requirement
- **§ 164.514(e)(1) -** Limited Data Set
- **§ 164.514(e)(2) -** Implementation Specification: Limited Data Set
- **§ 164.514(e)(3) -** Implementation Specification: Permitted purposes for uses and disclosures
- **§ 164.514(e)(4) -** Implementation Specifications: Data Use Agreement
- **§ 164.514(f)(1) -** Uses and Disclosures for Fundraising
- **§ 164.514(f)(2) -** Implementation Specifications: Fundraising Requirements
- **§ 164.514(g) -** Uses and Disclosures for Underwriting and Related Purposes
- **§ 164.514(h)(1) -** Verification Requirements
- **§ 164.514(h)(2) -** Implementation Specifications: Verification
- **§ 164.520 -** Notice of Privacy Practices for Protected Health Information
- **§ 164.520(a) -** Notice of Privacy Practices
- **§ 164.520(a)(1) -** Implementation Specification: Right to Notice
- **§ 164.520(a)(2) -** Implementation Specification: Notice requirements for covered entities creating or maintaining records subject to 42 U.S.C. 290dd-2.
- **§ 164.520(b) -** Implementation Specifications: Content of Notice
  - **§ 164.520(b)(1) -** Sub Implementation Specification: Required Elements

- **§ 164.520(c) -** Implementation Specifications: Provision of Notice
  - **§ 164.520(c)(1) -** Sub Implementation Specification: Specific Requirements for Health Plans
  - **§ 164.520(c)(2) -** Sub Implementation Specification: Specific Requirements for Certain Covered Health Care Providers
  - **§ 164.520(c)(3) -** Sub Implementation Specification: Specific Requirements for Electronic Notice
- **§ 164.520(d) -** Implementation Specifications: Joint Notice by Separate Covered Entities
  - **§ 164.520(d)(1) -** Sub Implementation Specification: Terms of the Joint Notice
- **§ 164.520(e) -** Implementation Specifications: Documentation

§ 164.522 - Right to Request Privacy Protection for Protected Health Information

- **§ 164.522(a)(1) -** Right of an Individual to Request Restriction of Uses and Disclosures
- **§ 164.522(a)(2) -** Implementation Specifications: Terminating a Restriction
- **§ 164.522(a)(3) -** Implementation Specification: Documentation
- **§ 164.522(b)(1) -** Confidential Communications Requirements
- **§ 164.522(b)(2) -** Implementation Specifications: Conditions on Providing Confidential Communications

§ 164.524 - Access of Individuals to Protected Health Information

- **§ 164.524(a) -** Access to Protected Health Information
- **§ 164.524(a)(1) -** Implementation Specification: Right of Access
- **§ 164.524(a)(2) -** Implementation Specification: Unreviewable Grounds for Denial
- **§ 164.524(a)(3) -** Implementation Specification: Reviewable Grounds for Denial
- **§ 164.524(a)(4) -** Implementation Specification: Review of a Denial of Access
- **§ 164.524(b) -** Implementation Specifications: Requests for Access and Timely Action
  - **§ 164.524(b)(2) -** Sub Implementation Specification: Timely Action by the Covered Entity
- **§ 164.524(c) -** Implementation Specifications: Provision of Access.
  - **§ 164.524(c)(2) -** Sub Implementation Specification: Form of Access Requested
  - **§ 164.524(c)(4) -** Sub Implementation Specification: Fees
- **§ 164.524(d) -** Implementation Specifications: Denial of Access
  - **§ 164.524(d)(2) -** Sub Implementation Specification: Denial
  - **§ 164.524(d)(4) -** Sub Implementation Specification: Review of Denial Requested
- **§ 164.524(e) -** Implementation Specification: Documentation

§ 164.526 - Amendment of Protected Health Information

- **§ 164.526(a) -** Amendment of Protected Health Information

- **§ 164.526(a)(1) -** Implementation Specification: Right to Amend
- **§ 164.526(a)(2) -** Implementation Specification: Denial of Amendment
- **§ 164.526(b) -** Implementation Specifications: Requests for Amendment and Timely Action
- **§ 164.526(c) -** Implementation Specifications: Accepting the Amendment
- **§ 164.526(d) -** Implementation Specifications: Denying the Amendment
  - **§ 164.526(d)(1) -** Sub Implementation Specification: Denial
- **§ 164.526(e) -** Implementation Specification: Actions on Notices of Amendment
- **§ 164.526(f) -** Implementation Specification: Documentation

§ 164.528 - Accounting of Disclosures of Protected Health Information

- **§ 164.528(a) -** Right to an Accounting of Disclosures
  - **§ 164.528(a)(1) -** Implementation Specification: Conditions on Right to an Accounting of Disclosures
- **§ 164.528(b) -** Implementation Specifications: Content of the Accounting
- **§ 164.528(c) -** Implementation Specifications: Provision of the Accounting
- **§ 164.528(d) -** Implementation Specification: Documentation

§ 164.530 - Administrative Requirements

- **§ 164.530(a)(1) -** Personnel Designations
  - **§ 164.530(a)(2) -** Implementation Specification: Personnel Designations
- **§ 164.530(b)(1) -** Training
  - **§ 164.530(b)(2) -** Implementation Specifications: Training
- **§ 164.530(c)(1) -** Safeguards
  - **§ 164.530(c)(2) -** Implementation Specification: Safeguards
- **§ 164.530(d)(1) -** Complaints to the Covered Entity
  - **§ 164.530(d)(2) -** Implementation Specification: Documentation of Complaints
- **§ 164.530(e)(1) -** Sanctions
  - **§ 164.530(e)(2) -** Implementation Specification: Documentation
- **§ 164.530(f) -** Mitigation
- **§ 164.530(g) -** Refraining from Intimidating or Retaliatory Acts
- **§ 164.530(h) -** Waiver of Rights
- **§ 164.530(i)(1) -** Policies and Procedures
- **§ 164.530(i)(2) -** Changes to Policies and Procedures
  - **§ 164.530(i)(3) -** Implementation Specification: Changes in Law

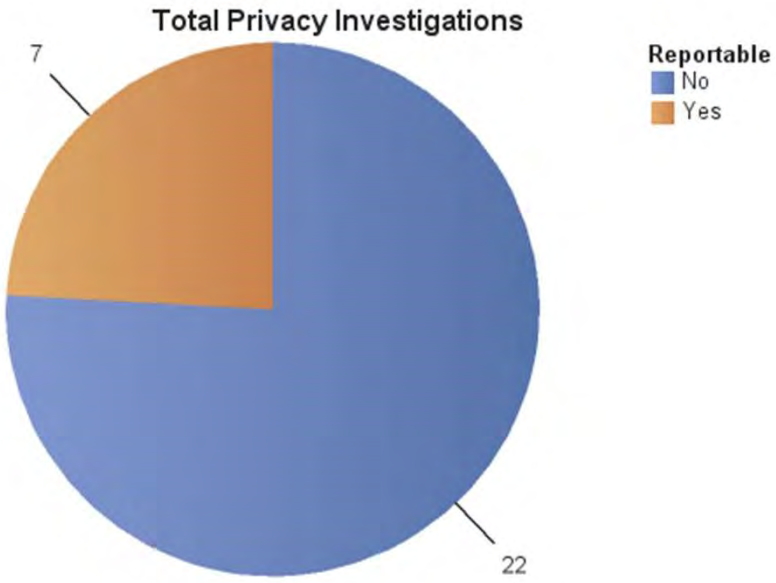
- **§ 164.530(i)(4) -** Implementation Specification: Changes to Privacy Practices Stated in the Notice
- **§ 164.530(i)(5) -** Implementation Specification: Changes to other Policies and Procedures
- **§ 164.530(j)(1) -** Documentation
- **§ 164.530(j)(2) -** Implementation Specification: Retention Period
- **§ 164.530(k) -** Group Health Plans
- **§ 164.532 -** Transition Provisions
- **§ 164.534 -** Compliance Dates for Initial Implementation of the Privacy Standards

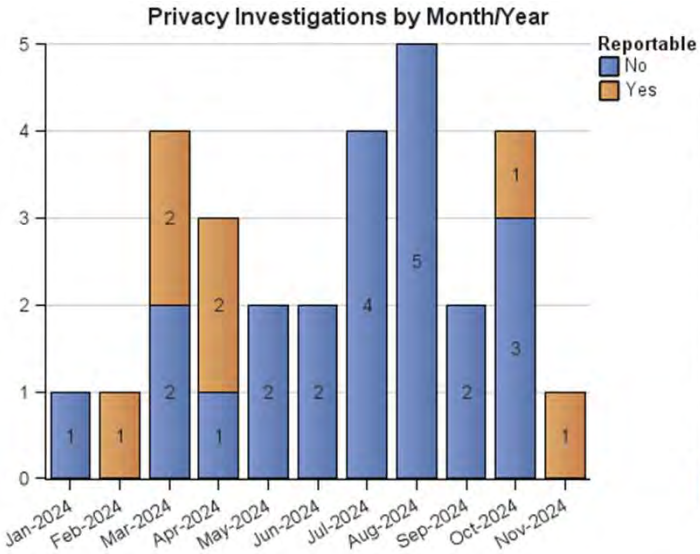
No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due CY2025 Q1
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Due CY2025 Q2
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		Due CY2025 Q2
4.	District Policy and Procedure management		Due CY2025 Q2
5.	Review, distribute, and assist leaders with new regulatory updates and guidance	Implemented YouCompli software December 2025	Ongoing
Written Compliance Guidance			
6.	Audit of required Compliance related policies.		Policies for Compliance are in the review process as of Jan 2025
7.	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)		Overdue – was due in CY2024 Q3
8.	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			
9.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.	Compliance and Business Ethics Committee has not met since 2023. Information reported to Executives and Board as needed.	Ongoing in conjunction with HR. Current to date.
10.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		External companies providing coding and claims processing services. New regulatory changes discussed at Billing and Coding Compliance Committee (BCCC

11.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		Ongoing. Well-developed process and procedure for Role-based access.
12.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards.		Training completed at orientation, via policy/procedure review, Learning Management System, email, in-person, departmental meetings, and "Just-in-time training"
Compliance Communication			
13.	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, Executives, and Board of Directors.
14.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Submitted to Executives and Board of Directors in quarterly and Annual Board reports	Current through January 2025
15.	Document test and review of Compliance Hotline.		Completed January 2025
16.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Completed January 2025
Compliance Enforcement and Sanction Screening			
17.	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.	Due CY2025 Q2 Annual re-validation for vendor exclusions completed for 2024.
18.	Develop an audit and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		Due 2025
19.	Audits (Fraud, Waste, and Abuse)		
	a. Arrangements with physician (database)	Physician Contracts are now in a review cycle. All	Due CY2025 Q2

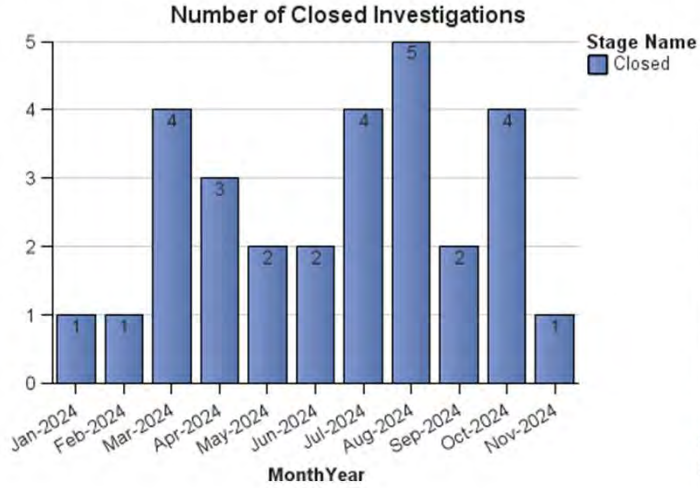
		templates created/reviewed in conjunction with legal counsel (BBK).	
	b. Financial Audits	FY 2025	External audit in progress as of 12/2024
	c. Payment patterns		Due Q2 2025
	d. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office. Presented to Board and Compliance monthly.
	e. Non-Physician vendor contract/payment audit		Due CY2025 Q3
	f. DME (Durable Medical Equipment)	HHS OIG target	Chargemaster audit due 2025 Q2
	g. Lab services	MAC target	Deferred
	h. Imaging services (high cost/high usage)	MAC target	Deferred
	i. Rehab services	HHS OIG workplan	Deferred
	j. Language Access Audits	OIG target	Due Q3 2024 – in progress
	k. Cash Box Audits		Random ongoing audits
	l. Imaging Report Compliance Audit	Waiting for corrective action plan	Completed January 2025
	m. Compliance/Accounting – Vendor Conflict of Interest Verification Audit		Due CY2025 Q2
20.	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 2025
	b. Periodic update to Security Risk Assessment		As needed
	c. Monthly employee access audits		Daily, ongoing
	d. HIPAA Walkthrough Audits	Implementing ComplyAssistant Software	In progress Jan 2025
	e. BAA Vendor Assessments	Implementing ComplyAssistant Software	In progress Jan 2025
	f. HIPAA Privacy and Security Audit Compliance and Documentation	Implementing ComplyAssistant Software	In progress Jan 2025
21.	Audit required signage		Due 2025
22.	Audit HIMS (Health Information Management) scanned document accuracy		Due 2025

23.	Develop metrics to assess the effectiveness and progress of the Compliance Program	See new guidance from DOJ Evaluation of Corporate Compliance Program (ECCP published 2024)	Due 2025
24.	Review CMS Conditions of Participation		Ongoing
25.	CMS Hospital Price Transparency Audit	MRF, SSPE, PE	Weekly
26.	EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 12/31/2024
Response to Detected Problems and Corrective Action			
27.	Verify that all identified issues related to potential fraud, waste, and abuse are promptly investigated and documented		Current through December 2025
28.	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.
29.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Annual Board Report for 2024 attached.
	a. Provide trend feedback to leadership to allow for data-driven decision-making		Quarterly
	I. Overall UOR process		January 2025
	II. Workplace Violence		January 2025
	III. Falls		January 2025
30.	Patient complaints		Documented and tracked in Unusual Occurrence Reporting system
31.	Breach Investigations	HIPAA, HITECH, CMIA	Ongoing. All state and federal reporting requirements were met in 2024.

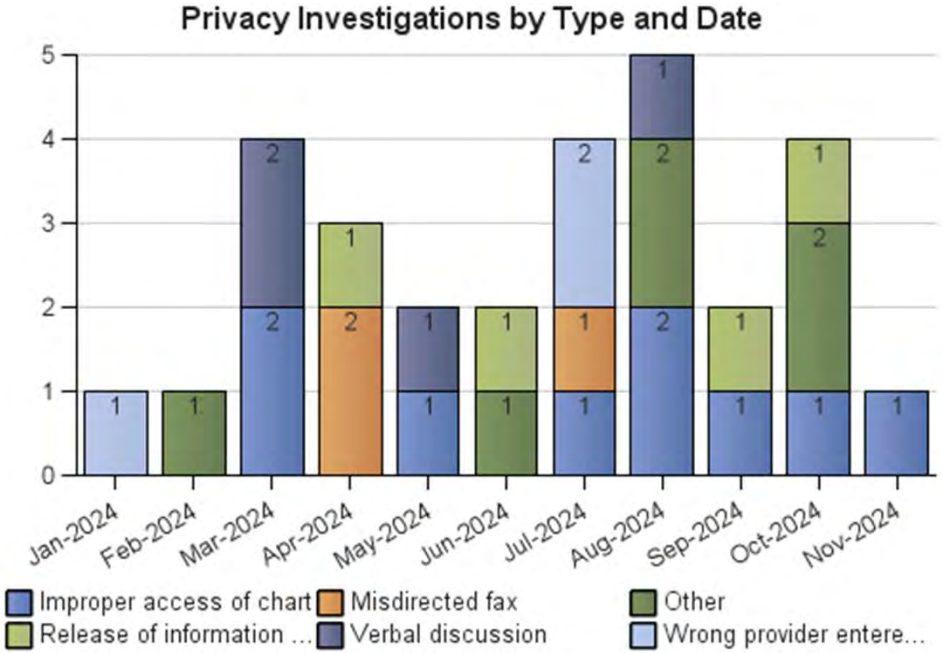




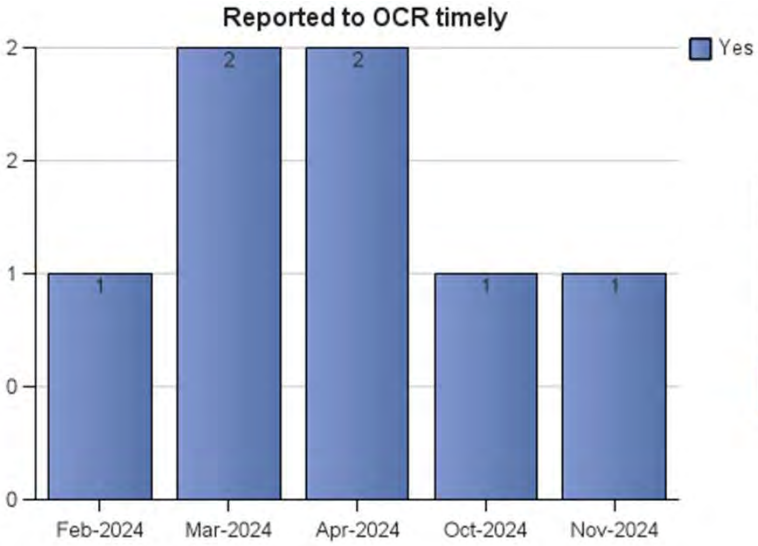
	No	Yes	Total
Jan-2024	1		1
Feb-2024		1	1
Mar-2024	2	2	4
Apr-2024	1	2	3
May-2024	2		2
Jun-2024	2		2
Jul-2024	4		4
Aug-2024	5		5
Sep-2024	2		2
Oct-2024	3	1	4
Nov-2024		1	1
Total	**22**	**7**	**29**



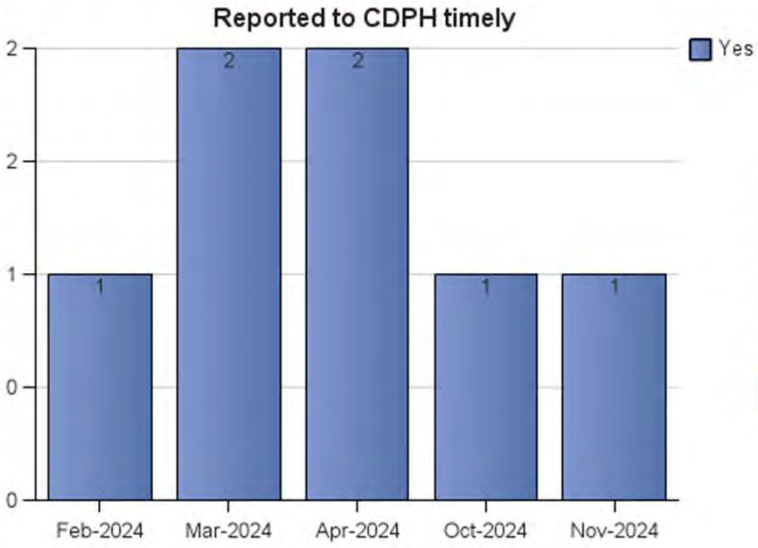
	Closed	Total
Sep-2024	2	2
Oct-2024	4	4
Nov-2024	1	1
May-2024	2	2
Mar-2024	4	4
Jun-2024	2	2
Jul-2024	4	4
Jan-2024	1	1
Feb-2024	1	1
Aug-2024	5	5
Apr-2024	3	3
Total	**29**	**29**



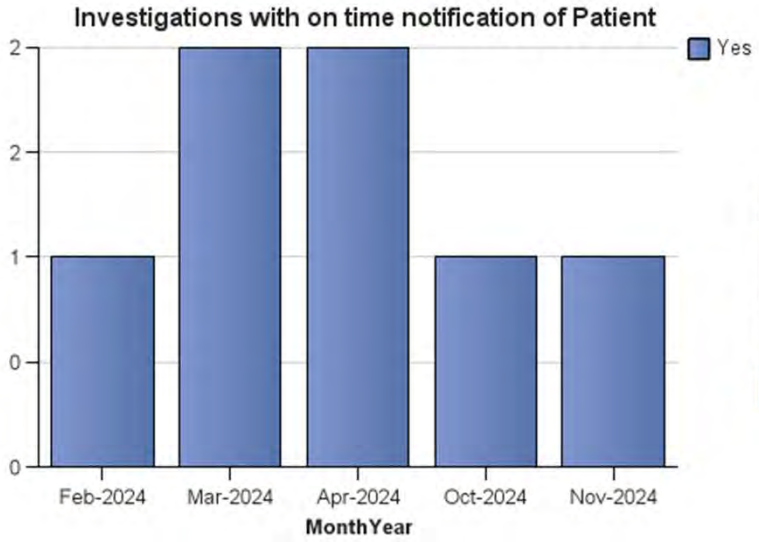
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Total
Improper access of chart			2		1		1	2	1	1	1	9
Misdirected fax				2			1					3
Other		1				1		2		2		6
Release of information concern				1		1			1	1		4
Verbal discussion			2		1			1				4
Wrong provider entered/selected	1						2					3
Total	**1**	**1**	**4**	**3**	**2**	**2**	**4**	**5**	**2**	**4**	**1**	**29**



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Oct-2024	1	1
Nov-2024	1	1
Total	7	7



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Oct-2024	1	1
Nov-2024	1	1
Total	7	7



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Oct-2024	1	1
Nov-2024	1	1
Total	7	7

DEPARTMENT OF HEALTH & HUMAN SERVICES
Voice - (800) 368-1019
TDD - (800) 537-7697
(FAX) - (415) 437-8329
http://www.hhs.gov/ocr/

OFFICE OF THE SECRETARY
Office for Civil Rights, Pacific Region
90 7th Street, Suite 4-100
San Francisco, California 94103

December 30, 2024

Patty Dickson
Compliance and Privacy Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514
Sent via email: **patty.dickson@nih.org**

Leeann Habte
Partner
Best, Best, & Krieger LLP
Sent via email: **leeann.habte@bbklaw.com**

OCR Reference Number: 24-558331

Dear Ms. Dickson and Ms. Habte:

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) received a breach notification report on January 3, 2024, from Northern Inyo Healthcare District, pursuant to the HITECH Breach Notification Rules, 45 C.F.R. §§ 164.408 and 164.414, respectively. The Breach Report indicated to OCR that Northern Inyo Healthcare District (the Covered Entity), may not be in compliance with the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health information and/or the Notification in the Case of Breach of Unsecured Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, D, and E, the Privacy, Security, and Breach Notification Rules).

Specifically, the breach notification report indicated that Keenan & Associates (Keenan) is a business associate of Northern Inyo Healthcare District who adjudicates claims for Northern Inyo Healthcare District's self-pay insurance plan. On Sunday, August 27, Keenan discovered certain disruptions occurring on some Keenan network servers. Keenan immediately began investigating the issue and discovered suspicious activity on a limited number of servers. As a precaution, Keenan disconnected the entire network to contain the incident. Keenan has engaged leading third-party cybersecurity and forensic experts to assist in the investigation and remediation, and law enforcement has been notified. Within hours of identifying the incident, Keenan had contained it.

Keenan's investigation determined that an unauthorized party gained access to certain Keenan internal systems at various times between approximately August 21, 2023, and August 27, 2023. Findings from the investigation indicate that the unauthorized party obtained some data from certain Keenan systems during this period. Keenan was able to retrieve the data involved from the unauthorized party and has taken steps to delete the data. At this time, Keenan has no reason to believe this data was further copied or retained by the unauthorized party.

Keenan conducted a thorough review of the data involved in order to identify individuals whose personal information was included. On or around December 11, 2023, Keenan completed its review of the data and began notifying covered entity clients of any client-related personal information included in these files. The review determined that the files contained personal health information along with other personal information for a subset of its clients.

Keenan is not aware of any fraud or misuse of any personal information as a result of this incident. Keenan does not believe personal information was targeted by the unauthorized party for identify theft purposes, but rather, such information happened to be included in documents taken by the unauthorized party as part of the ransomware incident to extort the company.

To help prevent a similar type of incident from occurring in the future, Keenan implemented additional security protocols designed to enhance the security of its network, internal systems, and applications. Keenan also continues to evaluate additional steps that may be taken to further increase its defenses going forward.

OCR investigated this Breach Report under the following potential violations: 45 C.F.R. §§ 164.308(a)(1)(ii)(A) - Risk Analysis, 164.308(a)(1)(ii)(B) - Risk Management, 164.308(a)(1)(ii)(D) – Information System Activity Review, 164.308(a)(5)(i) – Security Awareness and Training, 45 C.F.R. 164.308(a)(5)(ii)(B) – Protection from Malicious Software, 164.308(a)(5)(ii)(B), 164.308(a)(6)(i) – Security Incident Procedures, 164.308(a)(6)(ii) - Response and Reporting, 164.308(a)(7)(ii)(A) – Data Backup Plan, 164.312(a)(1) – Access Control, 164.312(a)(2)(iv) – Encryption and Decryption, 164.312(b) – Audit Controls, 164.312(c)(1) – Integrity Standard, 164.314(a)(1) – Business associate contracts or other arrangements, 164.404(a) - Notice to Individuals, 164.406(a) - Notice to the Media, 164.502(a) - Uses and disclosures, 164.530(c) – Safeguards, and 164.530(f) - Mitigation.

OCR enforces the Privacy, Security, and Breach Notification Rules and also enforces Federal civil rights laws that prohibit discrimination in the delivery of health and human services because of race, color, national origin, disability, age, and, under certain circumstances, sex, and religion and the exercise of conscience.

Summary of Investigation

On March 18, 2024, OCR notified the Covered Entity, of the investigation. On May 1, 2024, OCR received the Covered Entity's responses to the investigatory questions. A summary of the Covered Entity's responses, applicable to this investigation, is provided below:

The Covered Entity is a local governmental entity that operates a self-insured health plan for medical insurance provided as an employee benefit to its employees. The Covered Entity employes 433 individuals and is covered under HIPAA as a health plan.

The Covered Entity operates Northern Inyo Hospital, a general acute care hospital, where a majority of its employees work. This hospital is designated as a Critical Access Hospital by the Center for Medicare and Medicaid Services. As a small Critical Access Hospital, Northern Inyo Hospital is

only licensed for 25 beds and has an average daily census of 4.8. It serves Bishop, California and its rural surrounding areas.

Keenan adjudicates health care claims data as a third-party administrator for the Covered Entity's employee health insurance plan. Keenan receives protected health information (PHI) from Covered Entity employees in their health care claims. Therefore, Keenan is a business associate of the Covered Entity as defined at 45 C.F.R. § 160.103.

On December 11, 2023, Keenan, via its legal counsel, informed the Covered Entity of a cybersecurity ransomware incident that occurred on Keenan's databases between August 21, 2023, and August 27, 2023. The incident was reported pursuant to the Covered Entity's Business Associate Agreement (BAA) with Keenan.

On August 27, 2023, Keenan discovered disruption on some of its network servers. Once it began investigating the issue, Keenan discovered suspicious activity on a limited number of servers and disconnected its network to contain the suspicious activity. Keenan then reportedly engaged third-party cybersecurity experts to assist in investigating and responding to the incident. Additionally, Keenan notified law enforcement of the incident.

Upon investigation, Keenan determined that an unauthorized party gained access to certain Keenan internal systems at various times between August 21, 2023, and August 27, 2023. During this period, the unauthorized party stole files from a limited number of Keenan file shares. The unauthorized party also deployed ransomware, which encrypted data on some Keenan systems.

On January 18, 2024, Covered Entity's counsel requested additional information from Keenan regarding the breach incident. The letter requested specific information about Keenan's reports to law enforcement, a copy of the four-factor risk assessment Keenan conducted, a copy or summary of the forensic report Keenan conducted, and an explanation of what actions Keenan has taken to mitigate harm and to remediate any security vulnerabilities identified.

On February 16, 2024, Keenan responded to the Covered Entity's request stating it notified the FBI after discovering the incident and that it was continuing to support the FBI's investigation. Keenan also noted it first reported the incident to the FBI on or about August 30, 2023. Keenan did not provide a copy of its report or notification to the FBI of the incident. However, Keenan did provide the Covered Entity with its four-factor risk assessment as well as its confidential forensic report from its third-party forensics' vendor. Keenan also provided the Covered Entity what it believed to be the root cause of the incident as well as the steps taken to remediate the vulnerabilities identified. Among those listed were replaced on-premises network server where the vulnerability was exploited and purchased and implemented additional security tools.

In response to the incident and Keenan's responses, the Covered Entity completed the following corrective and/or mitigating actions:

1. The Covered Entity notified affected individuals, explaining the security incident, what information was involved, steps taken to mitigate, as well as steps individuals may consider taking in response to this incident. Specifically, the Covered Entity informed the

affected individuals of a complimentary 24-month membership in Experian IdentityWorksSM Credit 3B offered by Keenan.

2. Requested a Corrective Action Plan from Keenan associated with its lack of timely notification of the suspected breach and security incident that resulted in unauthorized access to PHI.

3. Provided OCR with copies of correspondence between Keenan and the Covered Entity as it relates to the corrective actions taken by Keenan in response to the breach incident.

Technical Assistance

OCR is providing technical assistance regarding the HIPAA/HITECH Privacy and Security Rules:

Covered Entities or Business Associates, such as Northern Inyo Healthcare District, are required to complete regular risk analyses and corresponding risk management. Specifically, the Security Management Process standard, at 45 C.F.R. § 164.308(a)(1)(i) in the Administrative Safeguards section of the Security Rule, requires organizations to implement policies and procedures to prevent, detect, contain, and correct security violations. The Security Management Process standard has four required implementation specifications. Two of the implementation specifications are Risk Analysis and Risk Management. The required implementation specification for Risk Analysis, at 45 C.F.R. § 164.308(a)(1)(ii)(A), requires organizations to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held by the organization, including all ePHI created, received, maintained, or transmitted. The required implementation specification for Risk Management, at 45 C.F.R. § 164.308(a)(1)(ii)(B), requires organizations to implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level. Risk Management is an integral part of the security management process; including identification of key staff responsible for completing mitigation and projected completion dates. Both Risk Analysis and Risk Management are standard information security processes and are critical to an organization's Security Rule compliance efforts.

You are encouraged to visit OCR's website, where you will find educational materials to help you learn more about the HIPAA/HITECH Privacy, Security, and Breach Notification Rules:

https://www.hhs.gov/hipaa/for-professionals/index.html;
https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html; and
http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html.

OCR reviewed the documentation provided by the Covered Entity, including its policies and procedures as they relate to the HIPAA Privacy, Security, and Breach Notification Rules.

Based on the foregoing, OCR is closing this case without further action, effective the date of this letter. OCR's determination as stated in this letter applies only to the allegations in this complaint that were reviewed by OCR.

If you have any questions regarding this matter, please contact Steven Soto, the OCR investigator assigned to this case, at (213) 310-4684 (Voice) or by e-mail at Steven.Soto@hhs.gov.

Sincerely,

Michael Leoz
Regional Manager

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mailstop: C5-15-12
Baltimore, Maryland 21244-1850

Center for Medicare

November 8, 2024

Stephen DelRossi
CEO
Northern Inyo Hospital
150 Pioneer Lane
Bishop, CA 93514-2599

Reference Number: 45082024

RE: Hospital Price Transparency – Closure Notice

Dear Stephen DelRossi,

The Centers for Medicare & Medicaid Services (CMS) completed a review of Northern Inyo Hospital's website http://www.nih.org on November 8, 2024 and determined that the deficiencies identified in the Notice of Violation and Request for Corrective Action Plan (CAP) issued August 7, 2024 have been rectified.

Please consider this a **notification that this ends our compliance review referenced in the August 7, 2024 Notice of Violation and Request for Corrective Action Plan (CAP).**

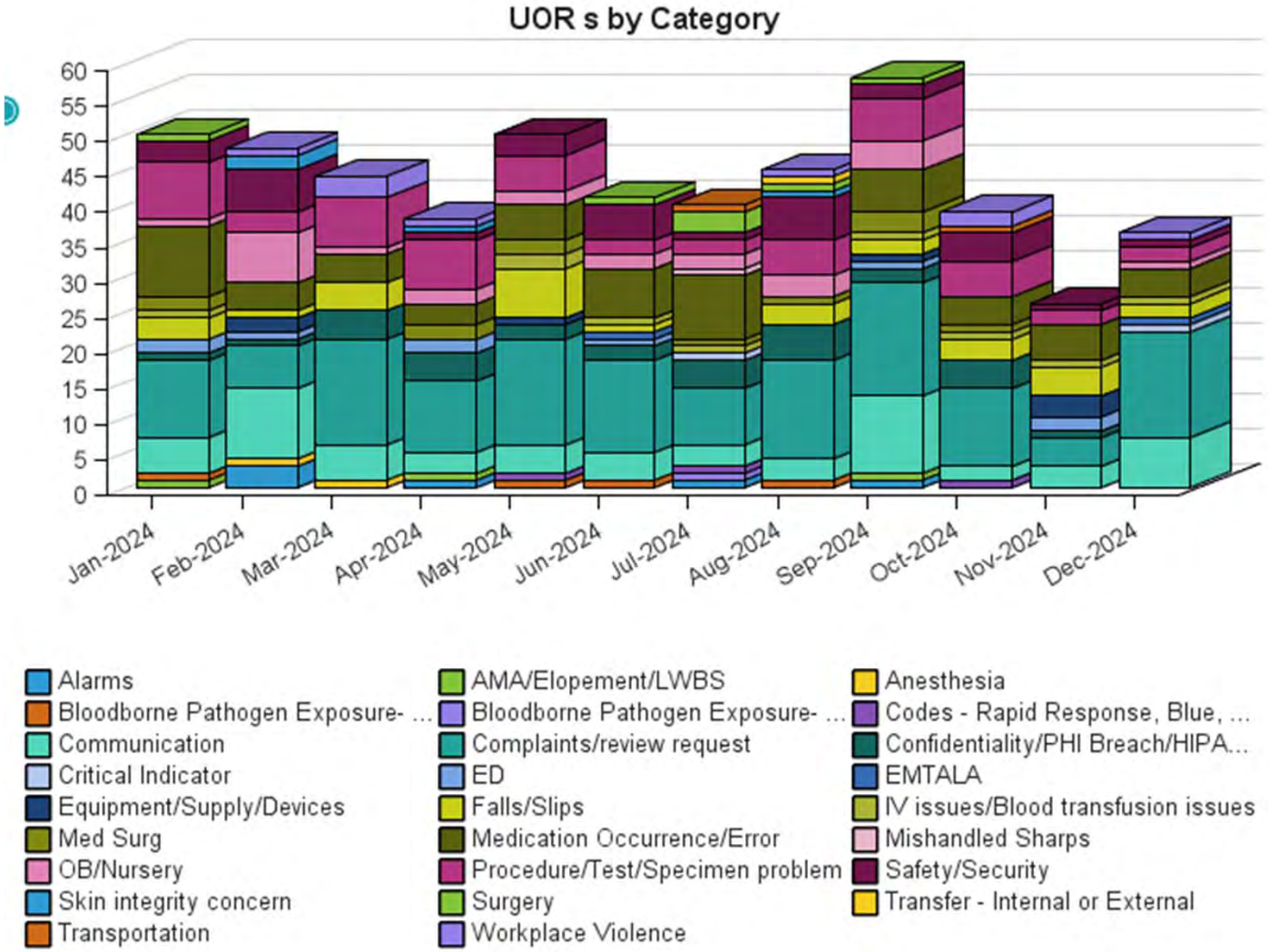
CMS may continue to evaluate your hospital's compliance. It is incumbent upon Northern Inyo Hospital to remain in full compliance with all CMS Hospital Price Transparency requirements at 45 C.F.R. Part 180, including compliance with new regulations that may become effective or implemented after the date of this notice.

If you have questions, please contact us at HPTCompliance@cms.hhs.gov.

Calendar Year 2024
Unusual Occurrence Report
(UOR) Data

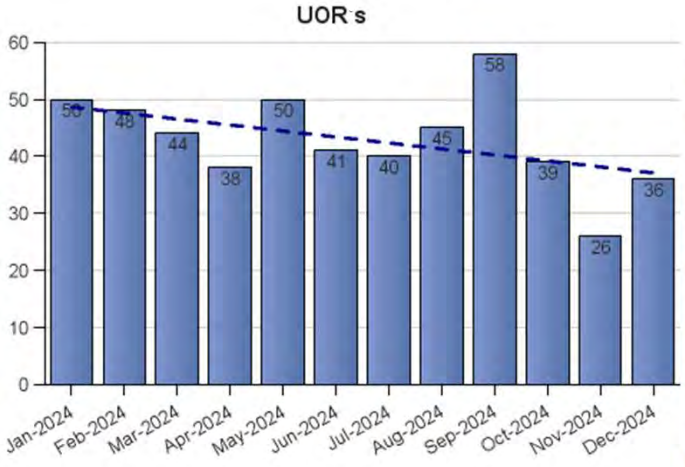
Some of the 2024 systemic changes resulting from UORs:

- Laser labeling of pathology slides.
- Medication protocol, supplies, and infusion pump programming process es streamlined for easier access in emergencies.
- Additional staffing added to clinic to ensure all voicemails are reviewed daily.
- Adjusted thresholds in Pioneer Medical Building to allow for easier/safer access to Rehab areas.
- Updated form processes and monitoring of EDD (Employment Development Department – unemployment insurance, disability insurance, paid family leave) to improve services to affected patients.
- Implemented an improved process to verify drug pricing, as it fluctuates frequently to ensure correct drug pricing.
- Pre-op workflow improved to ensure pre-op tests are not missed, all documentation verified.
- Relocated the Authorization and Referral Department to a clinical area to assist with providing correct documentation, review and streamline the authorization process to provide improved and faster service for authorization.
- Posted Service Animal signs around District entrances to inform the public of District policy and California/Federal laws regarding service animals vs. support animals.
- Building or re-building order sets in the electronic health record to ensure streamlined orders during emergencies in multiple medical and surgical areas.

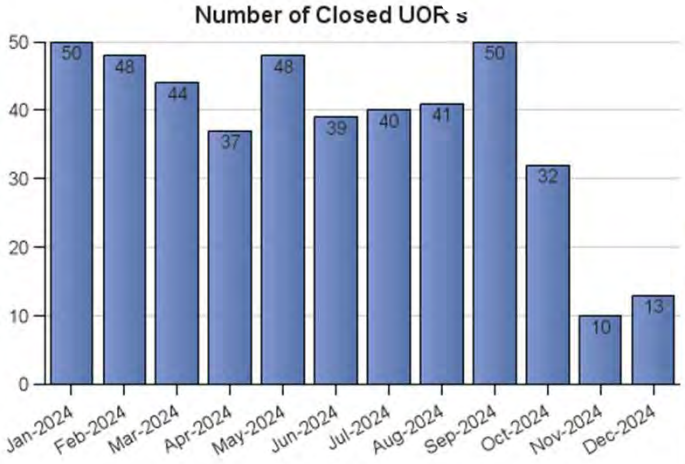

UOR s by Category
60
55
50
45
40
35
30
25
20
15
10
5
0
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
Dec-2024
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
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

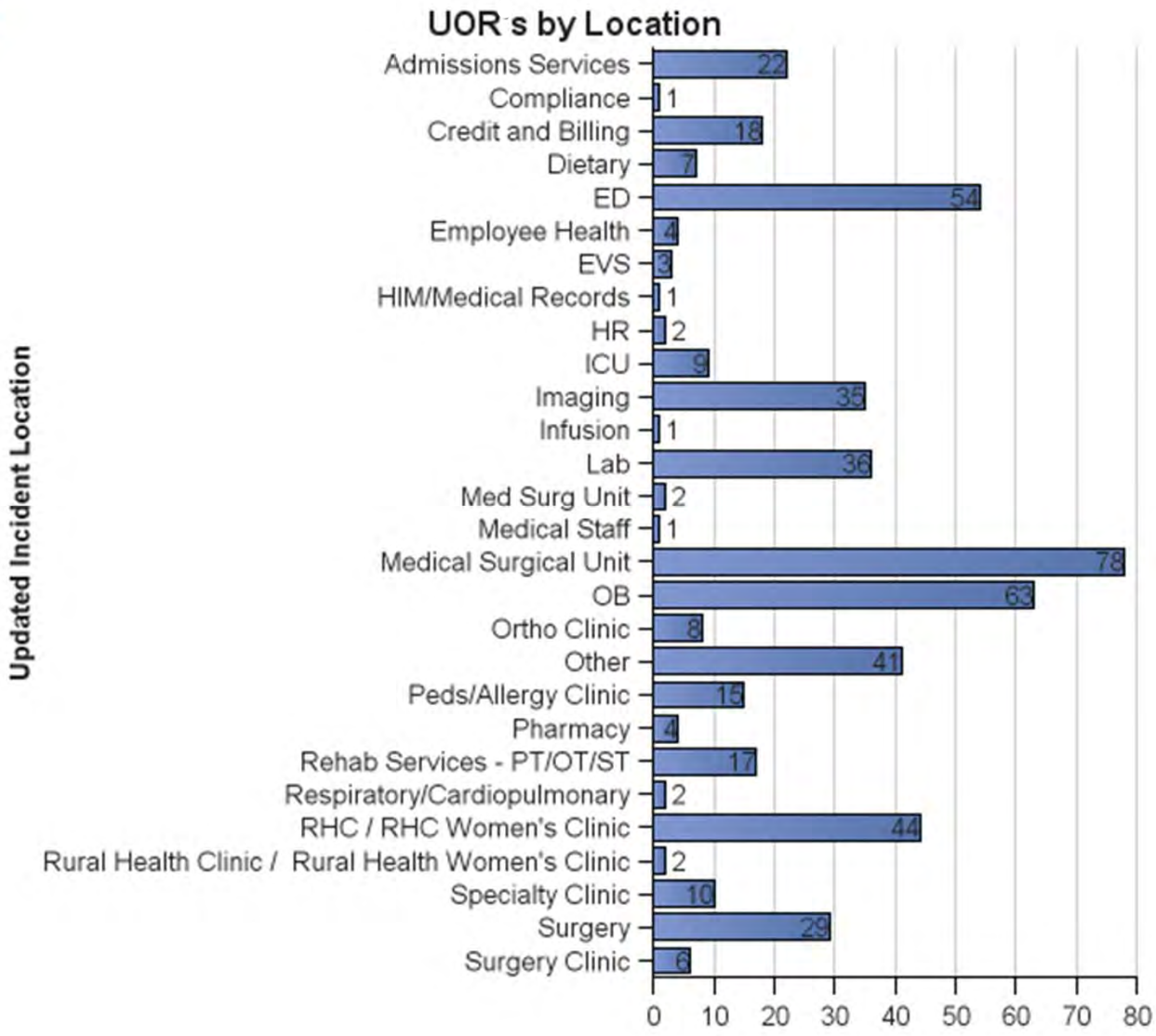
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Total
Alarms		3		1			1		1				6
AMA/Elopement/LWBS	1			1					1				3
Anesthesia		1	1										2
Bloodborne Pathogen Exposure- Sharps Injury	1				1	1		1					4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane							1						1
Codes - Rapid Response, Blue, Deescalation					1		1			1			3
Communication	5	10	5	3	4	4	3	3	11	2	3	7	60
Complaints/review request	11	6	15	10	15	13	8	14	16	11	4	15	138
Confidentiality/PHI Breach/HIPAA violation	1	1	4	4	2	2	4	5	2	4	1		30
Critical Indicator							1					1	2
ED	2	1		2		1			1		2		9
EMTALA						1						1	2
Equipment/Supply/Devices		2			1				1		3		7
Falls/Slips	3	1	4		7	1		3	2	3	4	2	30
IV issues/Blood transfusion issues	1				2	1	1		1	1	1	1	9
Med Surg	2			2	2		1	1	3	1			12
Medication Occurrence/Error	10	4	4	3	5	7	9		6	4	5	4	61
Mishandled Sharps							1						1
OB/Nursery	1	7	1	2	2	2	2	3	4			1	25
Procedure/Test/Specimen problem	8	3	7	7	5	2	2	5	6	5	2	2	54
Safety/Security	3	6		1	3	5	1	6	2	4	1	1	33
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		1	9
Total	**50**	**48**	**44**	**38**	**50**	**41**	**40**	**45**	**58**	**39**	**26**	**36**	**515**



Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	38
May-2024	50
Jun-2024	41
Jul-2024	40
Aug-2024	45
Sep-2024	58
Oct-2024	39
Nov-2024	26
Dec-2024	36
Total	**515**



	Closed
Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	39
Jul-2024	40
Aug-2024	41
Sep-2024	50
Oct-2024	32
Nov-2024	10
Dec-2024	13
Total	**452**

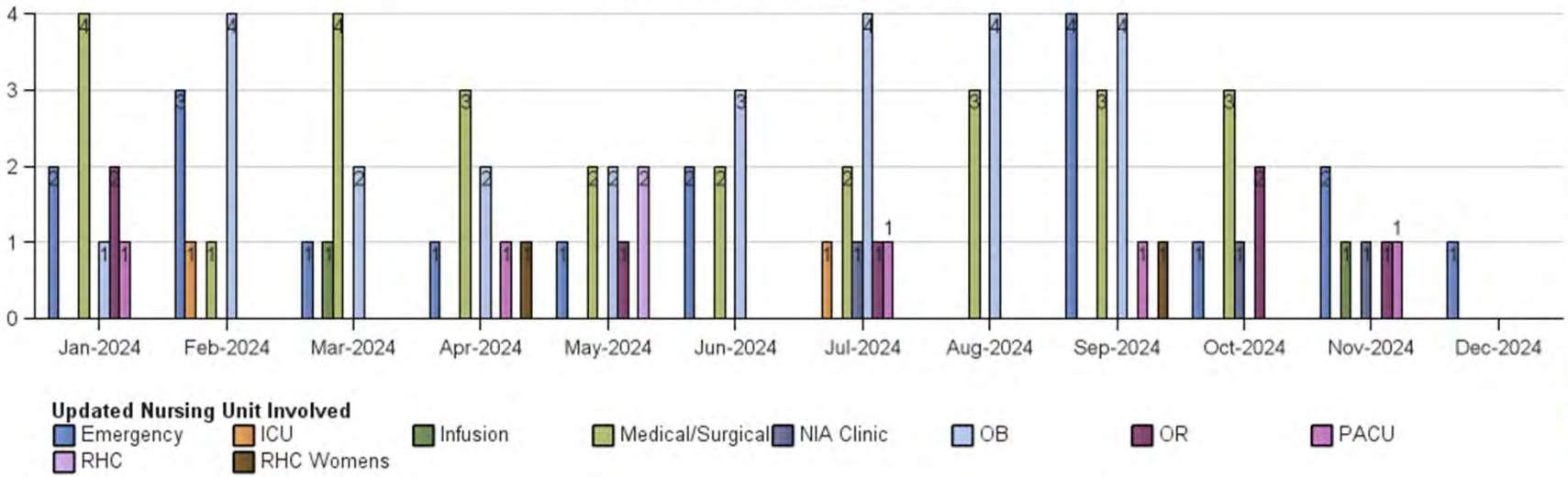

UOR s by Location
Updated Incident Location
Admissions Services
Compliance
Credit and Billing
Dietary
ED
Employee Health
EVS
HIM/Medical Records
HR
ICU
Imaging
Infusion
Lab
Med Surg Unit
Medical Staff
Medical Surgical Unit
OB
Ortho Clinic
Other
Peds/Allergy Clinic
Pharmacy
Rehab Services - PT/OT/ST
Respiratory/Cardiopulmonary
RHC / RHC Women's Clinic
Rural Health Clinic / Rural Health Women's Clinic
Specialty Clinic
Surgery
Surgery Clinic
22
1
18
7
54
4
3
1
2
9
35
1
36
2
1
78
63
8
41
15
4
17
2
44
2
10
29
6
0
10
20
30
40
50
60
70
80

Data for previous slide

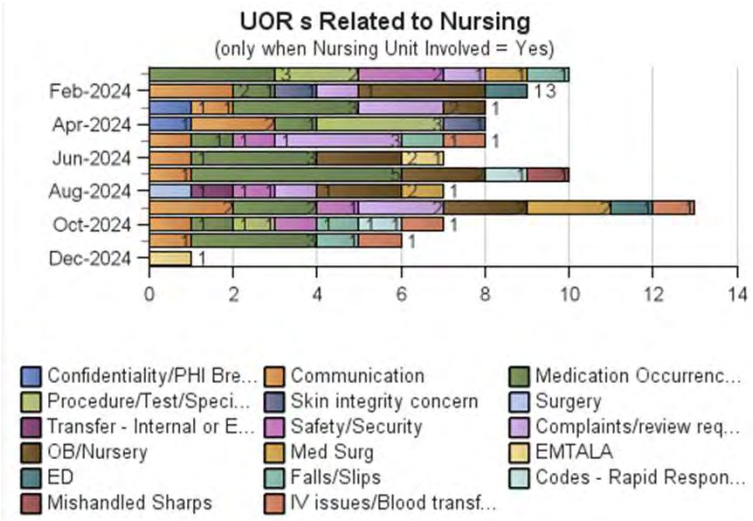
Admissions Services	22
Compliance	1
Credit and Billing	18
Dietary	7
ED	54
Employee Health	4
EVS	3
HIM/Medical Records	1
HR	2
ICU	9
Imaging	35
Infusion	1
Lab	36
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	78
OB	63
Ortho Clinic	8
Other	41
Peds/Allergy Clinic	15
Pharmacy	4
Rehab Services - PT/OT/ST	17
Respiratory/Cardiopulmonary	2
RHC / RHC Women's Clinic	44
Rural Health Clinic / Rural Health Wor	2
Specialty Clinic	10
Surgery	29
Surgery Clinic	6
Total	**515**

UOR s Related to Nursing by Nursing Unit Involved

(only when Nursing Unit Involved = Yes)

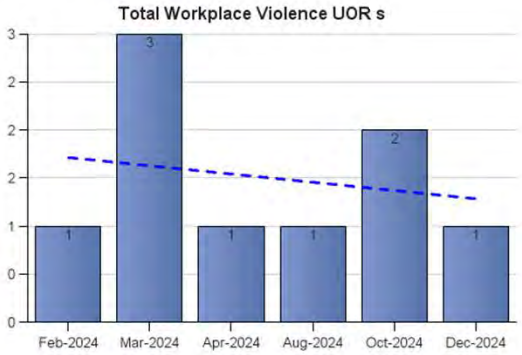


	Yes
Emergency	18
ICU	2
Infusion	2
Medical/Surgical	27
NIA Clinic	3
OB	26
OR	7
PACU	5
RHC	2
RHC Womens	2
Total	**94**

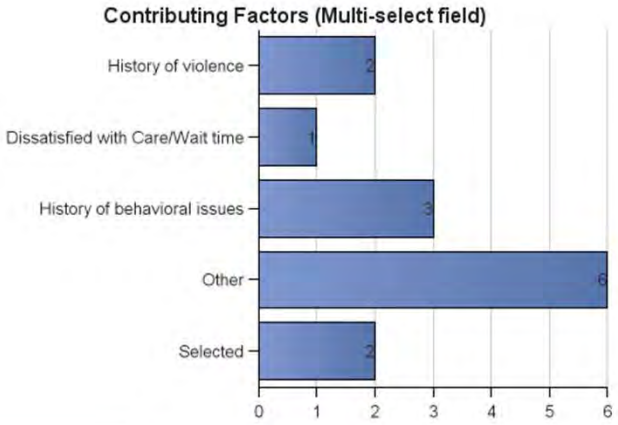


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Total
Confidentiality/PHI Breach/HIPAA violation			1	1									**2**
Communication		2	1	2	1	1	1		2	1	1		**12**
Medication Occurrence/Error	3	1	3	1	1	3	5		2	1	3		**23**
Procedure/Test/Specimen problem	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**
EMTALA						1						1	**2**
ED		1							1				**2**
Falls/Slips	1				1					1	1		**4**
Codes - Rapid Response, Blue, Deescalation							1			1			**2**
Mishandled Sharps							1						**1**
IV issues/Blood transfusion issues					1				1	1	1		**4**
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**13**	**7**	**6**	**1**	**94**

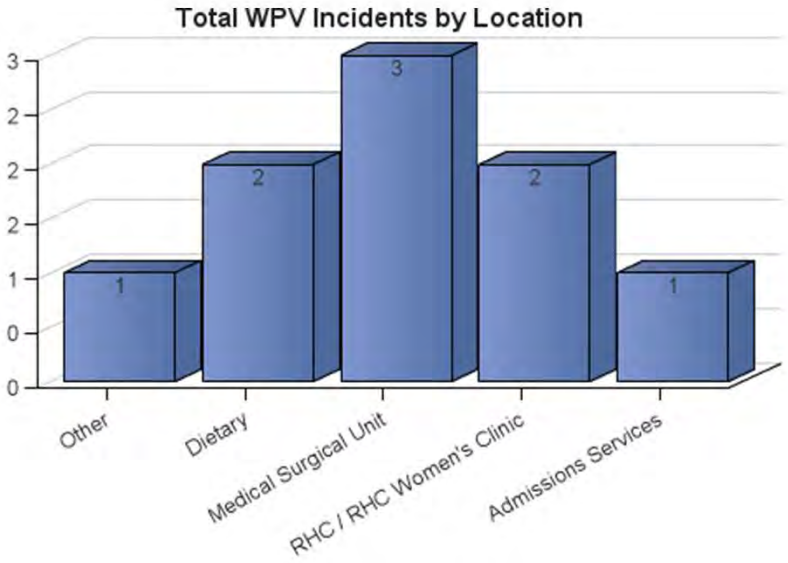
WORKPLACE VIOLENCE



	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Dec-2024	Total
Workplace Violence	1	3	1	1	2	1	9
Total	**1**	**3**	**1**	**1**	**2**	**1**	**9**

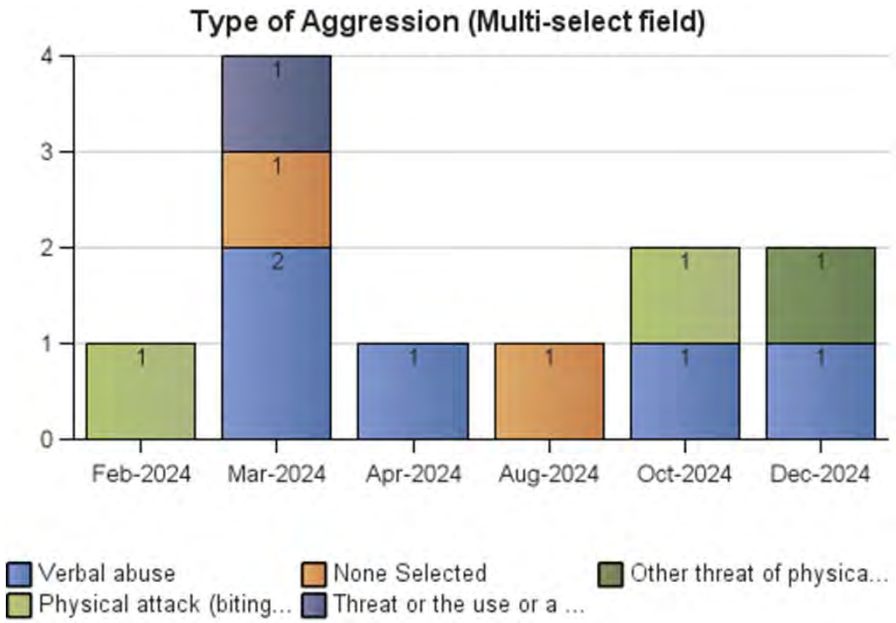


None Selected	2
Dissatisfied with Care/Wait time	1
History of behavioral issues	3
History of violence	2
Other	4
Total	**12**



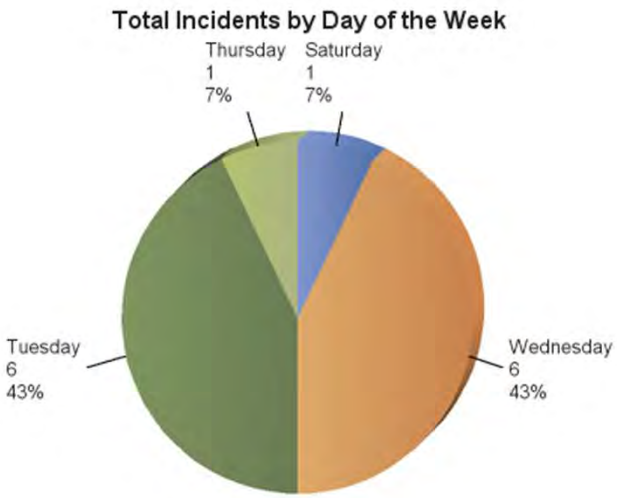
Other	1
Dietary	2
Medical Surgical Unit	3
RHC / RHC Women's Clinic	2
Admissions Services	1
Total	**9**

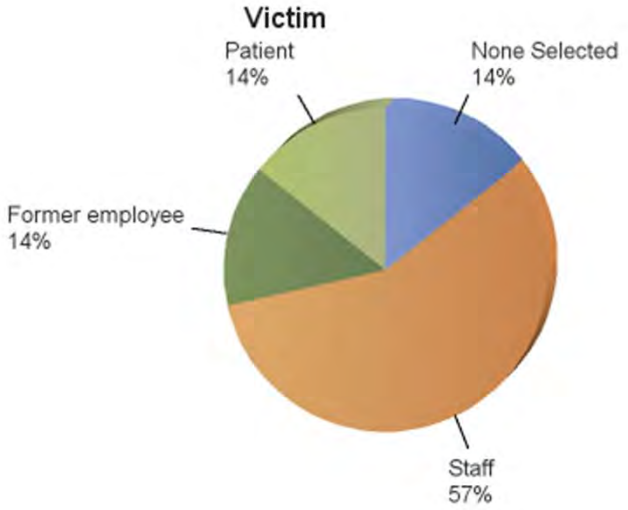
WORKPLACE VIOLENCE

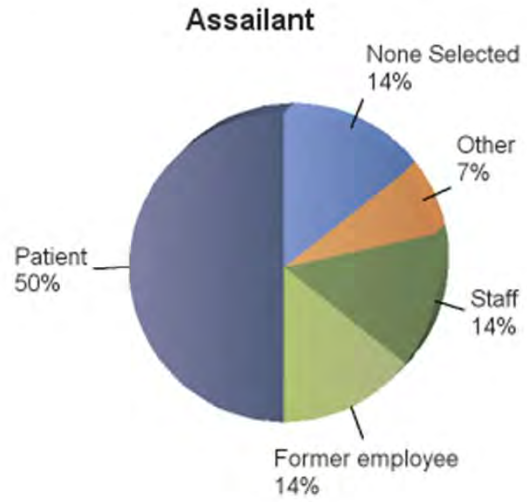


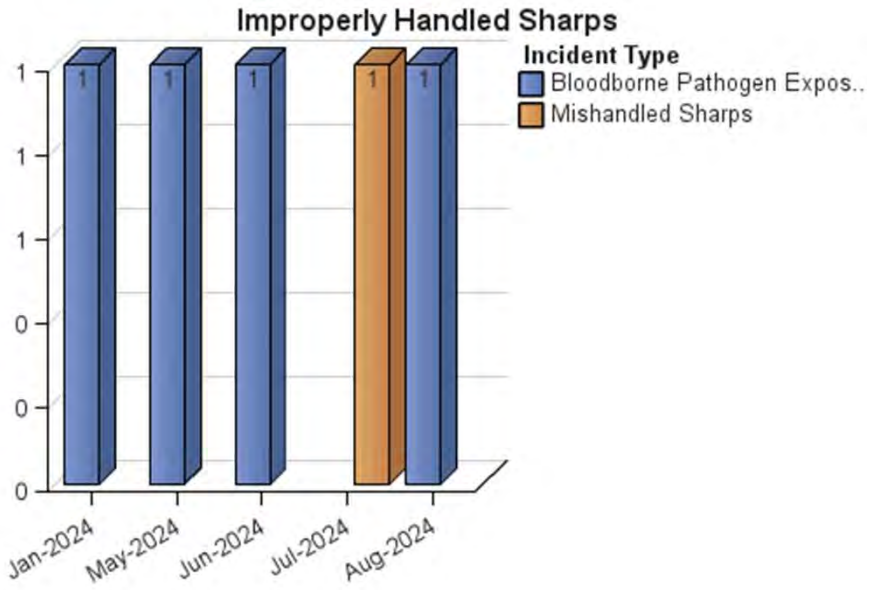
	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Dec-2024	Total
Verbal abuse		2	1		1	1	5
None Selected		1		1			2
Other threat of physical force						1	1
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1				1		2
Threat or the use or a weapon/object		1					1
Total	**1**	**4**	**1**	**1**	**2**	**2**	**11**

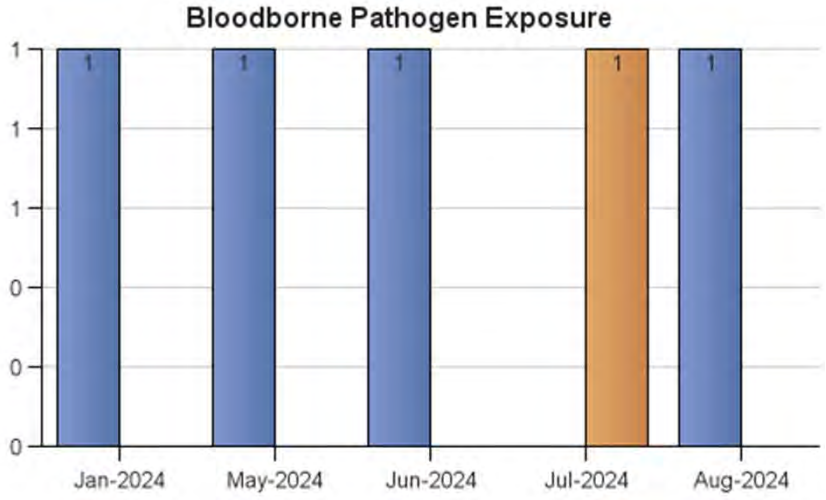
WORKPLACE VIOLENCE





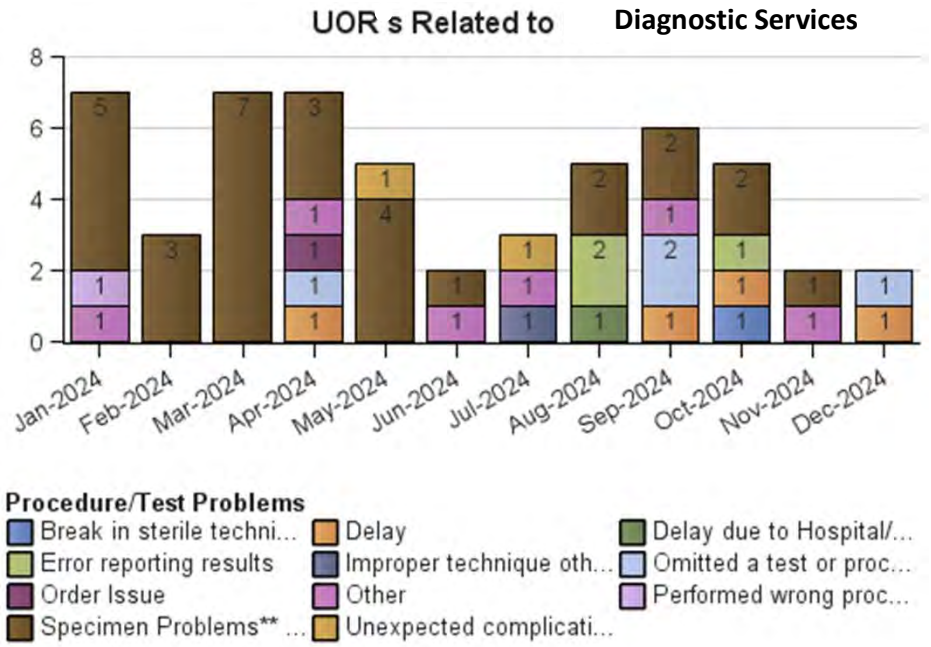






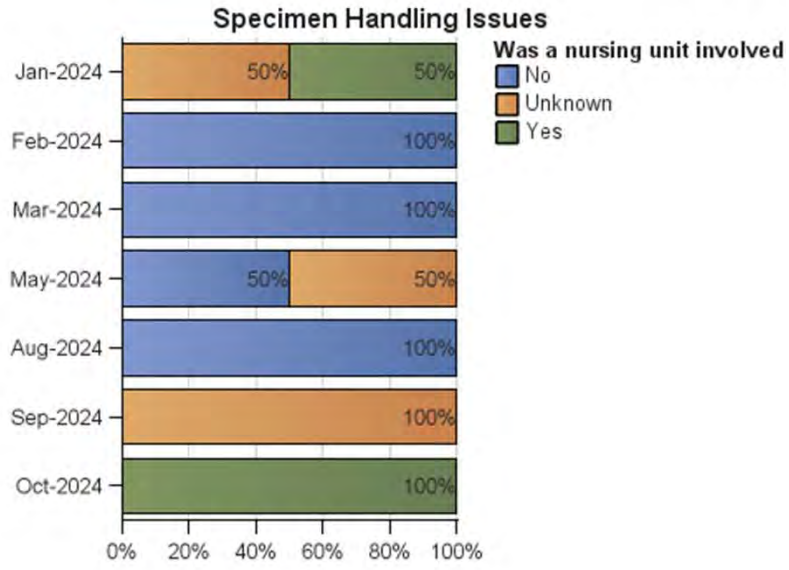
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Mishandled Sharps				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

	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

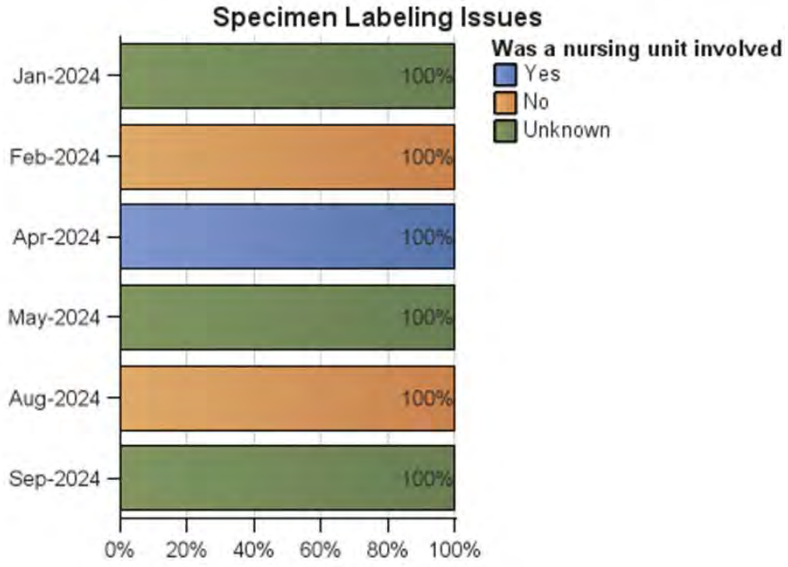


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024	Dec-2024	Total
Break in sterile technique										1			1
Delay				1					1	1		1	4
Delay due to Hospital/Radiology systems problems or communication issues								1					1
Error reporting results								2		1			3
Improper technique other than a break in sterile technique							1						1
Omitted a test or procedure				1					2			1	4
Order Issue				1									1
Other	1			1		1	1		1		1		6
Performed wrong procedure	1												1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	5	3	7	3	4	1		2	2	2	1		30
Unexpected complications					1		1						2
Total	**7**	**3**	**7**	**7**	**5**	**2**	**3**	**5**	**6**	**5**	**2**	**2**	**54**

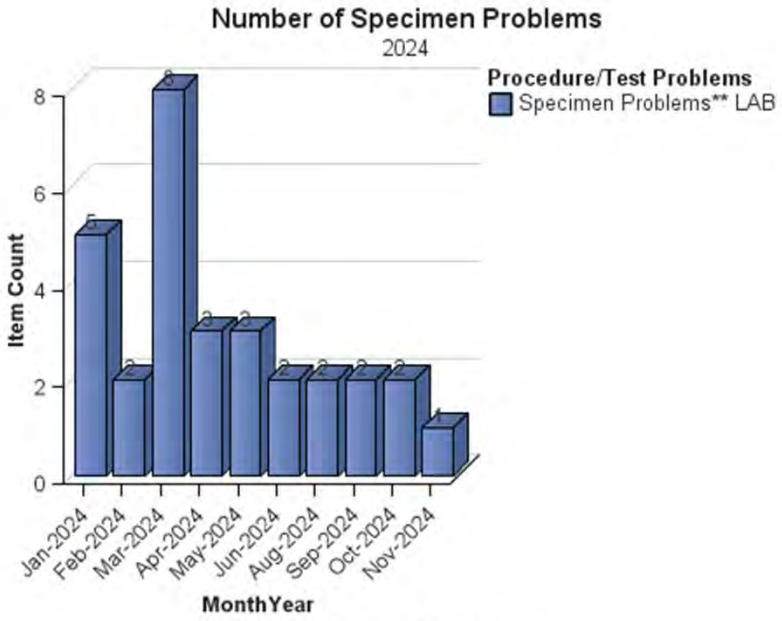
See new reports in the following pages

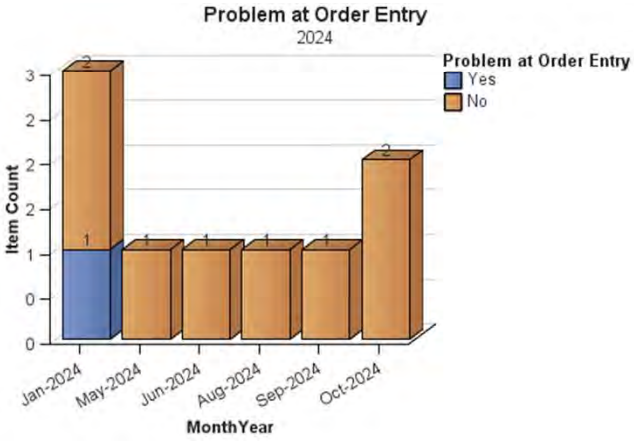


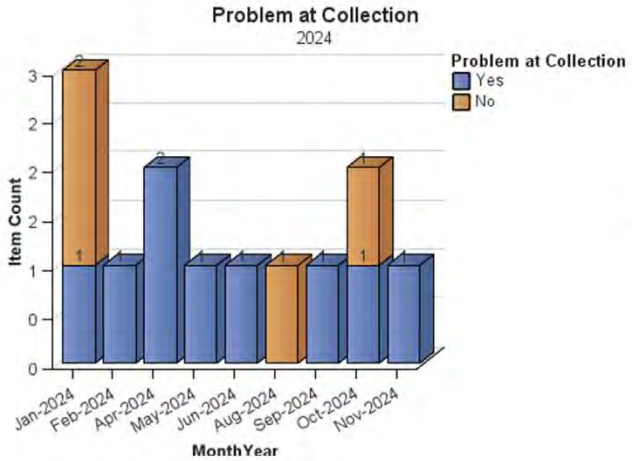
	Jan-2024	Feb-2024	Mar-2024	May-2024	Aug-2024	Sep-2024	Oct-2024	Total
No		1	7	1	1			10
Unknown	1			1		1		3
Yes	1						1	2
Total	**2**	**1**	**7**	**2**	**1**	**1**	**1**	**15**

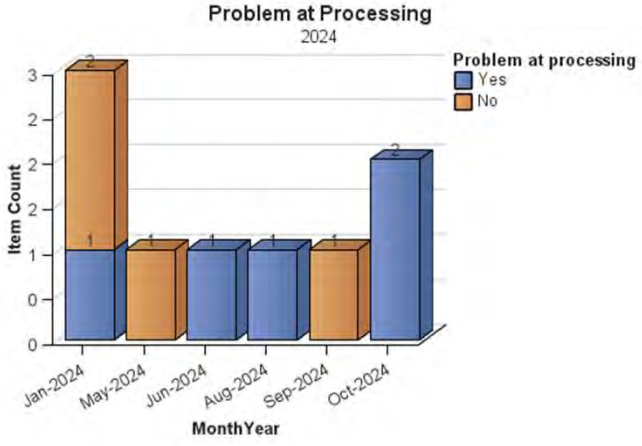


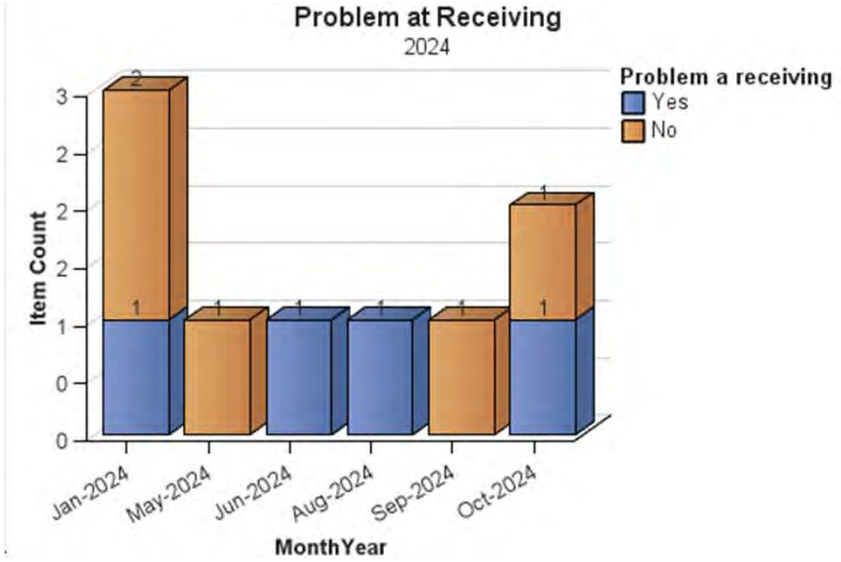
	Jan-2024	Feb-2024	Apr-2024	May-2024	Aug-2024	Sep-2024	Total
Yes			2				2
No		1			1		2
Unknown	1			2		1	4
Total	**1**	**1**	**2**	**2**	**1**	**1**	**8**

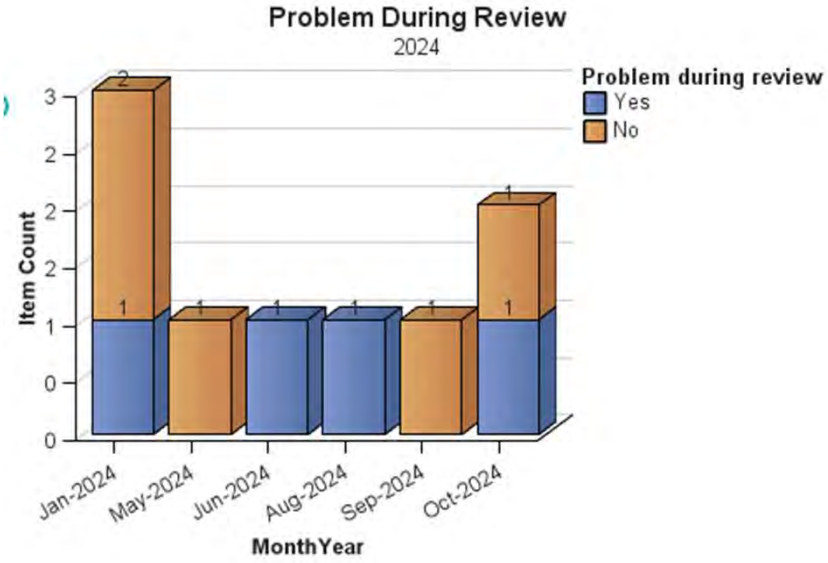

Number of Specimen Problems
2024
Procedure/Test Problems
Specimen Problems** LAB
Item Count
0
2
4
6
8
5
2
8
3
3
2
2
2
2
1
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
MonthYear

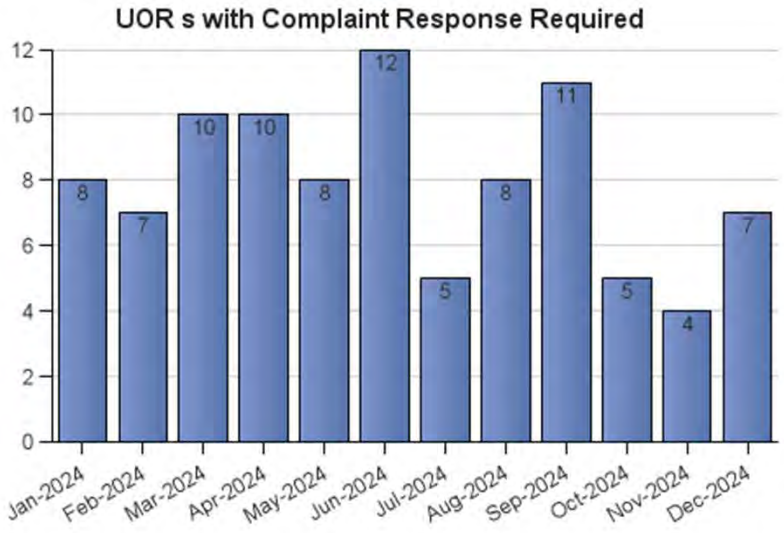

Problem at Order Entry
2024
Problem at Order Entry
Yes
No
Item Count
0
1
2
3
1
1
1
1
1
2
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024
MonthYear


Problem at Collection
2024
Problem at Collection
Yes
No
Item Count
0
1
2
3
1
1
2
1
1
1
1
1
2
1
Jan-2024
Feb-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
MonthYear

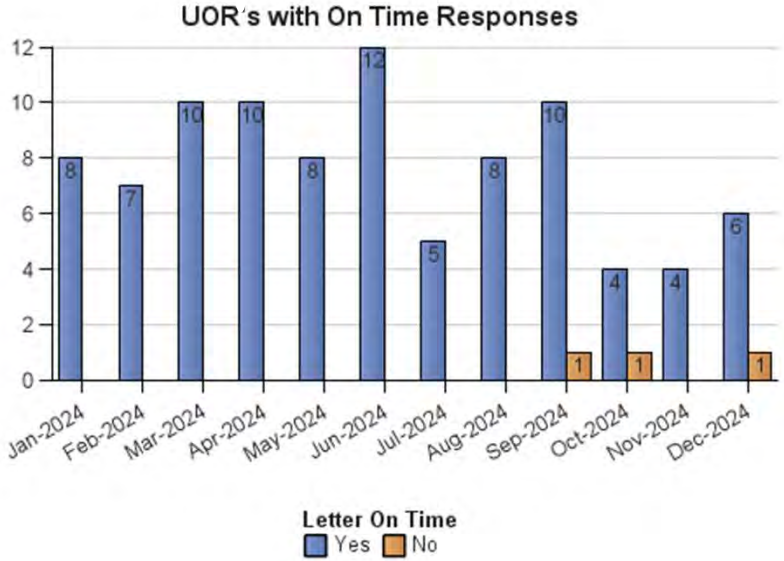

Problem at Processing
2024
Problem at processing
Yes
No
Item Count
0
1
2
3
1
1
1
1
1
2
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024
MonthYear


Problem at Receiving
2024
Problem a receiving
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

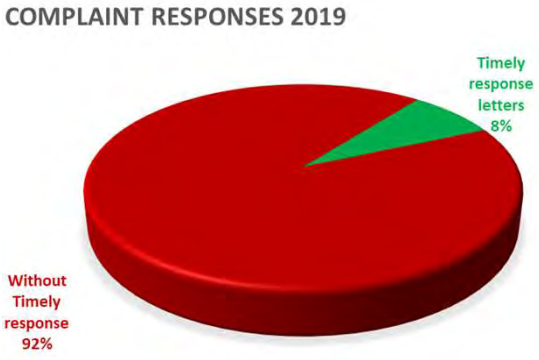

Problem During Review
2024
Problem during review
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

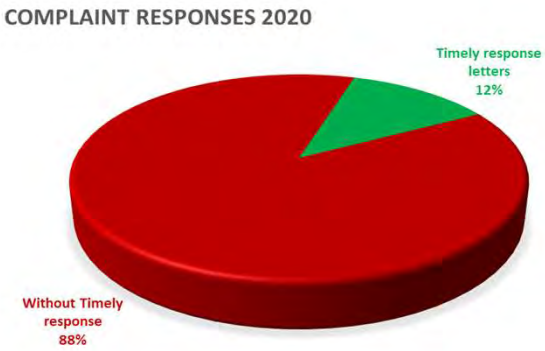


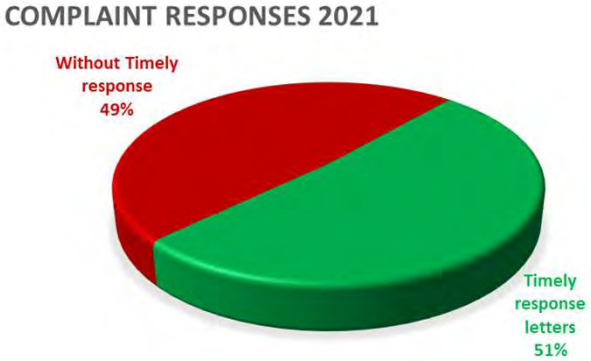
Jan-2024	8
Feb-2024	7
Mar-2024	10
Apr-2024	10
May-2024	8
Jun-2024	12
Jul-2024	5
Aug-2024	8
Sep-2024	11
Oct-2024	5
Nov-2024	4
Dec-2024	7
Total	**95**

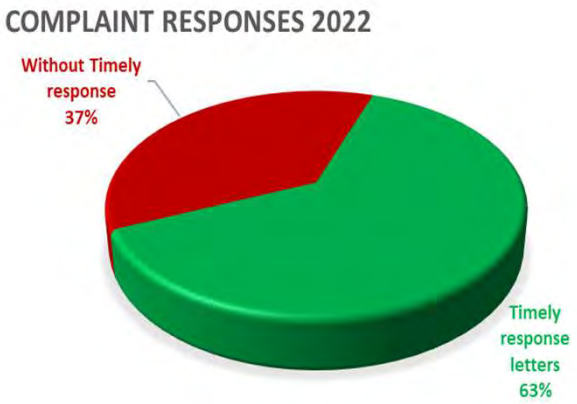


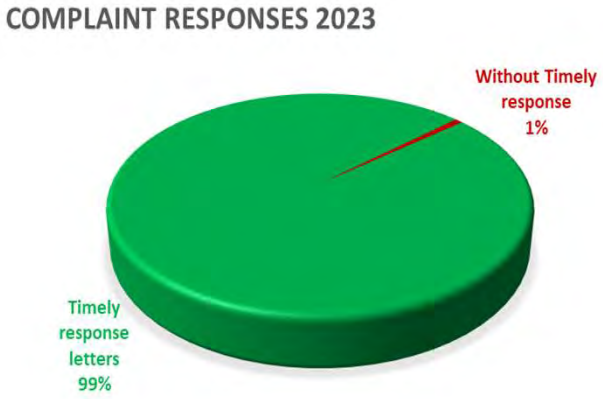
	Yes	No	Total
Jan-2024	8		**8**
Feb-2024	7		**7**
Mar-2024	10		**10**
Apr-2024	10		**10**
May-2024	8		**8**
Jun-2024	12		**12**
Jul-2024	5		**5**
Aug-2024	8		**8**
Sep-2024	10	1	**11**
Oct-2024	4	1	**5**
Nov-2024	4		**4**
Dec-2024	6	1	**7**
Total	**92**	**3**	**95**

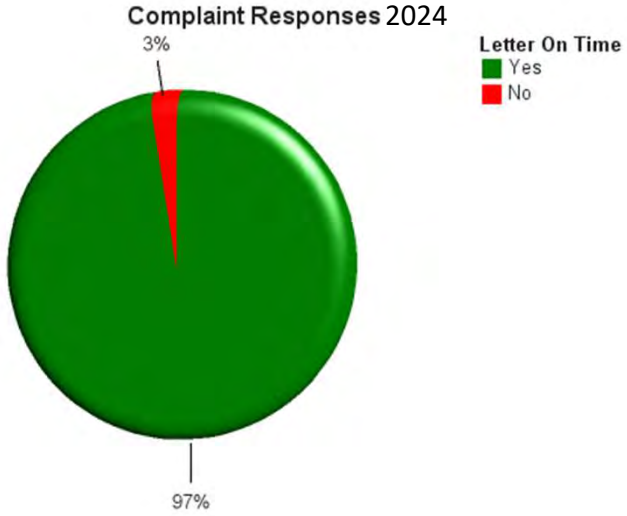






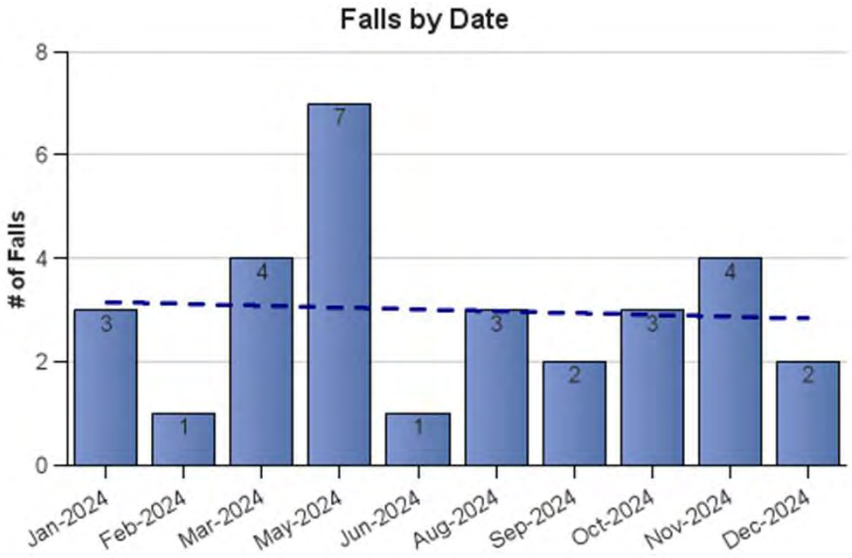






Goal is 100% Green (timely responses)

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	Yes	No	Total
Not Identified	8				8
ED	1		2	1	4
Inpatient		3		6	9
Outpatient	9				9
Total	**18**	**3**	**2**	**7**	**30**

# 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	1	6	4	1	**18**
Confused		3	1						**4**
Oriented		4	5	1					**10**
Total	**1**	**10**	**7**	**2**	**1**	**6**	**4**	**1**	**32**

# of Falls	Falls/Slips	Total
Dietary	1	**1**
ED	4	**4**
EVS	1	**1**
Imaging	1	**1**
Medical Surgical Unit	9	**9**
OB	1	**1**
Other	5	**5**
Rehab Services - PT/OT/ST	6	**6**
Specialty Clinic	1	**1**
Surgery	1	**1**
Total	**30**	**30**

# of Falls	Was the Patient Assessed for Fall Risk		
	Not assessed	Yes	Total
Workforce	8		8
Outpatient	9		9
Inpatient		9	9
ED	1	3	4
Total	**18**	**12**	**30**

# of Falls	Was the Patient Assessed for Falls Protocol				
	Not assessed	Yes	Unknown	No	Total
Workforce	8				8
Outpatient	9				9
Inpatient		8	1		9
ED	1	2		1	4
Total	**18**	**10**	**1**	**1**	**30**

# of Falls	Received a Sedative w/in the Last 4 Hours			
	Not assessed	Yes	No	Total
Workforce	8			8
Outpatient	9			9
Inpatient		1	8	9
ED	1	1	2	4
Total	**18**	**2**	**10**	**30**

# of Falls	The Patient Is			
	Not assessed	Oriented	Confused	Total
Workforce	8			8
Outpatient	9			9
ED	1	3		4
Inpatient		6	3	9
Total	**18**	**9**	**3**	**30**

# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	8		8
ED	1	3	4
Inpatient		9	9
Outpatient	9		9
Total	**18**	**12**	**30**

# of Falls	Siderails			
	Not assessed	Siderails down	Siderails up	Total
Workforce	8			8
Outpatient	9			9
ED	1	2	1	4
Inpatient		2	7	9
Total	**18**	**4**	**8**	**30**

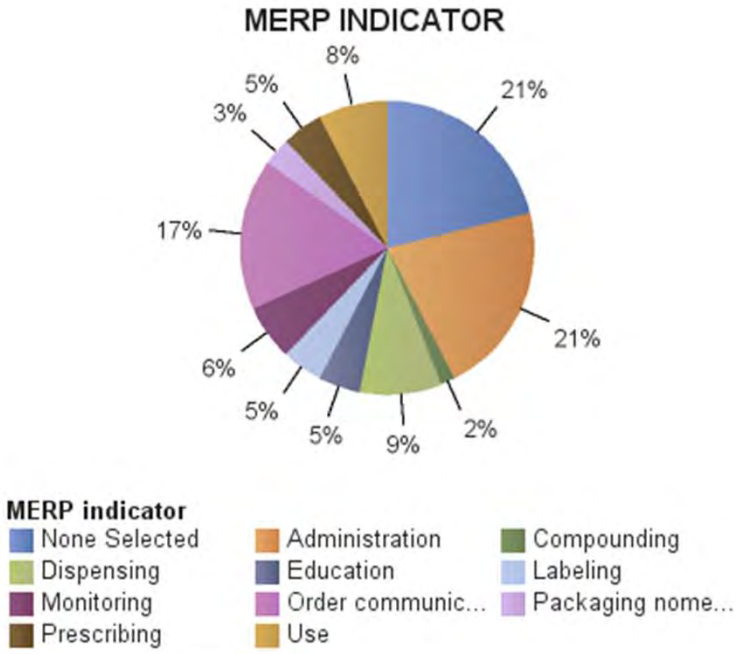
# of Falls	Restraints		
	Not assessed	None	Total
Workforce	8		8
Outpatient	9		9
Inpatient		9	9
ED	1	3	4
Total	**18**	**12**	**30**

# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	8			8
Outpatient	9			9
Inpatient		3	6	9
ED	1	1	2	4
Total	**18**	**4**	**8**	**30**

# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	8			8
Outpatient	9			9
Inpatient		6	3	9
ED	1	3		4
Total	**18**	**9**	**3**	**30**

# 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	8			8	8			8	8			8	8			8
ED	1	2	1	4	1	1	2	4	2	2		4	2		2	4
Inpatient	1	5	3	9	7		2	9	5	3	1	9	4	1	4	9
Outpatient	9			9	9			9	9			9	9			9
Total	**19**	**7**	**4**	**30**	**25**	**1**	**4**	**30**	**24**	**5**	**1**	**30**	**23**	**1**	**6**	**30**

Medication Error Reduction Plan (MERP)

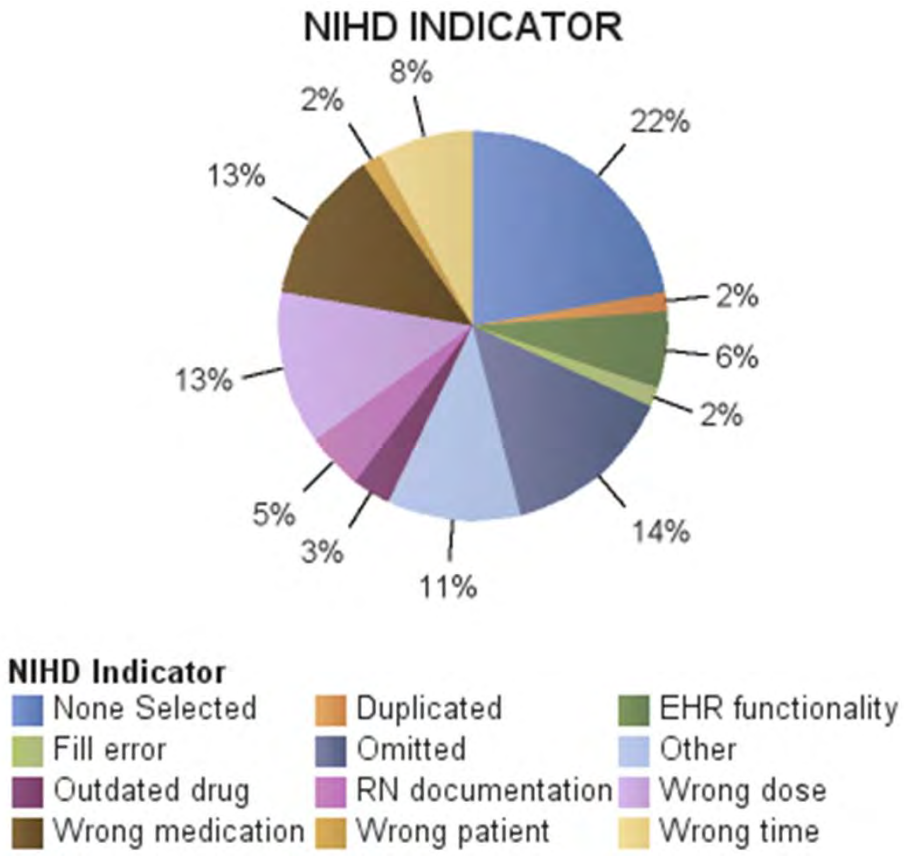


None Selected	14
Administration	14
Compounding	1
Dispensing	6
Education	3
Labeling	3
Monitoring	4
Order communication	11
Packaging nomenclature	2
Prescribing	3
Use	5
Total	**66**

	# 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**
Nov-2024	4	1	**5**
Dec-2024	4		**4**
Total	**44**	**14**	**58**

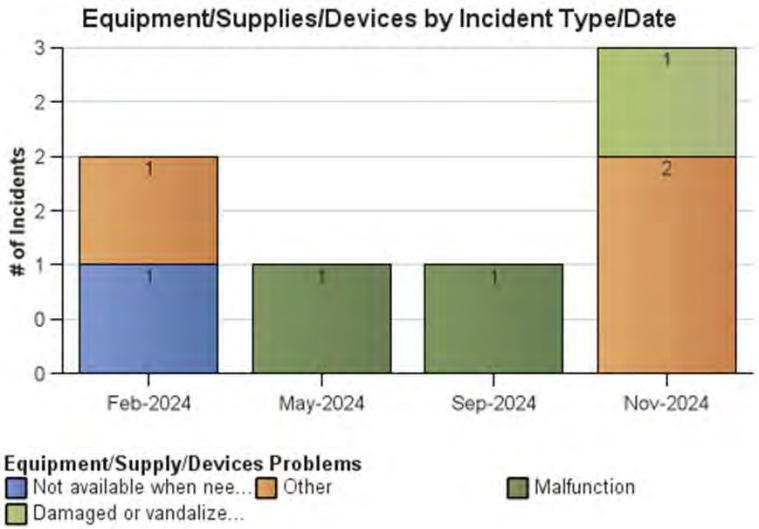
All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

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

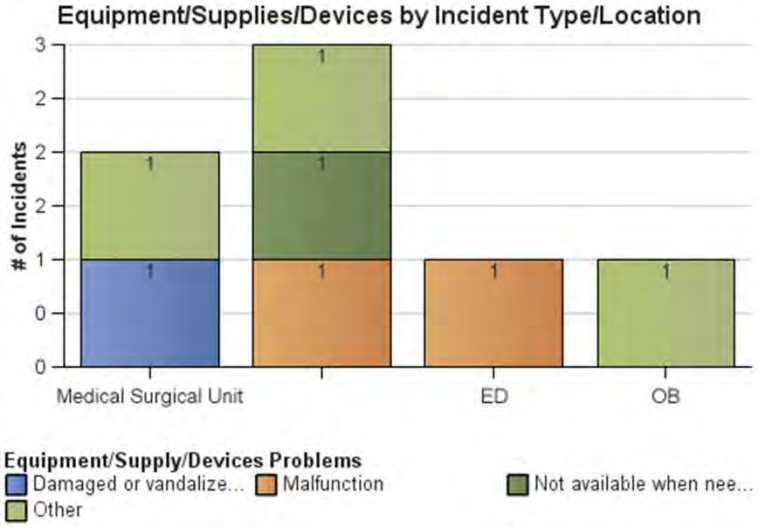


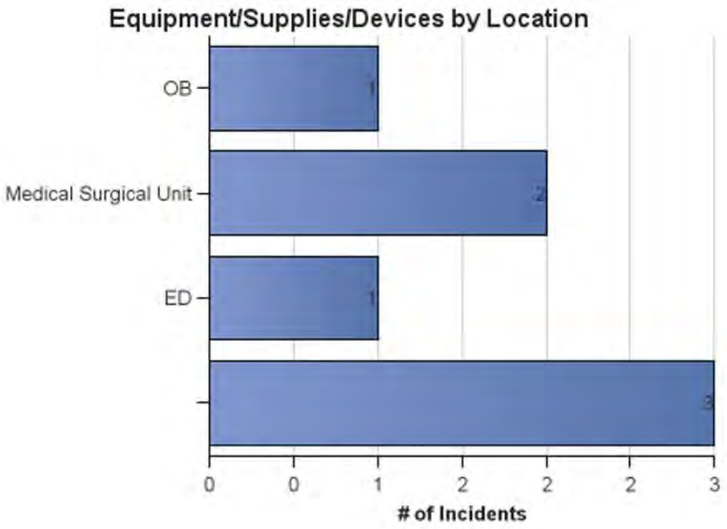
None Selected	14
Duplicated	1
EHR functionality	4
Fill error	1
Omitted	9
Other	7
Outdated drug	2
RN documentation	3
Wrong dose	8
Wrong medication	8
Wrong patient	1
Wrong time	5
Total	**63**

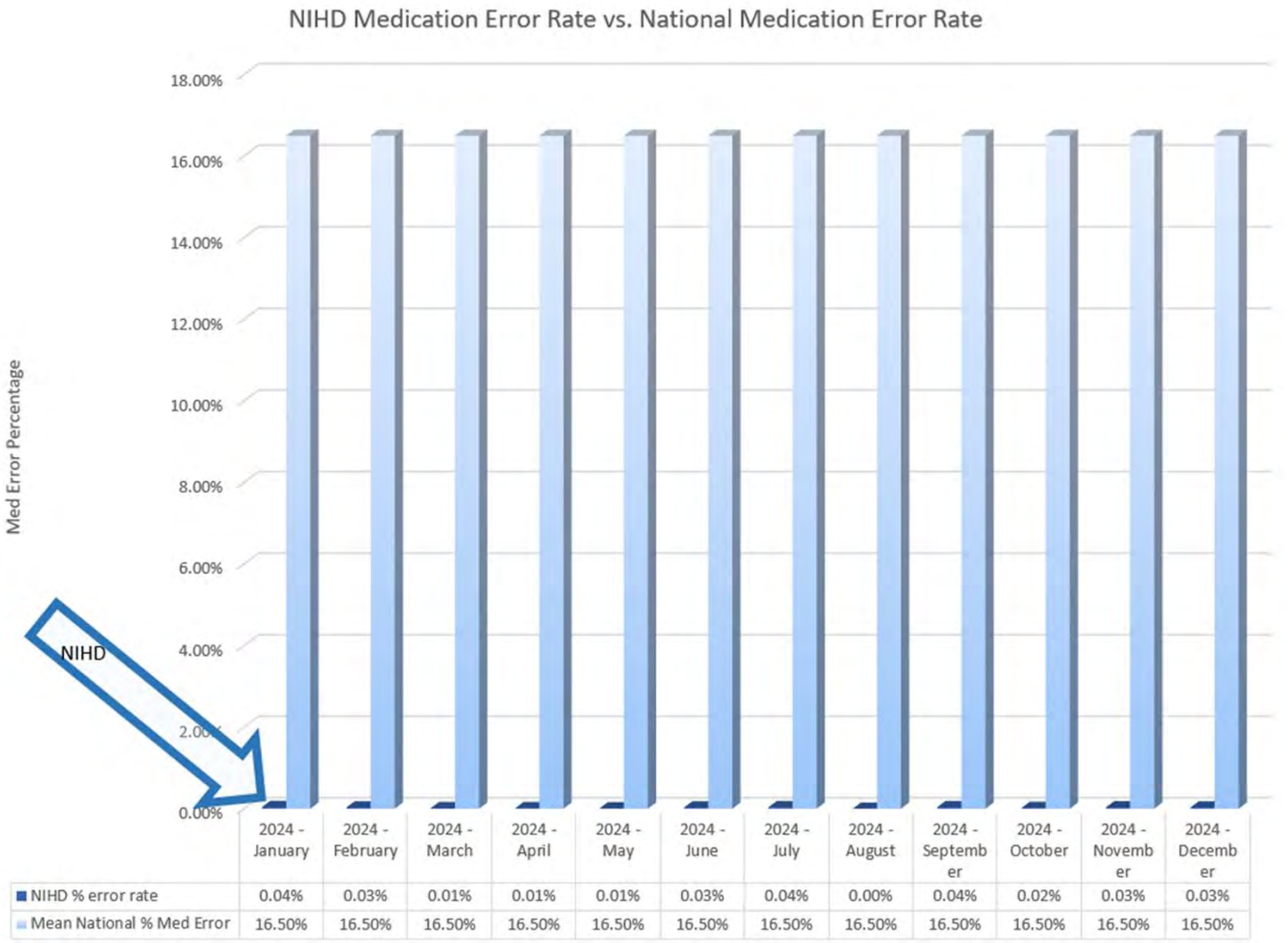
Total numbers of errors and occurrences are not equal to the indicators since some error/occurrences have more than one indicator.



No Data Available

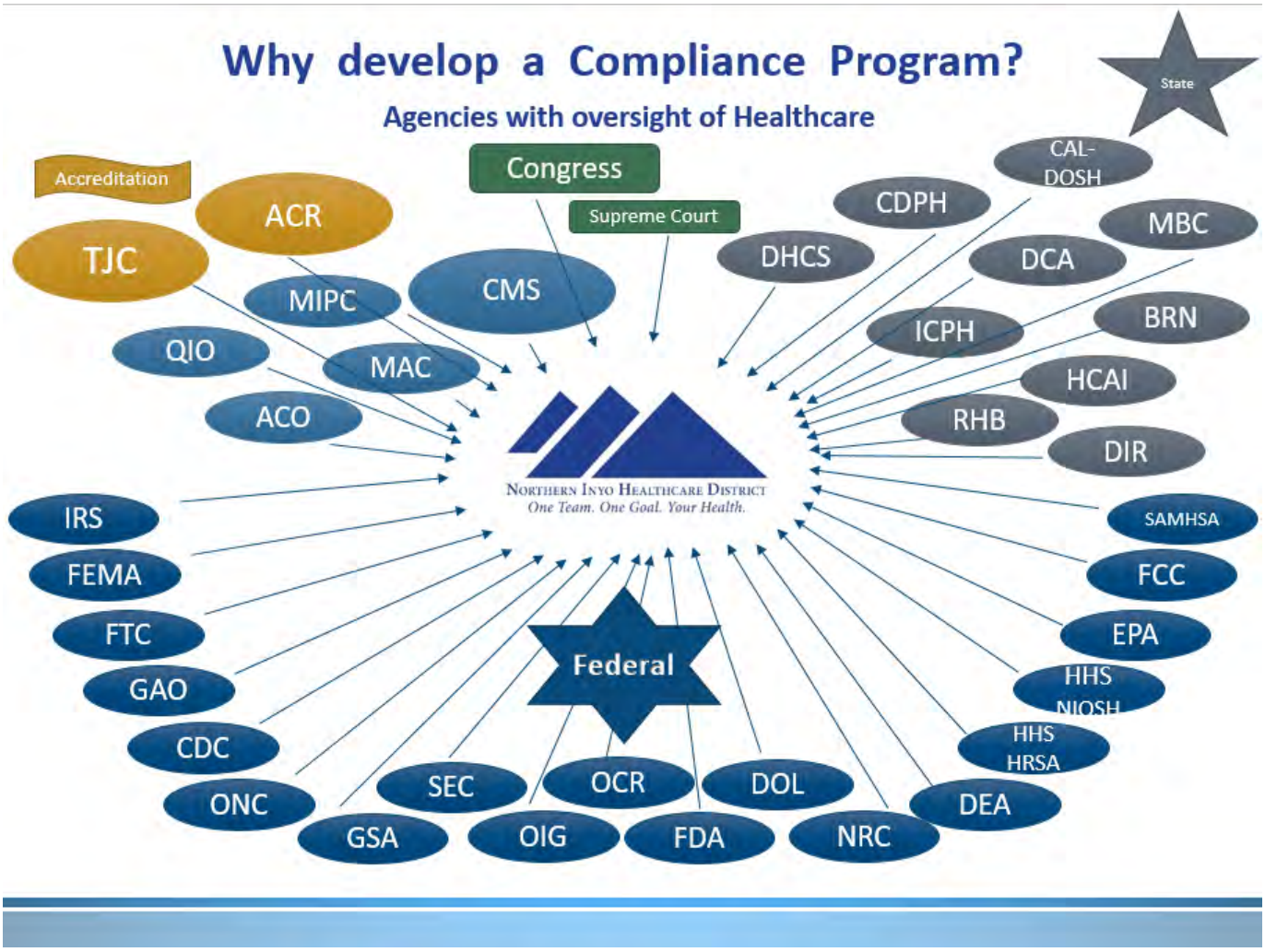





NIHD Medication Error Rate vs. National Medication Error Rate
Med Error Percentage
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
NIHD
2024 - January
2024 - February
2024 - March
2024 - April
2024 - May
2024 - June
2024 - July
2024 - August
2024 - September
2024 - October
2024 - November
2024 - December
NIHD % error rate 0.04% 0.03% 0.01% 0.01% 0.01% 0.03% 0.04% 0.00% 0.04% 0.02% 0.03% 0.03%
Mean National % Med Error 16.50% 16.50% 16.50% 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%9325%25%20during%20medication%20administration.
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%	
2024 - September	16,250	6	0.04%	8%-25%	16.50%	99.96%	
2024 - October	14,778	3	0.02%	8%-25%	16.50%	99.98%	
2024 - November	11,959	4	0.03%	8%-25%	16.50%	99.97%	
2024 - December	12,532	4	0.03%	8%-25%	16.50%	99.97%	



YouCompli

In December 2024, Northern Inyo Healthcare District began implementing YouCompli. YouCompli will assist the Compliance team with knowing about and being prepared for regulatory changes from the regulators in the image above.

The software program uses AI technology to comb regulatory bodies for changes to regulations, laws, and formal guidance. Legal scholars and specialists then review the changes and develop questions to allow our department leadership teams to determine if the regulation applies to our facility and departments. Once determined to be relevant, the program contains the changes in the regulatory language and areas to document our policy, operational, and procedural plans to ensure compliance with the changes.

As part of the implementation project, we have reviewed changes with effective dates prior to January 1, 2025 to ensure compliance.

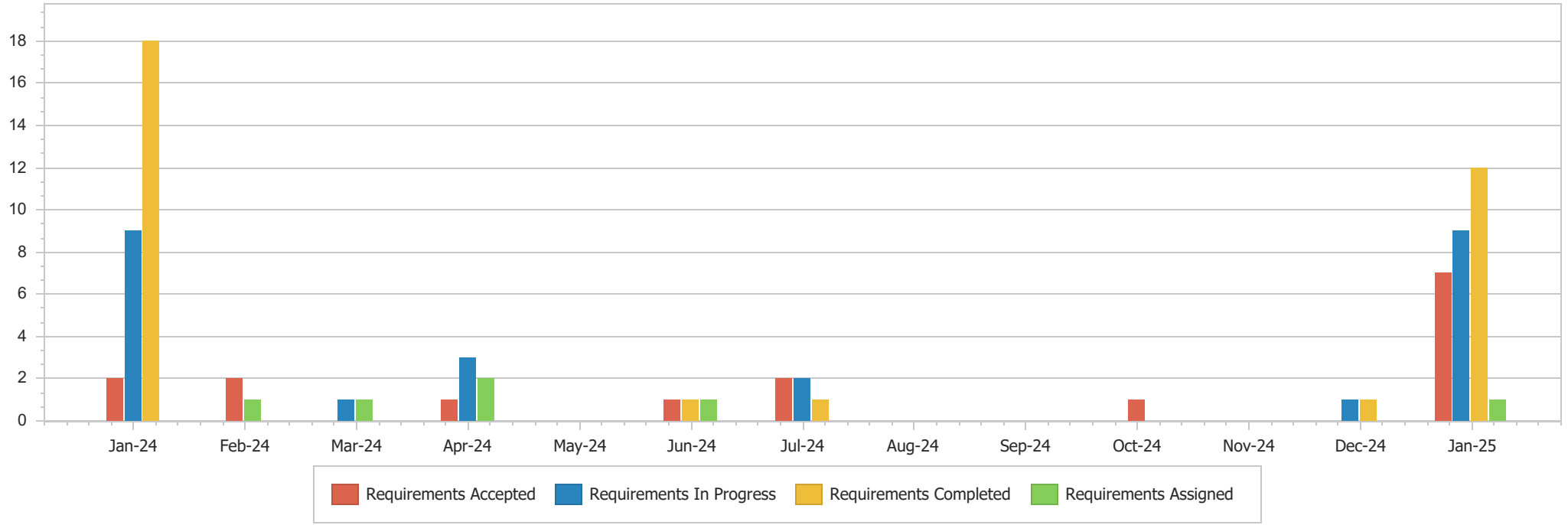
The following pages contain the agencies constantly monitored for changes that may affect Northern Inyo Healthcare District.

Agency for Healthcare Research & Quality (AHRQ)
CA Physician Assistant Board
California Board of Behavioral Sciences
California Board of Registered Nursing
California Department of Consumer Affairs
California Department of Health Care Access and Information
California Department of Health Care Services (Medi-Cal)
California Department of Managed Health Care
California Department of Managed Health Care Services - BHIN
California Department of Public Health
California Health and Human Services Agency
California Health Facilities Financing Authority
California Office of Administrative Law
California Office of Statewide Health Planning and Development
California State and Consumer Services Agency
California State Assembly
California State Board of Pharmacy
Centers for Disease Control & Prevention (CDC)
Centers for Medicare & Medicaid Services (CMS)

Clinical Laboratory Improvement Amendments (CLIA)
CMS - Center for Clinical Standards and Quality
Department of Commerce (DoC)
Department of Defense (DoD)
Department of Energy
Department of Health & Human Services (HHS)
Department of Justice (DOJ)
Department of Labor (DOL)
Department of Transportation (DOT)
Department of Veteran's Affairs
Drug Enforcement Administration (DEA)
Employee Benefits Security Administration
Environmental Protection Agency (EPA)
Federal Aviation Administration (FAA)
Federal Communications Commission (FCC)
Federal Trade Commission (FTC)
Food & Drug Administration (FDA)
Health Resources and Services Administration (HRSA)
Internal Revenue Service (IRS)
JD Noridian
JE Noridian
Medical Board of California
Medicare Program Integrity Contractors
National Institutes of Health (NIH)
Nuclear Regulatory Commission (NRC)
Occupational Safety & Health Administration (OSHA)
Occupational Safety and Health Division
Office for Civil Rights (OCR)
Office of Diversion Control (DOJ-ODC)
Office of Inspector General (OIG)
Office of Labor Management & Standards (OLMS)
Office of the National Coordinator for Health Information Technology (ONC)
Securities & Exchange Commission (SEC)
State of California Department of Justice (Attorney General)
Substance Abuse and Mental Health Services Administration (SAMHSA)
The National Institute for Occupational Safety and Health (NIOSH)
Treasury (TREASURY)
US Congress (USC)
US State Department Office of Civil Rights (S/OCR)
Wage & Hour Division (WHD)

YouCompli
FROM CHAOS TO CONFIDENCE

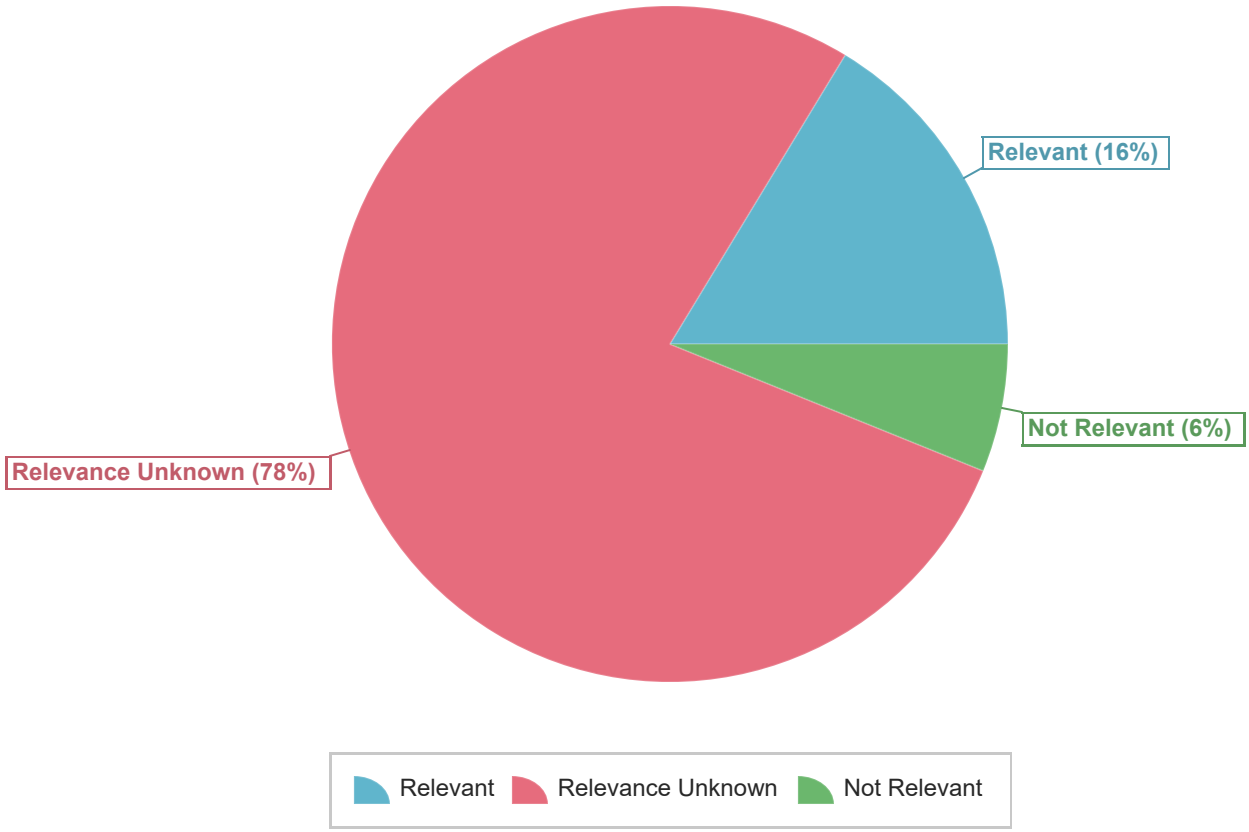
Requirement Status Overview by Month



Effective Date

Status	Jan-24	Feb-24	Mar-24	Apr-24	Jun-24	Jul-24	Oct-24	Dec-24	Jan-25	Total
Accepted	2	2		1	1	2	1		7	16
Assigned		1	1	2	1				1	6
Completed	18				1	1		1	12	33
In Progress	9		1	3		2		1	9	25
Total	29	3	2	6	3	5	1	2	29	80

Requirement Relevance Overview



Effective Dates : 09/01/2024 - 01/31/2025	
Requirement Total	196
Relevant	32
Not Relevant	12
Relevance Unknown	152

Examples of Regulatory Updates that are relevant and in progress in the YouCompli System:

Update Procedures Related to Licensing and Reporting Under the Health and Safety Code

Requirement ID #2180
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: In Progress, Status Date: 01/27/2025
Description: Organizations should update procedures related to licensing and reporting under the Health and Safety Code.
Regulation 2074 » Requirement 2180

Update Procedures for Determining Immediate Jeopardy

Requirement ID #2200
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/13/2024
Status: In Progress, Status Date: 01/27/2025
Description: Providers should update procedures to reflect updated requirements for determining immediate jeopardy.
Regulation 2146 » Requirement 2200

Update Procedures for Safeguarding Conscience Rights in Health Care

Requirement ID #1823
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 03/11/2024
Status: In Progress, Status Date: 12/19/2024
Description: Organizations should update procedures related to safeguarding conscience rights in health care.
Regulation 1777 » Requirement 1823

Update Procedures Related to the Execution of Informed Consent Forms Before Surgery and Sensitive Procedures

Requirement ID #1919
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 04/19/2024
Status: Accepted, Status Date: 12/13/2024
Description: Organization should update procedures to reflect revisions to the informed consent form example for surgical procedures and sensitive examinations.
Regulation 1873 » Requirement 1919

Update Procedures Related to Billing and Coding for MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing

Requirement ID #1989
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 07/01/2024
Status: Accepted, Status Date: 12/13/2024
Description: Organizations should update their procedures to reflect updated billing and coding guidance for MolDX: molecular syndromic panels for infectious disease pathogen identification testing.
Regulation 1943 » Requirement 1989

Update Procedures for Suicide Screenings in General Acute Care Hospitals

Requirement ID #1224
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures for suicide screenings in general acute care hospitals.
Regulation 1190 » Requirement 1224

Update Procedures Related to Earthquake Building Compliance

Requirement ID #2122
Risk Category: Capital and Facilities Management
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to earthquake building compliance.
Regulation 2072 » Requirement 2122

Update Procedures Related to Disclosure of HIV Records

Requirement ID #2123
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to the disclosure of HIV records.
Regulation 2073 » Requirement 2123

Update Procedures Related to Vital Records

Requirement ID #2124
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to vital records.
Regulation 2074 » Requirement 2124

Update Procedures Related to Tuberculosis Tests and Care

Requirement ID #2147
Risk Category: Clinical Care Delivery
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/16/2024
Description: Organizations should update procedures related to tuberculosis tests and care.
Regulation 2097 » Requirement 2147

Update Procedures Related to Hospitals Requirements to Submit Plans for Increasing Supplier Diversity

Requirement ID #1698
Risk Category: Supply Chain / Procurement
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2024
Status: Accepted, Status Date: 12/19/2024
Description: Organization should update procedures to reflect revisions to the requirements for hospitals to submit plans for increasing supplier diversity.
Regulation 1655 » Requirement 1698

Update Procedures Related to the Hospital Fair Billing Program

Requirement ID #1753
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2024
Status: Accepted, Status Date: 12/19/2024
Description: Organization should update procedures to reflect revisions to the hospital fair billing program.
Regulation 1708 » Requirement 1753

Update Procedures for Texting of Patient Information and Orders for Hospitals and CAHs

Requirement ID #1828
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 02/08/2024
Status: Accepted, Status Date: 12/19/2024
Description: Organizations should update procedures to reflect CMS' expectations regarding the texting of patient information and orders for hospitals and critical access hospitals.
Regulation 1782 » Requirement 1828

Update Procedures Related to Hybrid Hospital-Wide Inpatient Quality Reporting Program

Requirement ID #2193
Risk Category: Quality/Performance Improvement
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 12/30/2024
Description: Organization should update procedures to reflect revisions to the voluntary inpatient quality reporting program.
Regulation 2138 » Requirement 2193

Update Procedures for Human Leukocyte Antigen (HLA) Equivalency Tables

Requirement ID #2207
Risk Category: Transplant
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/05/2024
Status: Accepted, Status Date: 01/13/2025
Description: Organizations should revise their procedures regarding the Human Leukocyte Antigen (HLA) Equivalency tables.
Regulation 2153 » Requirement 2207

Update Procedures for Time-share and Leased Space Arrangements in Critical Access Hospitals (CAHs)

Requirement ID #2211
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 11/20/2024
Status: Accepted, Status Date: 01/17/2025
Description: Providers should update procedures regarding requirements for time-share and leased space arrangements in Critical Access Hospitals (CAHs).
Regulation 2157 » Requirement 2211

Update Procedures Regarding Health Data, Technology, and Interoperability: Protecting Care Access

Requirement ID #2221
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/17/2024
Status: Accepted, Status Date: 01/24/2025
Description: Organizations should update procedures regarding the Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability final rule (HTI–2 Rule).
Regulation 2167 » Requirement 2221

Copy of Update Procedures for CY 2025 Physician Fee Schedule Reporting and Returning Overpayments

Requirement ID #2224
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/27/2025
Description: Organizations should update procedures regarding the reporting and returning of overpayments.
Regulation 2126 » Requirement 2224

Update Procedures Related to Nonrecurring Policy Changes

Requirement ID #2187
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/27/2025
Description: Organization should update procedures to reflect revisions to nonrecurring policy changes.
Regulation 2134 » Requirement 2187

Update Procedures for Data Collection on Vascularized Composite Allografts (VCA) Living Donors

Requirement ID #2225
Risk Category: Transplant
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 12/11/2024
Status: Accepted, Status Date: 01/28/2025
Description: Organizations should update procedures regarding modifying data collection on vascularized composite allografts (VCA) living donors.
Regulation 2170 » Requirement 2225

Update Procedures for Health Data Information Sharing

Requirement ID #1805
Risk Category: Health Care Reform-Related Risks
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 02/08/2024
Status: Accepted, Status Date: 01/29/2025
Description: Organizations should update procedures and/or be aware of enhancements regarding information blocking regulations.
Regulation 1759 » Requirement 1805

Update Procedures for Confidentiality of Substance Use Disorder Patient Records Revisions

Requirement ID #1838
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 04/16/2024
Status: Accepted, Status Date: 01/29/2025
Description: Organizations should update procedures for the confidentiality of substance use disorder patient records.
Regulation 1792 » Requirement 1838

Update Procedures for HIPAA Privacy Rule and Reproductive Health Care

Requirement ID #1915
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 06/25/2024
Status: Accepted, Status Date: 01/29/2025
Description: Organizations should update procedures for HIPAA Privacy Rule changes that prohibit the disclosure of PHI related to lawful reproductive health care in certain circumstances.
Regulation 1869 » Requirement 1915

Update Procedures Related to ESRD Prospective Payment System (PPS) and Dialysis for AKI (CY) 2025

Requirement ID #2235
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/30/2025
Description: Organizations should update their procedures for ESRD PPS and dialysis services provided for AKI for CY 2025.
Regulation 2178 » Requirement 2235

Update Procedures Related to Nondiscrimination in Health Programs and Activities

Requirement ID #1932
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 07/05/2024
Status: Accepted, Status Date: 01/31/2025
Description: Organization should update procedures to reflect revisions to nondiscrimination in health programs and activities.
Regulation 1886 » Requirement 1932

Update Procedures Related to Nondiscrimination on the Basis of Disability in Health Programs and Activities

Requirement ID #1937
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 07/08/2024
Status: Accepted, Status Date: 01/31/2025
Description: Organization should update procedures to reflect revisions to nondiscrimination on the basis of disability in health programs and activities
Regulation 1891 » Requirement 1937

Update Procedures for Nondiscrimination in Health Programs or Activities

Requirement ID #479
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 08/18/2020
Status: Accepted, Status Date: 01/31/2025
Description: Organizations should update procedures to ensure that individuals are not discriminated against based on race, color, national origin, sex, age, or disability.
Regulation 457 » Requirement 479

Update Procedures for Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report Acute Respiratory Illnesses

Requirement ID #2141
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 10/22/2024
Status: Accepted, Status Date: 01/31/2025
Description: Organizations should update procedures regarding Condition of Participation (CoP) requirements for hospitals and Critical Access Hospitals (CAHs) to report acute respiratory illnesses.
Regulation 2091 » Requirement 2141

FYI - Calendar Year (CY) 2025 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Requirement ID #2238
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/31/2025
Description: CMS has updated the CY 2025 clinical laboratory fee schedule and laboratory services subject to reasonable charge payment.
Regulation 2181 » Requirement 2238

FYI - Billing for Care Coordination Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Requirement ID #2239
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 01/31/2025
Description: CMS has updated the billing for care coordination services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).
Regulation 2182 » Requirement 2239

Update Procedures for Designation of Pharmacist-In-Charge

Requirement ID #2240
Risk Category: Compliance and Regulatory
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 04/01/2025
Status: Accepted, Status Date: 02/03/2025
Description: Organizations should update procedures for revised pharmacist-in-charge-requirements at pharmacies.
Regulation 2183 » Requirement 2240

FYI - Calendar Year 2025 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Requirement ID #2242
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 02/03/2025
Description: CMS has updated the calendar year 2025 DMEPOS fee schedule.
Regulation 2185 » Requirement 2242

Update Procedures for Implementation of ESRD Prospective Payment System (PPS) and Dialysis for Individuals with AKI (CY) 2025

Requirement ID #2253
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 02/05/2025
Description: Organizations should update their procedures for ESRD PPS and dialysis services provided for individuals with acute kidney injury (AKI).
Regulation 2196 » Requirement 2253

Update Procedures Regarding Billing Requirements for Intensive Outpatient Program (IOP) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Requirement ID #2256
Risk Category: Revenue Cycle
Risk Profile:
Assigned By: Patty Dickson
Assigned To: Patty Dickson
Effective Date: 01/01/2025
Status: Accepted, Status Date: 02/05/2025
Description: Organizations should revise their procedures to reflect the billing requirements for Intensive Outpatient Programs (IOP) when up to 3 services are provided, as well as when 4 or more IOP services are performed.
Regulation 2199 » Requirement 2256

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150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

Date: 02/09/2025
To: Board of Directors
From: J. Adam Hawkins, DO Chief Medical Officer
Re: CMO Report

Medical Staff Department update

Project Updates:

BETA Heart:

January marked the beginning of NIHD's journey towards implementing a Culture of Safety using Just Culture principles as part of the BETA HEART program. This required a tremendous amount of coordination and effort across many different departments throughout our organization to ensure we were prepared. I am very proud to be serving as the Executive Lead for NIHD's pursuit of validation of all 5 domains associated with BETA HEART. This is a multi-year pursuit that is one of the pillars of our new strategic plan. The following is a brief synopsis of the work completed by our leadership team and staff up to this point:

1.)Readiness Assessment:
The purpose of the readiness assessment is to help our organization understand its level of readiness to initiate and continue BETA HEART, a comprehensive approach designed to reduce harm in healthcare and support patients, family members and clinicians after an adverse event. Subsequently, the assessment will be completed annually to help the BETA HEART team that is supporting NIHD understand how our organization is progressing as we continue implementing HEART. The assessment is a short series of questions designed to gather initial perspectives from leaders and staff. Our HEART team informed me that we far exceeded the required number of respondents which will allow for an accurate assessment of our organizations baseline.

2.) GAP Analysis and In-person Focus Group Session:
A Gap Analysis was completed as part of our onboarding after opting into BETA HEART. The purpose is to assist our team in understanding the current perspectives

and perceptions of key stakeholders as they relate to the organization's safety, transparency and culture. This will allow our team to better customize an approach to the implementation of HEART that is sensitive to our organization's specific needs.

The first step in this process included an extensive review of our organizations internal documents, bylaws, policies, and procedures. This was followed by an in person visit from our BETA HEART team leads who conducted focus group sessions with varying groups within our organization, including a few members of our Board of Directors. Approximately two to four weeks after the focus group sessions, BETA will report findings and recommendations to our executive leadership team. The report is intended to help NIHD recognize and respond to potential barriers to the successful implementation of HEART. Findings are intended to guide the development and operationalization of initial implementation action plans, targeted education, and consensus building.

3.) An Annual Culture of Safety Survey (SCORE Survey):
All HEART members are required to administer, on an annual basis, a culture of safety survey. Our Quality Department has completed the internal mapping process for our organization which will allow for us to be ready for the survey go-live date of February 24, 2025. This survey will serve as our organizations baseline as we progress through the HEART program for years to come.

4.) BETA HEART Workshops:
As part of the HEART program, BETA hosts three Workshops per year where 2 of the 5 domains will be discussed. The first of these workshops is taking place February 23 - 24 in Pasadena, CA. This workshop will focus on learning the importance of measuring organizational culture and debriefing results with frontline staff and how to cultivate a culture of fairness and accountability. Members will also learn about developing a systematic response to adverse events that includes a timely response, effective initial management and systems-based analysis informed by an understanding of human factors. NIHD will be well represented during this workshop as the following leaders plan on attending; Allison Partridge CNO/COO, Adam Hawkins CMO, Alison Murray CHRO, Patty Dickson Compliance Officer, and Ali Feinberg Quality Department Manager.

Anesthesia Staffing:

NIHD has seen steady increase in our surgical volumes, epidurals for laboring women, and births over the past year. As a result of this overall encouraging trend, our Anesthesia provider staffing model required reimagining. We have historically relied on a two anesthesia provider model. One of the Anesthesiologists would take on the "day provider" role and provide coverage for our elective surgical cases. The other Anesthesiologist would assume the "call provider" roll and be

available for any emergent procedural needs. However, due to the recent increase in surgical volumes this “call provider” would often be providing coverage for elective cases during the day and taking call at night, an unsustainable workload for our physicians.

To mitigate the hardships of the existing model as a result of the increase in surgical volumes, have been engaged in discussions with Dr. Ted Rasoumoff and Dr. Paul Kim, our two full-time local anesthesiologists, to expand weekday anesthesia coverage. This will allow for a more sustainable workload and ultimately improve both the quality and safety of the care for our patients. In the coming months, we will be moving to a three Anesthesiologist model Monday - Thursday where we will have two dedicated “day providers” and a dedicated “call provider.” An additional benefit of this staffing model will include more redundancy in our backup coverage which will prevent last minute cancellations of elective cases due to provider illness or emergency.

The administrative team at NIHD is proud to stand behind Dr. Rasoumoff and Dr. Kim as we work together to solidify the Anesthesia staffing model at The District. The patients, clinical staff, and surgeons at NIHD have benefited tremendously from the stability that Dr. Kim and Dr. Rasoumoff have brought to this vital department. Without their professional leadership, commitment to clinical excellence, and collaborative style, it is unlikely our surgical volumes would have seen the growth that has prompted the need for expanded anesthesia coverage.

Health Lifestyle Talks:

After a short hiatus over the Holidays, we will resume our NIHD Health Lifestyle Talks series. These will consist of a mix of in person and virtual talks administered from our providers touching on broad topics that most affect our communities health. These talks are meant to be informative and also allow a chance for our community to interact with our providers while diving deep into health-related topics. We will be posting the speakers and topics in the coming weeks.

Physician Recruitment Update:

There is a lot to be excited about regarding medical staff recruitment. Many of the current recruitment efforts we are participating in are not ready for discussion at a public meeting. However, I am encouraged that our already dynamic and highly qualified medical staff will continue to grow throughout the New Year. As always, my priorities in physician recruitment include findings qualified providers that fit a clinical community need, represent our organizational values, and drive fiscal sustainability. I hope to have updates that are appropriate for open session in the near future!

Quality Department Update:

Cancer Screening:

As part of our recently adopted strategic plan, The District has committed to increase screening rates for colorectal, breast, and cervical cancer by 10% year over year. This goal was created based on data derived from the 2022 NIHD Community Needs Assessment which found Cancer to be the 5th most important health priority and 2nd leading cause of health-related mortality amongst Inyo County residents.

In an effort to increase cervical, colorectal, and breast cancer screening rates amongst our community members, we have recently rolled out several new initiatives, targeting outreach and streamlined workflows. Most cancer screenings occur or originate at a patient's annual wellness visit, when they meet with their primary care provider (PCP) and review risk factors and appropriate levels of screening. In 2025 we have begun notifying patients via text messages when they are coming due for their annual wellness exams. Getting patients scheduled and through the door is the first steps in being able to ensure they are up to date on their cancer screenings. These messages will be sent out monthly to the patients who are coming due for appointments that month.

Once a patient is scheduled for an appointment, the Rural Health Clinic (RHC) has implemented an automated daily provider "huddle sheet." Each patient that is scheduled for the day appears on the provider "huddle sheet", which pulls pertinent clinical information about the patients from the electronic health record (EHR) into an easy to use format, which then helps the care team prepare for the patient's visit. This sets our providers up to ensure that no opportunities for cancer screenings or other important screenings are overlooked during the patient's visit.

We will be collecting data on cancer screening rates, and as the new outreach and information efforts are underway which will allow us to see if our efforts are driving an improvement in our performance as a District.

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150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

Date: February 2025
To: Board of Directors
From: Andrea Mossman, Chief Financial Officer
Re: Quarterly Accounting Office Report

Projects

1. 1099 tax forms were submitted to the IRS and vendors by the January 31, 2025 deadline.
2. W2 forms were provided to employees by the January 31, 2025 deadline.
3. The Ludi Physician Compensation Tool is a mobile application set to go live on April 1, 2025. This application will enable providers to log time, ensure contract compliance, track approvals, calculate payments, and generate reports for both providers and administration. By streamlining workflows, it enhances efficiency while strengthening contract compliance controls.
4. We are actively automating tasks within our accounting software, MultiView, to enhance the accuracy and timeliness of statistics and reports. One such initiative, Payroll 360, will integrate payroll financial and statistical data into the ledger, providing leaders with greater reporting capabilities and transparency.
5. The FYE 2024 Medicare Cost Report was submitted in November 2024 and will be amended upon completion of the audit.
6. We continually work on audits with Medicare and the state on prior cost and financial reports.
7. We are actively recruiting for key accounting positions to support the timely and accurate preparation of financial statements and audits.
8. Our audit firm's outsourced department is providing an average of 20 hours per week of accounting support to address the backlog. This assistance will help ensure we are caught up by June 30th, facilitating a more timely audit.

9. Due to internal staffing challenges and the audit firm's peak season, the audit is delayed. However, we are working diligently with the firm to complete it as soon as possible.

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150 Pioneer Lane
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Date: February 2025
To: Board of Directors
From: Neill Lynch, Purchasing Director
Re: Quarterly Purchasing and Clinical Engineering Report

Purchasing Department

1. IV solution shortage mitigation is complete, and incident command has closed. However, we will continue to monitor the situation.
2. Negotiations for the Ortho Clinical Diagnostics chemistry analyzer are complete. Equipment receipt and installation are tentatively scheduled with project management.
3. Disaster preparedness, and Personal Protective Equipment (PPE) subcommittee tasks received. PPE has been inventoried, and recommendations have been submitted to the NIHD Disaster Preparedness Team.

Clinical Engineering

1. Completed standard break/fix activities.
2. Completed scheduled preventative maintenance for ICU, Surgery, PACU, Pediatrics, Specialty Clinic, and Lab Blood Bank.
3. Current project management activities include
    a. Nuclear Medicine UPS fix
    b. Mammo/Stereo equipment decommission and installation

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150 Pioneer Lane
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Date: February 2025
To: Board of Directors
From: Janai Lind, Director of Revenue Cycle & Tanya De Leo, Director of Patient Access
Re: Quarterly Revenue Cycle Report

Revenue Cycle Updates: Projects

1. Jorie AI went live on February 1, 2025, for a portion of billing, with plans to expand into additional areas throughout the year. This project will automate and streamline processes across authorizations, eligibility reviews, billing, and cash posting, resulting in improved cash collections and reduced AR days.
2. ADHC Underpayment Recovery has initiated its analysis, utilizing the healthcare industry's most advanced forensic audit system. Their proprietary software and payer contract experts perform a forensic analysis on each remittance from the past 12-24 months to assess contractual compliance. They collaborate with payers to recover underpayments, typically recovering 10%-20% of collections.
3. Healthcare Reimbursement Solutions (HRS) is preparing Medicare Bad Reports for FY20-23 to amend the Cost Reports and recover additional funds.
4. Upfront collections began in late January 2025, increasing collections at the time of service, improving the overall collections rate, and reducing vendor costs.
    a. We collected over $50,000 in January 2025, $18,000 more than last year, and twice as much as in January 2024.
    b. In February 2025's first five business days, we've collected over $21,000, surpassing February 2024's total.

Business Office: January 2025 statistics and changes from November 2024

1. Gross AR Days are at 75, a slight increase from previous months but a 15-day improvement compared to January 2024 (90 days). This increase was due to the termination of the Medicare and Managed Care vendor, which impacted work quality.

We are making progress toward our goal of 60 days.

2. The percentage of AR over 90 days is 39%, down from 44% in December 2024 and 50% in January 2024. We are making progress toward our goal of 15%.
3. Discharged not final billed (DNFB) is $6.9M (11 days), down from $7.5M (12 days) in December 2024 and $8.6M (14 days) in January 2024. We are making progress toward our goal of 8 days.
4. Gross denials were 21% in January 2025, down from 24% in December 2024 and 42% in January 2024. We are making progress toward our goal of 10%.

Patient Access: Update

1. In addition to upfront cash collection training, we are implementing customer service training across all areas.
2. We are updating the internal price estimator tool in collaboration with Experian to load current prices and payer contracts, ensuring accurate out-of-pocket estimates for patients.
3. We are also working on interfacing with Valley Health and Toiyabe Health to electronically send orders to NIHD.
4. Pediatric Patient Access is collaborating with Quality on Well Child Checks campaigns using I2I.
    a. I2I is a data integration and analytics portal that offers a comprehensive patient view with actionable insights into user-centered workflows for outreach tasking, and care coordination.

1. Artera, the patient text reminder system, is running smoothly, with ongoing process improvements based on patient feedback.

NORTHERN INYO HEALTHCARE DISTRICT
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DATE: February 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights as of December 2024

Financial Summary

1. Net Income: December's net income was $5.9M, which was $4.9M higher than last December. This was due to accruals for rate range IGT of $9M. For the year, net income was at $7.3M due to favorable IGT compared to this time last year.
2. Operating Income: December's operating loss was $(3.3M), which was lower than last year due to lower net revenue and higher expenses. This was due to lower volumes along with increased labor costs. For the year, operating loss was higher than last year by $(4M) due to higher write-off rates, primarily Medicare and Medicare Advantage along with slightly higher expenses.
3. EBIDA: December's EBIDA was favorable by $6.3M due to timing of IGT. For the year, EBIDA was favorable by $9.9M.
4. Revenue Breakdown: December's volume and revenue was lower for most areas including admissions, surgeries, clinics, and ER visits. For the year, gross revenue is higher by 5% due to increased volumes in most areas but net revenue is lower due to higher write-off rates, primarily in Medicare and Medicare Advantage.

Deductions Summary

1. Contractual Adjustments: Contractual discounts were lower for the month due to volume but higher as a % of gross revenue due to higher write-off rates. For the year, deductions as a % of gross revenue is in line with budget at 47%.
2. Bad Debt: For December, bad debt declined due to AR >270 days declining.
3. Write-offs: Other write-offs were higher than prior year and budget due to aged AR cleanup.

Salaries

1. Per Adjusted Patient Day / Adjusted Employee per Occupied Bed (Adjusted EPOB): For December and year-to-date, wages per patient were lower than last year due to higher volume in the outpatient setting.
2. Total Salaries: For December and year-to-date, wages were higher due to higher pay rate and increase employed FTEs.
3. Average Hourly Rate: Average hourly rate was lower than budget and up 3% compare to last year due to merits.

Benefits

1. Total Benefits: For December and year-to-date, benefits were lower due to reduced medical, dental vision, and federal taxes.
2. Benefits % of Wages: For the year, we were at 43% of wages, which was lower than prior year by (16%).

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For the year, we were (28%) under budget and (18%) under prior year-to-date. This was due to higher volume meaning we were more productive.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For December, we were (3%) lower than budget. For the year, we were lower than budget and prior year. This was due to benefit costs declining. For the year, we were at 51% and our goal was 50%.

Contract Labor

1. Contract Labor Expense: For the year, contract labor was 11% higher due to staffing challenges and rates higher than planned.
2. Contract Labor Rates: Rates are higher than budgeted by 52%. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor is (5%) lower than prior year.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were (8%) under budget and (16%) under prior year-to-date.
2. Supplies: For the year, supplies were lower than prior year-to-date due to lower pharmacy costs.

3. Total Expenses: For the year, expenses were under budget by (4%) yet 1% higher than prior year. This was due to higher wage costs for increase FTEs and wage rates.

Stats Summary

1. Admits (excluding Nursery): For December, admits were (9%) lower due to less surgeries. For the year, admits were 7% higher due to higher deliveries and medical admits.
2. Inpatient Days (excluding Nursery): For December, inpatient days increased 8%. For the year, inpatient days increased 22%.
3. Average Daily Census: Average census increased 22% compared to last year-to-date.
4. Average Length of Stay (ALOS): Average length of stay increased 14% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 13% higher than last year-to-date.
6. Surgical Procedures: For December, surgeries were (15%) under prior year due to general and orthopedics. For the year, surgical procedures were flat with increases in general, urology and cardiology offsetting with decreases in orthopedics, ophthalmology, and gynecology.
7. Emergency Department (ED) Visits: Emergency visits were lower by (5%) compared to last December yet higher than last year-to-date by 2% leading to higher medical admits.
8. Diagnostic Imaging (DI) Exams: For the month and the year-to-date, DI exams were higher by 3%.
9. Rehab Visits: Rehab visits were up 56% compared to last year-to-date due to better staffing and corrected billing issues.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were up 55% compared to last year-to-date.
11. Observation Hours: Observations hours were down (18%) compared to last year-to-date due to change in observation methodology in the women and surgical service lines.
12. Rural Health Clinic (RHC) Visits: For December, RHC was down (6%) and was flat to prior year-to-date.
13. Other Clinics: For the year, all clinics increased 14% due to new providers.

Northern Inyo Healthcare District

December 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Net Income (Loss)	5,868,595	(788,680)	6,657,275	(844%)	1,000,942	4,867,653	(486%)	7,319,134	(5,313,592)	12,632,726	238%	1,640,740	5,678,394	346%
Operating Income (Loss)	(3,343,933)	(1,070,650)	(2,273,284)	212%	654,759	(3,998,692)	611%	(3,699,864)	(7,078,937)	3,379,074	48%	(677,579)	(3,022,285)	446%
EBIDA (Loss)	6,277,759	(425,102)	6,702,861	(1,577%)	1,345,271	4,932,487	(367%)	9,869,997	(3,132,124)	13,002,121	415%	3,641,416	6,228,582	171%
IP Gross Revenue	2,658,147	3,508,170	(850,024)	(24%)	3,205,729	(547,583)	(17%)	21,371,274	21,457,501	(86,227)	(0%)	20,472,650	898,624	4%
OP Gross Revenue	12,983,214	14,511,663	(1,528,449)	(11%)	13,872,841	(889,626)	(6%)	85,995,521	86,499,931	(504,410)	(1%)	82,278,926	3,716,595	5%
Clinic Gross Revenue	1,632,767	1,737,292	(104,525)	(6%)	1,672,912	(40,145)	(2%)	10,450,186	9,985,986	464,200	5%	9,366,419	1,083,767	12%
Total Gross Revenue	**17,274,128**	**19,757,125**	**(2,482,997)**	**(13%)**	**18,751,482**	**(1,477,354)**	**(8%)**	**117,816,981**	**117,943,418**	**(126,437)**	**(0%)**	**112,117,995**	**5,698,986**	**5%**
Net Patient Revenue	**6,693,130**	**9,001,163**	**(2,308,033)**	**(26%)**	**9,569,687**	**(2,876,556)**	**(30%)**	**54,112,572**	**53,365,158**	**747,414**	**1%**	**56,593,655**	**(2,481,083)**	**(4%)**
Cash Net Revenue % of Gross	*39%*	*46%*	*(7%)*	*(15%)*	*51%*	*(12%)*	*(24%)*	*46%*	*45%*	*1%*	*2%*	*50%*	*(5%)*	*(9%)*
Admits (excl. Nursery)	62	68	(6)	(9%)	68	(6)	(9%)	434	406	28	7%	406	28	7%
IP Days	212	202	10	5%	202	10	5%	1,536	1,230	306	25%	1,230	306	25%
IP Days (excl. Nursery)	180	166	14	8%	166	14	8%	1,314	1,080	234	22%	1,080	234	22%
Average Daily Census	5.8	5.4	0.4	8%	5.4	0.4	8%	7.1	5.9	1.3	22%	5.9	1.3	22%
ALOS	2.9	2.4	0.5	19%	2.4	0.5	19%	3.0	2.7	0.4	14%	2.7	0.4	14%
Deliveries	21	18	3	17%	18	3	17%	111	98	13	13%	98	13	13%
OP Visits	3,887	3,301	586	18%	3,301	586	18%	23,117	20,356	2,761	14%	20,356	2,761	14%
Rural Health Clinic Visits	2,233	2,549	(316)	(12%)	2,549	(316)	(12%)	13,709	14,297	(588)	(4%)	14,297	(588)	(4%)
Rural Health Women Visits	505	411	94	23%	411	94	23%	3,116	2,751	365	13%	2,751	365	13%
Rural Health Behavioral Visits	202	158	44	28%	158	44	28%	1,144	979	165	17%	979	165	17%
Total RHC Visits	**2,940**	**3,118**	**(178)**	**(6%)**	**3,118**	**(178)**	**(6%)**	**17,969**	**18,027**	**(58)**	**(0%)**	**18,027**	**(58)**	**(0%)**
Bronco Clinic Visits	38	36	2	6%	36	2	6%	213	141	72	51%	141	72	51%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	265	293	(28)	(10%)	293	(28)	(10%)	2,139	2,072	67	3%	2,072	67	3%
Pediatric Clinic Visits	505	640	(135)	(21%)	640	(135)	(21%)	3,546	3,698	(152)	(4%)	3,698	(152)	(4%)
Specialty Clinic Visits	513	302	211	70%	302	211	70%	3,274	2,075	1,199	58%	2,075	1,199	58%
Surgery Clinic Visits	133	137	(4)	(3%)	137	(4)	(3%)	931	744	187	25%	744	187	25%
Virtual Care Clinic Visits	50	50	-	-%	50	-	-%	351	254	97	38%	254	97	38%
Total NIA Clinic Visits	**1,504**	**1,458**	**46**	**3%**	**1,458**	**46**	**3%**	**10,454**	**9,185**	**1,269**	**14%**	**9,185**	**1,269**	**14%**
IP Surgeries	5	20	(15)	(75%)	20	(15)	(75%)	71	131	(60)	(46%)	131	(60)	(46%)
OP Surgeries	117	123	(6)	(5%)	123	(6)	(5%)	791	730	61	8%	730	61	8%
Total Surgeries	**122**	**143**	**(21)**	**(15%)**	**143**	**(21)**	**(15%)**	**862**	**861**	**1**	**0%**	**861**	**1**	**0%**
Cardiology	1	-	1	-%	-	1	100%	4	1	3	300%	1	3	300%
General	58	72	(14)	(19%)	72	(14)	(19%)	425	382	43	11%	382	43	11%
Gynecology & Obstetrics	13	17	(4)	(24%)	17	(4)	(24%)	71	97	(26)	(27%)	97	(26)	(27%)
Ophthalmology	28	22	6	27%	22	6	27%	134	149	(15)	(10%)	149	(15)	(10%)
Orthopedic	9	25	(16)	(64%)	25	(16)	(64%)	145	170	(25)	(15%)	170	(25)	(15%)
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Podiatry	1	-	1	-%	-	1	-%	3	1	2	200%	1	2	200%
Urology	12	7	5	71%	7	5	71%	78	61	17	28%	61	17	28%
Diagnostic Image Exams	1,955	1,899	56	3%	1,899	56	3%	12,532	12,215	317	3%	12,215	317	3%
Emergency Visits	789	833	(44)	(5%)	833	(44)	(5%)	5,192	5,098	94	2%	5,098	94	2%
ED Admits	36	30	6	20%	30	6	20%	252	177	75	42%	177	75	42%
ED Admits % of ED Visits	5%	4%	1%	27%	4%	1%	27%	5%	3%	1%	40%	3%	1%	40%
Rehab Visits	740	547	193	35%	547	193	35%	5,199	3,334	1,865	56%	3,334	1,865	56%
OP Infusion/Wound Care Visits	732	285	447	157%	285	447	157%	2,725	1,756	969	55%	1,756	969	55%
Observation Hours	1,239	2,669	(1,430)	(54%)	2,669	(1,430)	(54%)	9,536	11,686	(2,150)	(18%)	11,686	(2,150)	(18%)

Provided by: Chief Financial Officer
Report Name: November 2024 Financial Summary

Northern Inyo Healthcare District

December 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PAYOR MIX														
Blue Cross	20.6%	21.3%	(0.7%)	(3.1%)	21.3%	(0.7%)	(3.1%)	25.4%	18.5%	7.0%	37.8%	18.5%	7.0%	37.8%
Commercial	10.0%	1.5%	8.5%	570.1%	1.5%	8.5%	570.1%	6.2%	3.3%	2.9%	89.3%	3.3%	2.9%	89.3%
Medicaid	34.2%	33.7%	0.5%	1.6%	33.7%	0.5%	1.6%	26.9%	25.6%	1.3%	5.1%	25.6%	1.3%	5.1%
Medicare	34.2%	41.6%	(7.3%)	(17.7%)	41.6%	(7.3%)	(17.7%)	39.0%	49.0%	(9.9%)	(20.3%)	49.0%	(9.9%)	(20.3%)
Self-pay	1.0%	2.0%	(1.0%)	(49.3%)	2.0%	(1.0%)	(49.3%)	1.8%	3.2%	(1.4%)	(42.5%)	3.2%	(1.4%)	(42.5%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	0.6%	0.4%	0.2%	45.9%	0.4%	0.2%	45.9%
Other	-%	-%	-%	-%	-%	-%	-%	-%	0.1%	(0.1%)	(100.0%)	0.1%	(0.1%)	(100.0%)
DEDUCTIONS														
Contract Adjust	(8,575,086)	(9,512,631)	937,545	(10%)	(8,812,993)	237,906	(3%)	(57,189,971)	(56,903,563)	(286,408)	1%	(48,775,755)	(8,414,215)	17%
Bad Debt	(526,905)	(656,523)	129,618	(20%)	(20,311)	(506,594)	2,494%	(1,180,267)	(4,164,470)	2,984,203	(72%)	(3,983,142)	2,802,876	(70%)
Write-off	(1,479,007)	(586,809)	(892,198)	152%	(350,060)	(1,128,947)	323%	(5,185,989)	(3,510,227)	(1,675,761)	48%	(2,768,397)	(2,417,592)	87%
CENSUS														
Patient Days	180	166	14	8%	166	14	8%	1,314	1,080	234	22%	1,080	234	22%
Adjusted ADC	38	31	6	20%	31	6	20%	40	32	7	23%	32	7	23%
Adjusted Days	1,169	971	198	20%	971	198	20%	7,245	5,915	1,330	22%	5,915	1,330	22%
Employed FTE	367.9	346.6	21.3	6%	346.6	21.3	6%	363.2	354.1	9.1	3%	354.1	9.1	3%
Contract Labor FTE	26.1	26.1	0.0	0%	26.1	0.0	0%	24.2	25.4	(1.3)	(5%)	25.4	(1.3)	(5%)
Total Paid FTE	394.0	372.8	21.3	6%	372.8	21.3	6%	387.4	379.5	7.9	2%	379.5	7.9	2%
EPOB (Employee per Occupied Bed)	2.2	2.2	(0.1)	(2%)	2.2	(0.1)	(2%)	1.7	2.1	(0.3)	(16%)	2.1	(0.3)	(16%)
EPOC (Employee per Occupied Case)	0.3	0.4	(0.0)	(12%)	0.4	(0.0)	(12%)	0.1	0.1	(0.0)	(17%)	0.1	(0.0)	(17%)
Adjusted EPOB	14.2	13.1	1.1	8%	13.1	1.1	8%	9.6	11.4	(1.8)	(16%)	11.4	(1.8)	(16%)
Adjusted EPOC	2.2	2.2	(0.1)	(3%)	2.2	(0.1)	(3%)	0.3	0.4	(0.1)	(17%)	0.4	(0.1)	(17%)
SALARIES														
Per Adjust Bed Day	3,132	3,648	(516)	(14%)	3,402	(270)	(8%)	2,860	3,567	(708)	(20%)	3,317	(458)	(14%)
Total Salaries	3,659,647	3,541,704	117,943	3%	3,303,307	356,340	11%	20,718,045	21,100,139	(382,094)	(2%)	19,621,350	1,096,695	6%
Average Hourly Rate	56.15	57.68	(1.52)	(3%)	53.79	2.36	4%	54.25	56.67	(2.42)	(4%)	52.70	1.55	3%
Employed Paid FTEs	367.9	346.6	21.3	325.4	346.6	21.3	6%	363.2	354.1	9.1	3%	354.1	9.1	3%
BENEFITS														
Per Adjust Bed Day	1,437	2,139	(702)	(33%)	1,289	148	11%	1,230	2,101	(872)	(41%)	1,698	(468)	(28%)
Total Benefits	1,678,868	2,076,763	(397,896)	(19%)	1,251,579	427,288	34%	8,910,177	12,429,103	(3,518,925)	(28%)	10,041,923	(1,131,746)	(11%)
Benefits % of Wages	46%	59%	(13%)	(22%)	38%	8%	21%	43%	59%	(16%)	(27%)	51%	(8%)	(16%)
Pension Expense	380,455	498,151	(117,696)	(24%)	500,532	(120,077)	(24%)	2,425,606	2,987,968	(562,362)	(19%)	2,620,712	(195,106)	(7%)
MDV Expense	1,018,880	748,612	270,268	36%	577,237	441,643	77%	4,661,954	4,491,672	170,282	4%	5,728,435	(1,066,481)	(19%)
Taxes, PTO accrued, Other	279,532	830,001	(550,468)	(66%)	173,810	105,722	61%	1,822,617	4,949,462	(3,126,845)	(63%)	1,692,776	129,841	8%
Salaries, Wages & Benefits	5,338,515	5,618,467	(279,952)	(5%)	4,554,886	783,628	17%	29,628,222	33,529,242	(3,901,019)	(12%)	29,663,273	(35,051)	(0%)
SWB/APD	4,568	5,786	(1,218)	(21%)	4,691	(123)	(3%)	4,090	5,669	(1,579)	(28%)	5,015	(926)	(18%)
SWB % of Total Expenses	53%	56%	(3%)	(5%)	51%	2%	4%	51%	55%	(4%)	(8%)	52%	(1%)	(1%)

Provided by: Chief Financial Officer
Report Name: November 2024 Financial Summary

Northern Inyo Healthcare District

December 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,281	2,244	37	2%	2,365	(83)	(4%)	2,082	2,262	(180)	(8%)	2,466	(384)	(16%)
Total Physician Fee	1,498,281	1,463,822	34,459	2%	1,416,488	81,793	6%	9,280,455	8,781,334	499,122	6%	8,893,390	387,065	4%
Total Contract Labor	672,468	299,933	372,535	124%	508,486	163,982	32%	3,024,285	2,096,353	927,932	44%	2,719,574	304,711	11%
Total Other Pro-Fees	495,336	415,366	79,970	19%	371,274	124,062	33%	2,777,399	2,500,734	276,666	11%	2,972,108	(194,709)	(7%)
Total Professional Fees	2,666,085	2,179,121	486,964	22%	2,296,248	369,837	16%	15,082,140	13,378,420	1,703,720	13%	14,585,072	497,067	3%
Contract AHR	145.23	64.84	80.39	124%	109.93	35.30	32%	119.08	78.48	40.60	52%	101.81	17.27	17%
Contract Paid FTEs	26.1	26.1	0.0	0%	26.1	0.0	0%	24.2	25.4	(1.3)	(5%)	25.4	(1.3)	(5%)
Physician Fee per Adjust Bed Day	1,282	1,508	(225)	(15%)	1,459	(177)	(12%)	1,281	1,485	(204)	(14%)	1,504	(223)	(15%)
PHARMACY														
Per Adjust Bed Day	382	475	(94)	(20%)	483	(101)	(21%)	292	468	(176)	(38%)	442	(150)	(34%)
Total Rx Expense	446,090	461,460	(15,369)	(3%)	468,935	(22,845)	(5%)	2,115,136	2,768,758	(653,621)	(24%)	2,615,189	(500,052)	(19%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	298	441	(142)	(32%)	350	(52)	(15%)	390	435	(45)	(10%)	478	(88)	(18%)
Total Medical Supplies	348,696	427,743	(79,047)	(18%)	340,164	8,532	3%	2,826,835	2,573,899	252,937	10%	2,829,649	(2,813)	(0%)
EHR SYSTEM														
Per Adjust Bed Day	10	139	(129)	(92%)	173	(163)	(94%)	28	137	(109)	(80%)	121	(93)	(77%)
Total EHR Expense	12,263	135,000	(122,737)	(91%)	168,118	(155,855)	(93%)	200,001	810,000	(609,999)	(75%)	715,877	(515,875)	(72%)
OTHER EXPENSE														
Per Adjust Bed Day	698	913	(214)	(23%)	764	(66)	(9%)	747	880	(133)	(15%)	822	(75)	(9%)
Total Other	816,251	886,444	(70,193)	(8%)	742,246	74,005	10%	5,409,237	5,202,310	206,928	4%	4,861,498	547,739	11%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	350	374	(24)	(6%)	355	(4)	(1%)	352	369	(17)	(5%)	338	14	4%
Total Depreciation and Amortization	409,164	363,578	45,586	13%	344,330	64,834	19%	2,550,863	2,181,468	369,395	17%	2,000,676	550,187	28%
TOTAL EXPENSES	10,037,064	10,071,813	(34,749)	(0%)	8,914,928	1,122,136	13%	57,812,436	60,444,096	(2,631,660)	(4%)	57,271,234	541,202	1%
Per Adjust Bed Day	8,589	10,373	(1,784)	(17%)	9,181	(592)	(6%)	7,980	10,219	(2,239)	(22%)	9,683	(1,703)	(18%)
Per Calendar Day	323,776	324,897	(1,121)	(0%)	287,578	36,198	13%	314,198	328,501	(14,303)	(4%)	311,257	2,941	1%

Provided by: Chief Financial Officer
Report Name: November 2024 Financial Summary

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	12/31/2024	Dec Budget	12/31/2023	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue								
Inpatient Patient Revenue	2,658,147	3,508,170	3,205,729	21,371,274	20,472,650	(850,024)	(547,583)	898,624
Outpatient Revenue	12,983,214	14,511,663	13,872,841	85,995,521	82,278,926	(1,528,449)	(889,626)	3,716,595
Clinic Revenue	1,632,767	1,737,292	1,672,912	10,450,186	9,366,419	(104,525)	(40,145)	1,083,767
Gross Patient Service Revenue	17,274,128	19,757,125	18,751,482	117,816,981	112,117,995	(2,482,997)	(1,477,354)	5,698,986
Deductions from Revenue						-		-
Contractual Adjustments	(8,575,086)	(9,512,631)	(8,812,993)	(57,189,971)	(48,775,755)	937,545	237,906	(8,414,215)
Bad Debt	(526,905)	(656,523)	(20,311)	(1,180,267)	(3,983,142)	129,618	(506,594)	2,802,876
A/R Writeoffs	(1,479,007)	(586,809)	(350,060)	(5,185,989)	(2,768,397)	(892,198)	(1,128,947)	(2,417,592)
Other Deductions from Revenue	-	-	-	(152,618)	-	-	-	(152,618)
Deductions from Revenue	(10,580,998)	(10,755,962)	(9,183,363)	(63,708,844)	(55,527,295)	174,965	(1,397,635)	(8,181,549)
Other Patient Revenue								-
Incentive Income	-	-	-	2,000	-	-	-	2,000
Other Oper Rev - Rehab Thera Serv	-	-	1,568	2,435	2,955	-	(1,568)	(520)
Medical Office Net Revenue	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	1,568	4,435	2,955	-	(1,568)	1,480
Net Patient Service Revenue	**6,693,130**	**9,001,163**	**9,569,687**	**54,112,572**	**56,593,655**	**(2,308,033)**	**(2,876,556)**	**(2,481,083)**
CNR%	**38.7%**	**45.6%**	**51.0%**	**45.9%**	**50.5%**	**-6.8%**	**-12.3%**	**-4.5%**
Cost of Services - Direct								-
Salaries and Wages	3,119,241	3,018,714	2,811,390	17,505,564	16,849,538	100,527	307,851	656,026
Benefits	1,445,404	1,787,968	1,069,389	7,615,781	8,591,399	(342,564)	376,014	(975,618)
Professional Fees	1,757,982	1,657,078	1,648,663	10,715,297	10,463,087	100,904	109,318	252,210
Contract Labor	366,331	163,390	422,431	2,397,811	2,419,954	202,941	(56,100)	(22,143)
Pharmacy	446,090	461,460	468,935	2,115,136	2,615,189	(15,369)	(22,845)	(500,052)
Medical Supplies	348,696	427,743	340,164	2,826,835	2,829,649	(79,047)	8,532	(2,813)
Hospice Operations	-	-	-	-	-	-	-	-
EHR System Expense	12,263	135,000	168,118	200,001	715,877	(122,737)	(155,855)	(515,875)
Other Direct Expenses	554,226	601,886	585,553	3,968,245	3,795,256	(47,660)	(31,327)	172,990
Total Cost of Services - Direct	8,050,233	8,253,239	7,514,645	47,344,671	48,279,947	(203,006)	535,588	(935,276)
General and Administrative Overhead								
Salaries and Wages	540,406	522,990	491,917	3,212,481	2,771,812	17,416	48,489	440,669
Benefits	233,464	288,796	182,190	1,294,397	1,450,525	(55,332)	51,274	(156,128)
Professional Fees	235,635	222,110	139,099	1,342,557	1,402,412	13,525	96,536	(59,854)
Contract Labor	306,137	136,543	86,055	626,474	299,620	169,594	220,082	326,854
Depreciation and Amortization	409,164	363,578	344,330	2,550,863	2,000,676	45,586	64,834	550,187
Other Administative Expenses	262,025	284,558	156,693	1,440,992	1,066,243	(22,533)	105,332	374,749
Total General and Administrative Overhead	1,986,831	1,818,574	1,400,284	10,467,765	8,991,287	168,257	586,548	1,476,478
Total Expenses	**10,037,064**	**10,071,813**	**8,914,928**	**57,812,436**	**57,271,234**	**(34,749)**	**1,122,136**	**541,202**
Financing Expense	201,339	180,831	180,113	1,205,269	1,078,396	20,508	21,226	126,873
Financing Income	181,031	238,960	228,125	1,403,692	1,368,747	(57,930)	(47,094)	34,945
Investment Income	45,165	46,181	59,633	285,249	717,791	(1,016)	(14,468)	(432,541)
Miscellaneous Income	9,187,671	177,659	238,538	10,535,325	1,310,176	9,010,012	8,949,133	9,225,149
Net Income (Change in Financial Position)	**5,868,595**	**(788,680)**	**1,000,942**	**7,319,134**	**1,640,740**	**6,657,275**	**4,867,653**	**5,678,394**
Operating Income	(3,343,933)	(1,070,650)	654,759	(3,699,864)	(677,579)	(2,273,284)	(3,998,692)	(3,022,285)
EBIDA	6,277,759	(425,102)	1,345,271	9,869,997	3,641,416	6,702,861	4,932,487	6,228,582
Net Profit Margin	87.7%	-8.8%	10.5%	13.5%	2.9%	96.4%	77.2%	10.6%
Operating Margin	-50.0%	-11.9%	6.8%	-6.8%	-1.2%	-38.1%	-56.8%	-5.6%
EBIDA Margin	93.8%	-4.7%	14.1%	18.2%	6.4%	98.5%	79.7%	11.8%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	9/30/2024	9/30/2023	10/31/2024	10/31/2023	11/30/2024	11/30/2023	12/31/2024	12/31/2023	PM Change	PY Change
Assets											
Current Assets											
Cash and Liquid Capital	18,718,414	17,374,679	18,771,541	16,909,058	15,130,616	10,295,002	9,784,681	9,262,111	9,536,326	(1,032,891)	(274,215)
Short Term Investments	6,418,451	7,574,716	10,555,533	6,876,555	10,658,191	6,872,978	8,158,191	6,873,880	10,810,616	902	(3,936,736)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,924,674	19,842,483	15,119,591	18,705,429	18,412,645	20,054,289	20,460,545	18,106,671	20,452,310	(1,947,618)	(2,345,639)
Other Receivables	4,754,052	4,823,782	794,581	4,771,477	1,149,410	9,458,105	2,837,260	18,665,903	3,258,427	9,207,798	15,407,476
Inventory	6,103,723	6,112,780	5,155,489	6,079,443	5,210,947	6,117,401	5,211,962	6,141,928	5,159,051	24,527	982,877
Prepaid Expenses	1,119,559	1,933,935	2,326,052	1,353,383	2,377,751	1,102,300	2,269,168	852,094	1,773,403	(250,206)	(921,309)
Total Current Assets	**55,038,873**	**57,662,375**	**52,722,787**	**54,695,345**	**52,939,560**	**53,900,075**	**48,721,807**	**59,902,587**	**50,990,133**	**6,002,512**	**8,912,455**
Assets Limited as to Use											
Internally Designated for Capital Acquisition	-	-	-	-		-		-	-	-	-
Short Term - Restricted	1,467,786	1,468,166	1,466,663	1,468,293	1,466,789	1,468,417	1,466,910	1,468,545	1,467,036	128	1,509
Limited Use Assets									-	-	-
LAIF - DC Pension Board Restricted	-	-	828,419	-	828,417	-	828,417	-	175,992	-	(175,992)
LAIF - DB Pension Board Restricted	10,346,490	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	13,076,830	10,346,490	13,076,830	-	(2,730,340)
PEPRA - Deferred Outflows	-	-	-	-		-	-	-	-	-	-
PEPRA Pension	-	-	-	-		-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097		573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	10,919,587	10,919,587	14,478,346	10,919,587	13,905,247	10,919,587	14,478,344	10,919,587	13,825,919	-	(2,906,332)
Revenue Bonds Held by a Trustee	376,411	359,303	752,501	353,592	746,796	347,848	760,392	342,104	754,688	(5,744)	(412,584)
Total Assets Limited as to Use	**12,763,784**	**12,747,056**	**16,697,511**	**12,741,473**	**16,118,832**	**12,735,852**	**16,705,646**	**12,730,236**	**16,047,643**	**(5,616)**	**(3,317,407)**
Long Term Assets											
Long Term Investment	1,846,138	755,869	2,790,423	999,950	2,797,561	747,654	3,057,305	748,961	1,318,315	1,307	(569,354)
Fixed Assets, Net of Depreciation	84,474,743	84,066,999	76,854,908	83,828,939	77,676,251	83,555,961	77,109,988	83,235,289	76,904,399	(320,672)	6,330,890
Total Long Term Assets	**86,320,881**	**84,822,868**	**79,645,331**	**84,828,890**	**80,473,812**	**84,303,615**	**80,167,293**	**83,984,250**	**78,222,714**	**(319,365)**	**5,761,536**
Total Assets	**154,123,537**	**155,232,299**	**149,065,629**	**152,265,708**	**149,532,205**	**150,939,543**	**145,594,746**	**156,617,074**	**145,260,490**	**5,677,531**	**11,356,584**
Liabilities											
Current Liabilities											
Current Maturities of Long-Term Debt	4,146,183	4,771,637	190,197	4,782,382	655,101	4,744,967	676,353	4,616,414	1,339,056	(128,553)	3,277,358
Accounts Payable	5,010,089	4,443,274	6,935,344	3,949,738	6,819,778	4,337,497	5,370,018	4,496,145	6,383,025	158,648	(1,886,880)
Accrued Payroll and Related	6,224,657	4,915,339	12,664,513	5,437,529	12,669,463	3,515,873	8,534,376	2,073,837	6,924,804	(1,442,036)	(4,850,967)
Accrued Interest and Sales Tax	109,159	78,276	96,606	166,600	166,957	192,433	240,254	275,828	94,216	83,395	181,611
Notes Payable	446,860	446,860	1,633,708	446,860	1,633,708	446,860	1,633,708	446,860	1,633,708	-	(1,186,847)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	-	-
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	12,599,823	12,593,614	1,873,995	12,591,545	1,873,995	12,589,475	1,873,995	12,589,475	1,861,577	-	10,727,898
Total Current Liabilities	**29,225,475**	**27,937,705**	**24,083,068**	**28,063,360**	**24,507,707**	**26,515,810**	**19,017,409**	**25,187,264**	**18,925,091**	**(1,328,546)**	**6,262,173**
Long Term Liabilities											
Long Term Debt	36,301,355	36,004,290	33,341,647	34,797,823	32,730,530	34,698,029	31,715,530	33,927,979	30,380,530	(770,050)	3,547,449
Bond Premium	165,618	156,207	193,852	153,070	190,715	149,933	187,578	146,796	184,441	(3,137)	(37,645)
Accreted Interest	16,991,065	17,271,137	17,409,141	16,560,403	17,504,273	16,653,761	17,599,405	16,742,795	17,694,537	89,034	(951,741)
Other Non-Current Liability - Pension	32,946,355	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	-	(14,311,308)
Total Long Term Liabilities	**86,404,394**	**86,377,989**	**98,202,303**	**84,457,651**	**97,683,181**	**84,448,078**	**96,760,176**	**83,763,925**	**95,517,170**	**(684,153)**	**(11,753,245)**
Suspense Liabilities	-	-	-	-	-	-		-	-	-	-
Uncategorized Liabilities (grants)	31,506	147,821	36,944	127,821	68,644	127,821	107,118	127,821	107,118	-	20,703
Total Liabilities	**115,661,375**	**114,463,515**	**122,322,315**	**112,648,832**	**122,259,532**	**111,091,709**	**115,884,703**	**109,079,010**	**114,549,379**	**(2,012,699)**	**(5,470,369)**
Fund Balance											
Fund Balance	31,992,031	36,994,377	23,268,194	36,447,220	23,786,064	36,928,877	26,459,404	38,750,385	26,459,404	1,821,507	12,290,980
Temporarily Restricted	1,467,786	1,468,166	2,610,594	1,468,293	2,610,720	1,468,417	2,610,841	1,468,545	2,610,967	128	(1,142,422)
Net Income	5,002,346	2,306,242	864,526	1,701,362	875,889	1,450,539	639,798	7,319,134	1,640,740	5,868,595	5,678,394
Total Fund Balance	**38,462,163**	**40,768,784**	**26,743,313**	**39,616,876**	**27,272,672**	**39,847,834**	**29,710,043**	**47,538,064**	**30,711,111**	**7,690,230**	**16,826,953**
Liabilities + Fund Balance	**154,123,537**	**155,232,299**	**149,065,629**	**152,265,708**	**149,532,205**	**150,939,543**	**145,594,746**	**156,617,074**	**145,260,490**	**5,677,531**	**11,356,584**
(Decline)/Gain		(90,686)	1,771,115	(2,966,591)	466,576	(1,326,165)	(3,937,458)	5,677,531	(334,256)	7,003,695	6,011,787

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2025

Calculation method agrees to SECOND and THIRD
SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ 7,319,134
+ Depreciation Expense	2,550,863
+ Interest Expense	1,205,269
Less GO Property Tax revenue	942,712
Less GO Interest Expense	248,775
"Income available for debt service"	**$ 9,883,780**
Denominator:	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	894,160
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,546,875
Total **Maximum Annual Debt Service**	**$ 2,553,735**
	1,276,868
Ratio: (numerator / denominator)	**7.74**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**No**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 16,135,991
Cash and Investments-non current	748,961
Sub-total	16,884,952
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(342,104)
Building and Nursing Fund	(1,468,545)
Total Unrestricted Funds	**$ 15,074,303**
Total Operating Expenses	$ 57,812,436
Less Depreciation	2,550,863
Net Expenses	55,261,572
Average Daily Operating Expense	$ 301,976
Days Cash on Hand	**50**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	54,139,871
Payments to Suppliers and Contractors	(39,122,037)
Payments to and on Behalf of Employees	(32,652,507)
Other Receipts and Payments, Net	9,063,208
Net Cash Provided (Used) by Operating Activities	(8,571,466)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	31,125
Property Taxes Received	460,981
Other	1,403,692
Net Cash Provided (Used) by Noncapital Financing Activities	1,895,798
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,776,909)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(1,205,269)
Purchase and Construction of Capital Assets	(306,301)
Payments on Lease Liability	(152,368)
Payments on Subscription Liability	(445,290)
Property Taxes Received	1,239,866
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(2,646,270)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	285,249
Rental Income	35,815
Net Cash Provided (Used) by Investing Activities	321,064
NET CHANGE IN CASH AND CASH EQUIVALENTS	(9,000,874)
Cash and Cash Equivalents - Beginning of Year	25,136,864
CASH AND CASH EQUIVALENTS - END OF YEAR	16,135,991

Key Financial Performance Indicators	Industry Benchmark	Dec-22	Dec-23	FYE 2024 Average	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Volume													
Admits	41	79	68	71	75	75	83	68	77	62	(15)	(9)	(6)
Deliveries	n/a	20	18	17	18	19	17	21	14	21	7	4	3
Adjusted Patient Days	n/a	965	971	1,035	1,164	1,362	1,312	1,335	970	1,169	198	134	198
Total Surgeries	153	109	143	146	134	168	133	176	129	122	(7)	(24)	(21)
ER Visits	659	765	833	840	903	905	947	859	789	789	-	(51)	(44)
RHC and Clinic Visits	n/a	4,580	4,576	4,607	4,252	4,921	4,808	4,907	4,515	2,940	(1,575)	(1,667)	(1,636)
Diagnostic Imaging Services	n/a	1,970	1,899	2,069	2,274	2,221	2,194	2,344	1,880	1,955	75	(114)	56
Rehab Services	n/a	870	547	662	719	808	887	1,142	903	740	(163)	78	193
AR & Income													
Gross AR (Cerner only)	n/a	$ 52,833,440	$ 53,913,830	$ 52,823,707	$ 56,859,164	$ 57,648,281	$ 58,109,192	$ 51,585,302	$ 48,660,966	$ 46,678,451	$ (1,982,515)	$ (6,145,256)	$ (7,235,379)
AR > 90 Days	$ 7,001,767.65	$ 24,888,377	$ 26,961,876	$ 24,488,432	$ 24,988,857	$ 32,958,845	$ 34,041,771	$ 22,371,529	$ 21,371,712	$ 19,718,299	$ (1,653,413)	$ (4,770,132)	$ (7,243,577)
AR % > 90 Days	15%	47.1%	50.78%	46.7%	44.5%	57.2%	58.6%	43.4%	43.9%	42.2%	-1.7%	-4.4%	-8.5%
Gross AR Days (per financial statements)	60	100	89	85	92	84	83	74	83	84	0	(2)	(5)
Net AR Days (per financial statements)	30	142	87	84	74	104	119	77	71	91	20	8	4
Net AR	n/a	$ 17,300,274	$ 20,452,310	$ 16,938,200	$ 21,642,722	$ 24,802,720	$ 19,842,483	$ 18,705,429	$ 20,054,289	$ 18,106,671	$ (1,947,618)	$ 1,168,471	$ (2,345,639)
Net AR % of Gross	n/a	32.7%	37.9%	31.9%	38.1%	43.0%	34.1%	36.3%	41.2%	38.8%	-2.4%	6.8%	0.9%
Gross Patient Revenue/Calendar Day	n/a	$ 526,761	$ 604,887	$ 619,457	$ 617,364	$ 683,348	$ 702,988	$ 698,314	$ 582,780	$ 557,230	$ (25,550)	$ (62,227)	$ (47,657)
Net Patient Revenue/Calendar Day	n/a	$ 175,193	$ 308,700	$ 292,759	$ 337,843	$ 315,574	$ 285,805	$ 290,232	$ 301,501	$ 215,907	$ (85,593)	$ (76,851)	$ (92,792)
Net Patient Revenue/APD	n/a	$ 5,628	$ 9,855	$ 8,757	$ 8,998	$ 7,183	$ 6,537	$ 6,740	$ 9,321	$ 5,727	$ (3,593)	$ (3,030)	$ (4,128)
Wages													
Wages	n/a	$ 3,064,591	$ 3,303,307	$ 3,285,431	$ 3,359,076	$ 3,241,107	$ 3,372,236	$ 3,622,038	$ 3,463,941	$ 3,659,647	$ 195,706	$ 374,216	$ 356,340
Employed paid FTEs	n/a	404.30	346.65	353.69	366.38	366.24	391.40	369.11	364.72	367.90	3.18	14.21	21.25
Employed Average Hourly Rate	$55.50	$ 42.79	$ 53.79	$ 53.32	$ 51.76	$ 49.96	$ 50.26	$ 55.40	$ 55.40	$ 56.15	$ 0.75	$ 2.83	$ 2.36
Benefits	n/a	$ (256,758)	$ 1,251,579	$ 1,640,216	$ 1,509,407	$ 1,478,605	$ 1,634,036	$ 1,896,266	$ 713,356	$ 1,678,868	$ 965,512	$ 38,652	$ 427,289
Benefits % of Wages	30%	-8.4%	37.9%	50.3%	44.9%	45.6%	48.5%	52.4%	20.6%	45.9%	25.3%	-4.5%	8.0%
Contract Labor	n/a	$ (122,471)	$ 508,486	$ 518,351	$ 507,387	$ 829,876	$ (112,642)	$ 543,829	$ 583,367	$ 672,468	$ 89,101	$ 154,117	$ 163,982
Contract Labor Paid FTEs	n/a	30.08	22.52	23.49	29.45	32.19	24.84	21.32	23.57	26.14	2.57	2.65	3.62
Total Paid FTEs	n/a	434.38	369.17	377.18	395.83	398.43	416.25	390.44	388.29	394.04	5.75	16.86	24.87
Contract Labor Average Hourly Rate	$ 81.04	$ (22.98)	$ 127.46	$ 126.74	$ 97.26	$ 145.55	$ 118.60	$ 143.96	$ 144.39	$ 145.23	$ 0.83	$ 18.49	$ 17.76
Total Salaries, Wages, & Benefits	n/a	$ 2,685,362	$ 5,063,372	$ 5,443,998	$ 5,375,870	$ 5,549,587	$ 4,893,631	$ 6,062,133	$ 4,760,664	$ 6,010,983	$ 1,250,319	$ 566,985	$ 947,611
SWB% of NR	50%	49.4%	61.0%	63.2%	51.3%	56.7%	57.1%	67.4%	52.6%	89.8%	37.2%	26.7%	28.8%
SWB/APD	2,572	$ 2,783	$ 5,215	$ 5,346	$ 4,618	$ 4,075	$ 3,731	$ 4,541	$ 4,906	$ 5,144	$ 238	$ (202)	$ (71)
SWB % of total expenses	50%	29.6%	56.8%	56.7%	59.6%	56.3%	55.1%	58.0%	49.7%	59.9%	10.2%	3.2%	3.1%

Physician Spend	Industry Benchmark	Dec-22	Dec-23	FYE 2024 Average	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Physician Expenses	n/a	$ 1,360,961	$ 1,416,488	$ 1,507,510	$ 1,553,004	$ 1,399,376	$ 1,621,308	$ 1,699,955	$ 1,508,531	$ 1,498,281	$ (10,249)	$ (9,229)	$ 81,793
Physician expenses/APD	n/a	$ 1,410	$ 1,459	$ 1,478	$ 1,334	$ 1,028	$ 1,236	$ 1,273	$ 1,555	$ 1,282	$ (272)	$ (196)	$ (177)
											$ -	$ -	$ -
Supplies													
Supply Expenses	n/a	$ 717,757	$ 809,100	$ 776,504	$ 387,610	$ 1,078,077	$ 785,983	$ 860,663	$ 1,034,853	$ 794,786	$ (240,066)	$ 18,283	$ (14,314)
Supply expenses/APD		$ 744	$ 833	$ 780	$ 333	$ 792	$ 599	$ 645	$ 1,066	$ 680	$ (386)	$ (100)	$ (153)
Other Expenses													
Other Expenses	n/a	$ 4,316,366	$ 1,625,968	$ 1,891,477	$ 1,696,938	$ 1,833,270	$ 1,576,147	$ 1,824,069	$ 2,271,303	$ 1,733,013	$ (538,290)	$ (158,464)	$ 107,045
Other Expenses/APD	n/a	$ 4,473	$ 1,675	$ 1,878	$ 1,458	$ 1,346	$ 1,202	$ 1,366	$ 2,341	$ 1,483	$ (858)	$ (395)	$ (192)
Margin													
Net Income	n/a	$ 1,552,152	$ 1,000,942	$ 383,763	$ 2,041,456	$ 248,064	$ 19,121	$ (1,152,036)	$ (250,823)	$ 5,868,595	$ 6,119,418	$ 5,484,832	$ 4,867,653
Net Profit Margin	n/a	28.6%	10.5%	3.0%	19.5%	2.5%	0.2%	-12.8%	-2.8%	87.7%	90.5%	84.7%	77.2%
Operating Income	n/a	$ (833,897)	$ 654,759	$ (686,403)	$ 1,459,716	$ (77,526)	$ (302,930)	$ (1,449,616)	$ (530,332)	$ (3,343,933)	$ (2,813,602)	$ (2,657,530)	$ (3,998,692)
Operating Margin	2.9%	-15.4%	6.8%	-10.9%	13.9%	-0.8%	-3.1%	-16.1%	-5.9%	-50.0%	-44.1%	-39.0%	-56.8%
EBITDA	n/a	$ 1,211,629	$ 1,345,271	$ 841,932	$ 2,482,790	$ 689,172	$ 459,316	$ (742,505)	$ 158,708	$ 6,277,759	$ 6,119,050	$ 5,435,827	$ 4,932,487
EBITDA Margin	12.7%	22.3%	14.1%	8.7%	23.7%	7.0%	4.7%	-8.3%	1.8%	93.8%	92.0%	85.0%	79.7%
Debt Service Coverage Ratio	3.70		2.3	3.3	0.8	7.3	5.5	3.3	3.4	7.7	4.4	4.4	5.4
Cash													
Avg Daily Disbursements (excl. IGT)	n/a	$ 309,340	$ 264,416	$ 355,328	$ 367,107	$ 398,922	$ 315,796	$ 399,234	$ 296,503	$ 367,542	$ 71,039	$ 12,214	$ 103,126
Average Daily Cash Collections (excl. IGT)	n/a	$ 202,468	$ 316,748	$ 299,110	$ 349,783	$ 262,199	$ 302,042	$ 359,292	$ 288,101	$ 273,563	$ (14,538)	$ (25,547)	$ (43,185)
Average Daily Net Cash		$ (106,872)	$ 52,332	$ (56,218)	$ (17,324)	$ (136,723)	$ (13,754)	$ (39,942)	$ (8,402)	$ (93,979)	$ (85,577)	$ (37,761)	$ (146,311)
Upfront Cash Collections		$ 23,945	$ 22,671	$ 36,146	$ 32,509	$ 37,333	$ 36,220	$ 57,023	$ 26,687	$ 22,508	$ (4,179)	$ (13,638)	$ (163)
Upfront Cash % of Gross Charges	1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.3%	0.2%	0.1%	0%	0%	0%
Unrestricted Funds	n/a	$ 22,685,676	$ 20,904,990	$ 23,536,438	$ 27,015,779	$ 24,366,780	$ 24,708,310	$ 22,963,678	$ 16,099,369	$ 15,074,303	$ (1,025,067)	$ (8,462,136)	$ (5,830,687)
Change of cash per balance sheet	n/a	$ (899,141)	$ (163,212)	$ (541,459)	$ 1,876,964	$ (2,648,999)	$ 341,530	$ (1,744,632)	$ (6,864,309)	$ (1,025,067)	$ 5,839,242	$ (483,608)	$ (861,855)
Days Cash on Hand (assume no more cash is collected)	196	77	79	72	98	84	58	77	43	50	7	(22)	(29)
Estimated Days Until Depleted		212	486	406	506	413	440	442	372	292	(81)	(114)	(194)
Years Until Cash Depletion		0.58	1.33	1.11	1.39	1.13	1.21	1.21	1.02	0.80	(0.22)	(0.31)	(0.53)

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

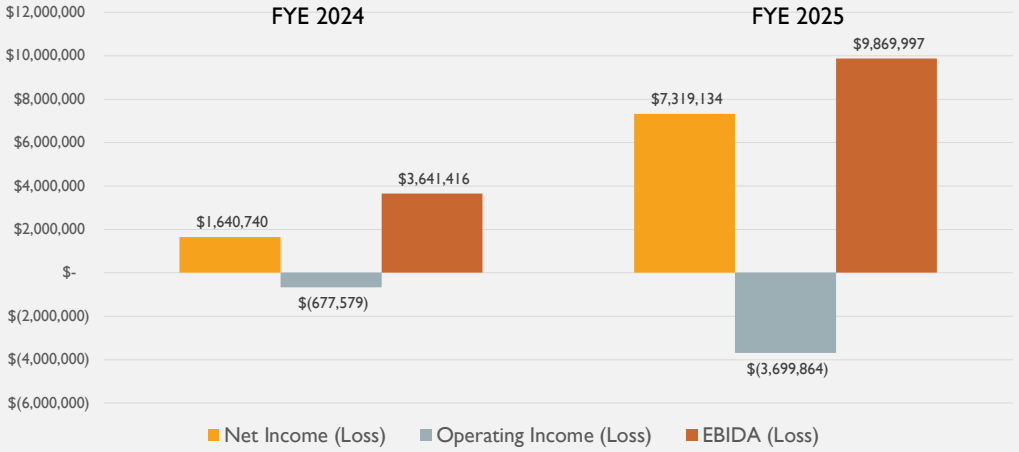
NIHD FINANCIAL UPDATE

December 2024

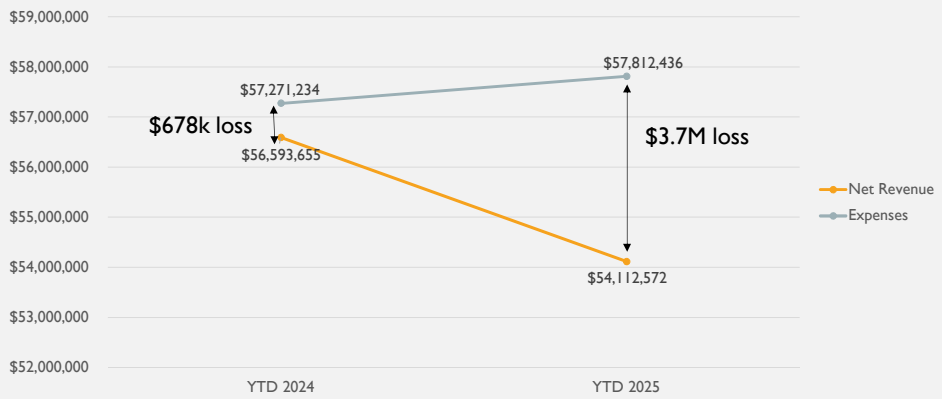
INCOME

DECEMBER 2024 FINANCIAL PERFORMANCE

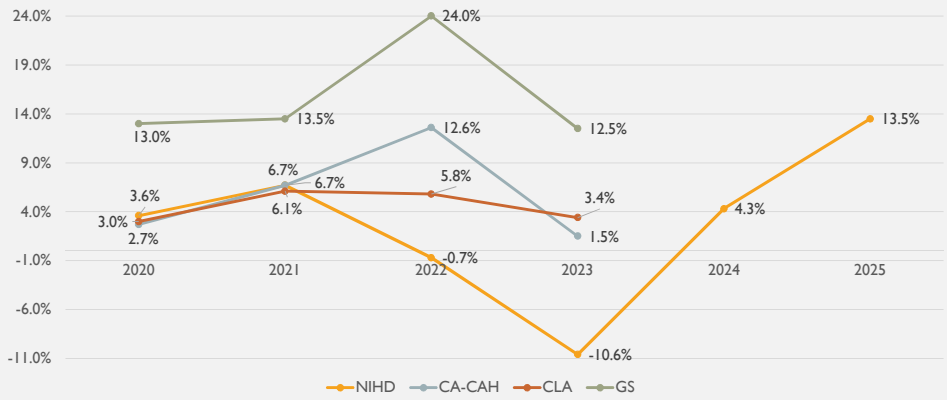
FYE 2025 FINANCIAL PERFORMANCE



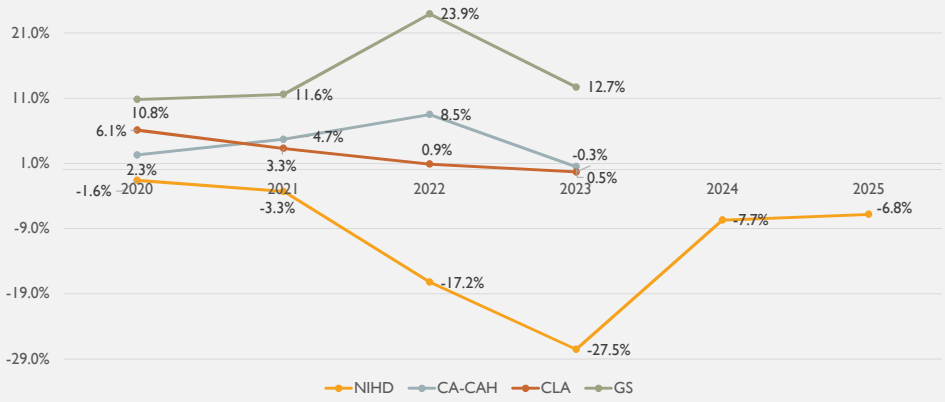
YTD OPERATING INCOME (LOSS) PERFORMANCE



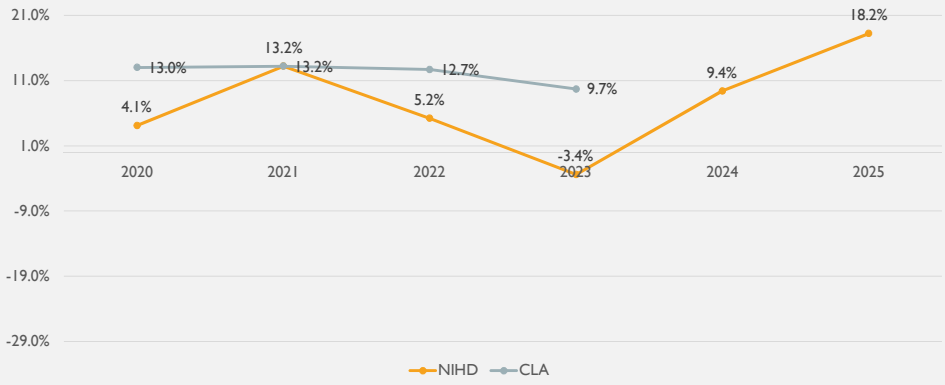
NET PROFIT MARGIN



OPERATING MARGIN

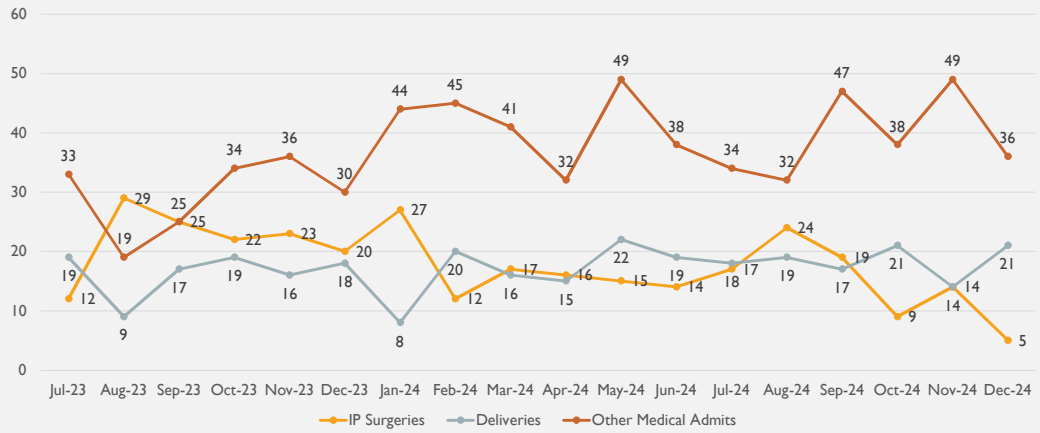


EBIDA MARGIN

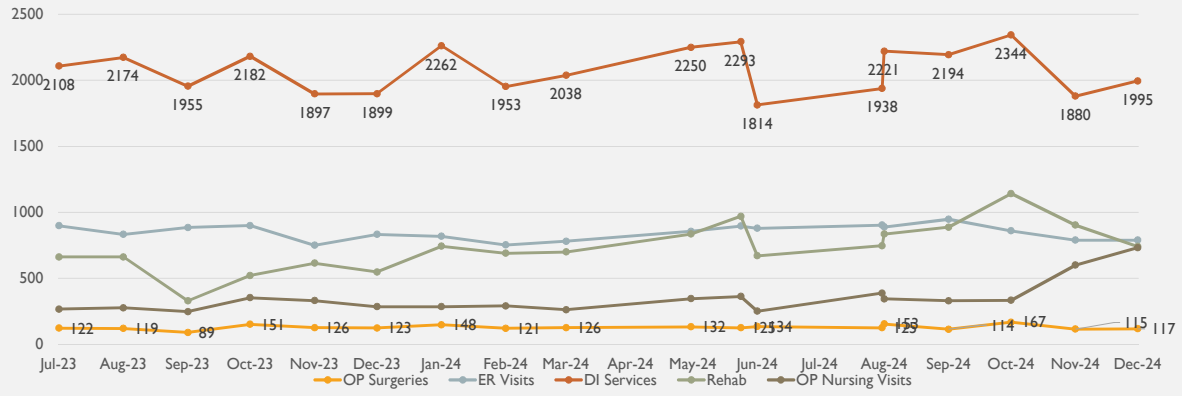


VOLUMES

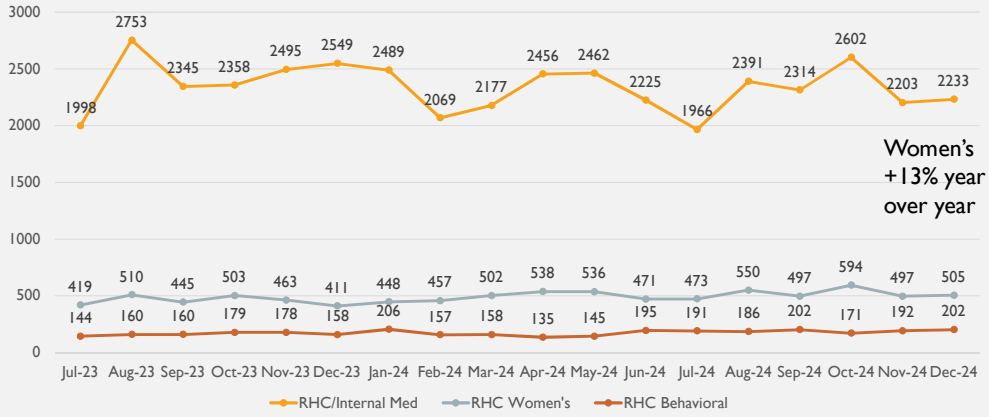
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE

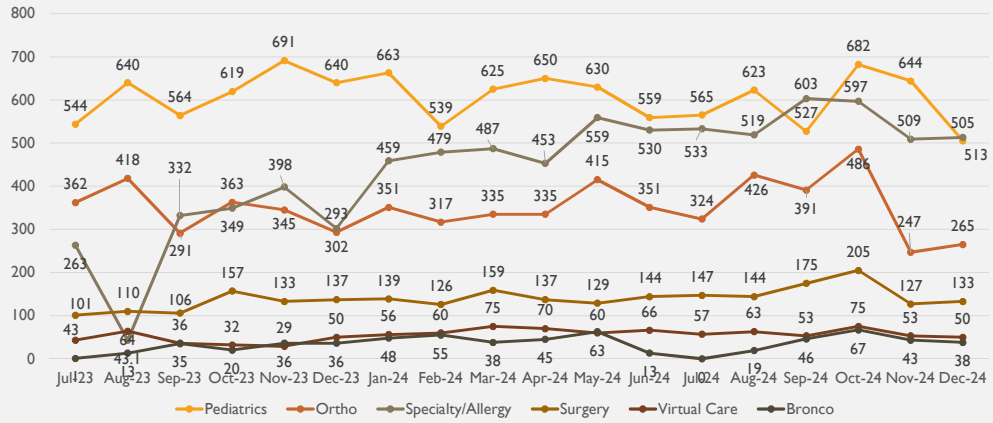


RHC VOLUME PERFORMANCE



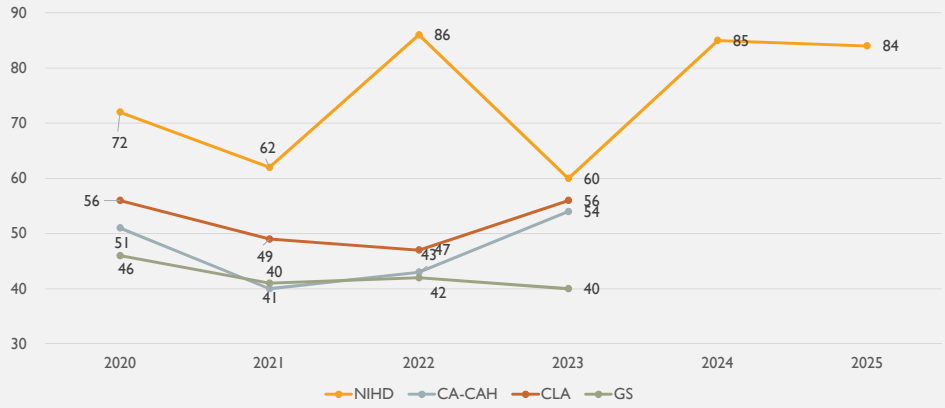
Women's +13% year over year

CLINIC VOLUME PERFORMANCE

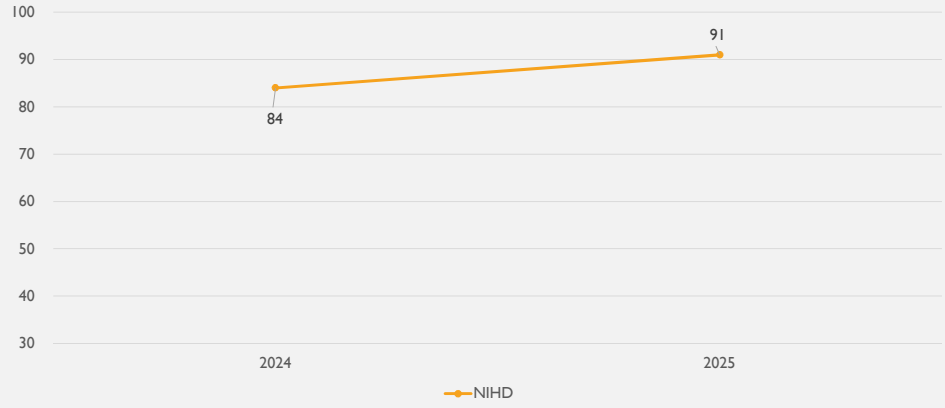


KEY PERFORMANCE INDICATORS

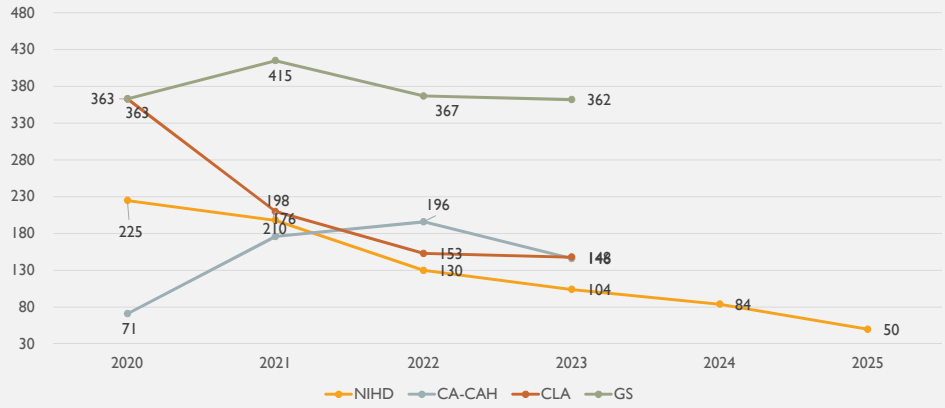
GROSS AR DAYS



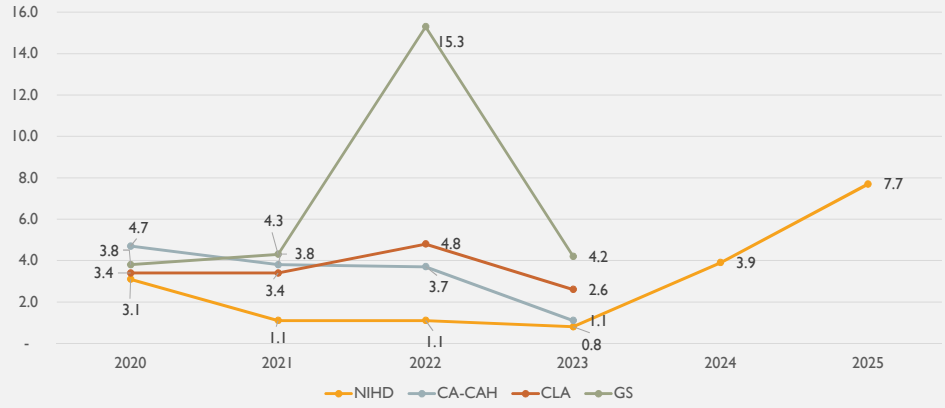
NET AR DAYS



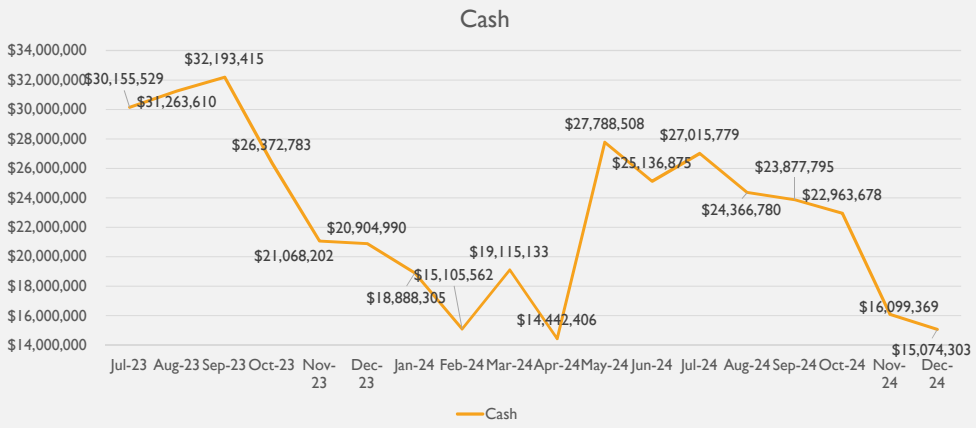
DAYS CASH ON HAND



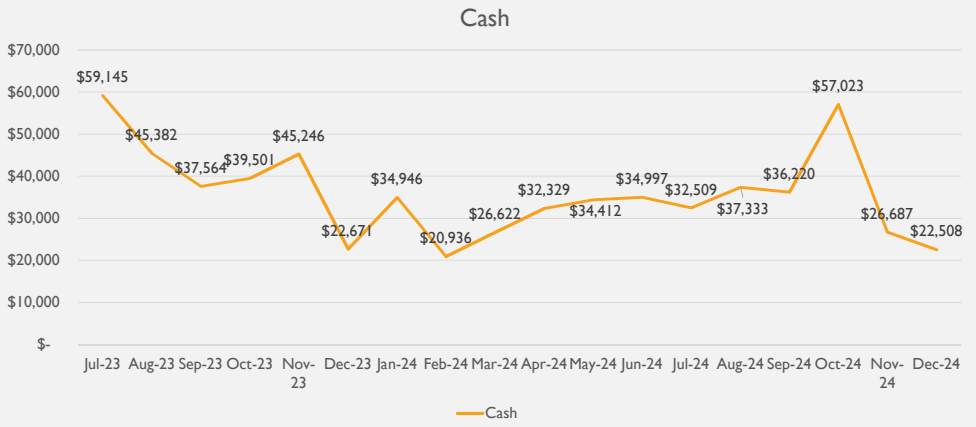
DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



UPFRONT CASH COLLECTIONS



WAGE COSTS

	December 2023	December 2024
Total Paid FTEs	369	394
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$5,063,372	$6,010,983
SWB % of total expenses (including contract labor)	56.8%	59.9%
Employed Average Hourly Rate	$53.79	$56.15
Benefits % of Wages	37.9%	45.9%