Northern Inyo Hospital

December 16 2020 Regular Meeting

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
December 16, 2020 at 5:30 p.m.
2957 Birch Street, Bishop, CA

Northern Inyo Healthcare District invites you to attend this Zoom meeting:

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

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

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: 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 30 minutes for all public comment 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 when that item is considered.
3. New Business:
   A. Election of Board officers for calendar year 2021 (*action item*).
   B. Chiller plant upgrade (*information item*).
   C. Workplace Investigation Policy and Procedure (*action item*).
   D. Board of Directors Access to Personnel Information (*information item*).
   E. General principles of Board Governance (*information item*).
   F. Stark Law and contract considerations relating to Fair Market Value (*information item*).

G. Covid-19 vaccine overview (*information item*).

H. Board acknowledgement of District operations in 2020 (*information item*).

I. Policy and Procedure approval, *Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer* (*action item*).

4. Chief of Staff Report, Charlotte Helvie, MD:

A. Policy and Procedure approvals (*action items*):

1. *Emergency Management Plan*
2. *Administration of Drugs and Biologicals*
3. *Cardiac Monitoring Policy*
4. *Dead on Arrival*
5. *Leaving Hospital Against Medical Advice Refusal or Treatment or Transfer*
6. *Qualitative Fit Testing*
7. *Safely Surrendered Baby Policy and Procedure*

B. Medical Staff and APP Staff Appointments (*action items*):

1. *David Plank, MD (plastic surgery) – Provisional Consulting Staff*
2. *Sarah Starosta, PA-C (RHC physician assistant) – Advanced Practice Provider Staff*

C. Medical Staff and APP Reappointments for Calendar Years 2021-2022 (*action items*):

1. Anu Agarwal MD, *Cardiology*
2. Abhilash Akinapelli MD, *Cardiology*
3. David Amsalem MD, *Emergency Medicine*
4. Lara Jeanine Arndal MD, *OB/GYN*
5. Thomas J. Boo MD, *Family Medicine*
6. Sierra Bourne MD, *Emergency Medicine*
7. Robbin Cromer-Tyler MD, *General Surgery*
8. Tracy Drew NP, *Family Nurse Practitioner*
9. Joy Engblade MD, *Internal Medicine*
10. Matthew Ercolani MD, *Urology*
11. James Fair MD, *Emergency Medicine*
12. Anne Gasior MD, *Family Medicine*
13. Anne Goshgarian MD, *Emergency Medicine*
14. Charlotte Helvie MD, *Pediatrics*
15. Samantha Jeppsen MD, *Emergency Medicine*

16. Jennifer Joos PA, *Family Practice*

17. Felix Karp MD, *Internal Medicine*

18. Katrinka Kip MD, *Pediatric Cardiology*

19. Earl Landrito MD, *Radiology*

20. Catherine Leja MD, *Family Medicine*

21. Bo Nasmyth Loy MD, *Orthopedic Surgery*

22. Tamara Loy NP, *Pediatric Nurse Practitioner*

23. Joseph Ludwick MD, *Pediatric Cardiology*

24. Atashi Mandal MD, *Internal Medicine*

25. Colleen McEvoy NP, *Pediatric Nurse Practitioner*

26. Monika Mehrens DO, *Family Medicine*

27. Jayson Morgan MD, *Cardiology*

28. David L. Nicholson CRNA, *Anesthesia*

29. Vlad Radulescu MD, *Cardiology*

30. Allison Robinson MD, *General Surgery*

31. Anna Rudolphi MD, *Emergency Medicine*

32. Jeanette Schneider MD, *Psychiatry*

33. Stefan Schunk MD, *Internal Medicine*

34. Uttama Sharma MD, *Family Medicine*

35. Saif H. Siddiqi MD, *Radiology*

36. Daniel Su MD, *Urology*

37. William Timbers MD, *Emergency Medicine*

38. Thomas-Duythuc To MD, *Cardiology*

39. Matthew Wise MD, *OB/GYN*

40. Mara Yolken NP, *Adult Nurse Practitioner*

D. Request for Extension of Appointment as per Bylaws Section 6.13.4 (*action items*):

1. Arrash Fard MD (*Cardiology*) – Adventist Health, Telemedicine Staff
2. Mark Robinson MD (*Orthopedic Surgery*) – Active Staff
3. J. Daniel Cowan MD (*Anesthesiology*) – Active Staff

E. Resignations (*action items*):

1. Robert Nathan Slotnick MD (*Obstetrics/Gynecology & Genetics*) – effective 9/4/20
2. Benjamin Ge MD (*Teleradiology – Quality Nighthawk*) – effective 9/2/20

3. Joe Miller, MD (*Urology*) – effective 11/2/20
4. Tamara McBride MD (*Family Medicine*) – effective 12/31/20
5. Stuart Souders MD (Diagnostic Radiology) – effective 12/31/20
6. Jake Ichino MD (*Cardiology, Renown*) – effective 12/31/20

F. Medical Executive Committee Meeting Report (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the November 18 2020 regular meeting
6. Financial and Statistical reports as of October 31 2020
7. Cerner Implementation update
8. Board Ad Hoc Committee meeting minutes

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9. NIHD Committee updates from Board members (*information items*).
10. Reports from Board members (*information items*).
11. Adjournment to Closed Session to/for:

    A. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b*))

    Title: Interim Chief Executive Officer.
12. Return to Open Session and report of any action taken (*information item*).
13. Adjournment.

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

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Workplace Investigations	
Scope: District Wide	Manual: Human Resources – Employee Handbook
Source: Human Resources	Effective Date: 1/1/2021

Purpose

The purpose of this policy is to provide guidance for conducting internal investigations of alleged violations of NIHD policies which prohibit unlawful discrimination, harassment, retaliation and alleged violations of other NIHD policies, rules and standards of conduct by employees. This policy also covers investigative procedures for investigations alleging policy violations by Chief Officers, including the CEO, COO, CFO, CNO and CMO.

Policy

Northern Inyo Healthcare District is committed to ensuring that all NIHD-initiated investigations are conducted in a fair, impartial, and thorough manner.

Procedures

Upon notification to a District supervisor or manager, including any Officer, Chief, Director, Manager or elected member of the Board of Directors, of a complaint or other information alleging a violation of district policy, an investigation will be conducted.

Responsibility

NIHD will initiate an appropriate investigation into allegations of violations of NIHD policy. The Director of Human Resources, or their designee, will have primary responsibility for investigating complaints relating to allegations of employee violations of NIHD policies.

In certain situation at the discretion of the Human Resources Director or the Board of Directors, NIHD's legal counsel may be delegated the responsibility to oversee investigations and be authorized to instruct other NIHD personnel to gather information for the investigation. In such cases, the assigned investigator(s) will follow legal counsel's instructions relating to communications and evidence to ensure that "attorney-client" and "attorney work product" privileges are preserved.

Situations to be investigated

The following list, while not all-inclusive, provides examples of the types of situations that NIHD will investigate:

- Alleged conduct that potentially deprives a company employee or third party (i.e., customer, persons or entities desiring to engage in business with the company) of rights because of race, color, religion, sex, sexual orientation, national origin, age, disability, marital status or other characteristics protected by law.
- Alleged verbal or physical conduct that potentially denigrates or shows hostile feelings toward any individual because of race, color, religion, sex, sexual orientation, national origin, age, disability, marital status or other characteristics protected by law. This includes conduct that has the purpose or effect of any of the following:

  - Creating an intimidating, hostile or offensive work environment.
  - Unreasonably interfering with an employee's work performance.
  - Affecting an individual's employment opportunity at the company.

- Alleged conduct or intentional behavior that potentially violates NIHD policy or affects the safety or well-being of fellow employees, visitors, operations or other NIHD-related activities. Such conduct includes threatening communication, physical injury or potential physical harm to another, aggressive or hostile action, intentional damage to company property, and possession of any weapon, regardless of government licensing.
- Claims relating to unfair labor practices.
- Conduct that violates NIHD rules, policies or standards of conduct or the law.

Third-party investigator requirements

The Director of Human Resources or Chief Executive Officer may approve the retention of a third party for purposes of conducting a NIHD-initiated investigation regarding allegations of employee violations of NIHD policy. The third party shall be qualified and must provide evidence of professional liability insurance (i.e., errors and omissions coverage) prior to conducting any NIHD-initiated investigation.

Confidentiality

NIHD investigator(s) will inform the complainant(s), respondents, and witnesses that the NIHD-initiated investigation is confidential and that information can only be shared on a need-to-know basis; however, if information is learned that personnel action or legal action is required, there is a potential that disclosure of this information may occur in the process.

Retaliation

NIHD prohibits retaliation including making threatening communication by verbal, written or electronic means against any individual who reports or provides any information concerning unlawful discrimination, harassment or other violations of NIHD policies, rules and standards of conduct. Any employee found to be engaging in retaliation will be subject to disciplinary action up to and including termination.

Risk assessment

NIHD investigator(s) will make a reasonable effort to ensure that the complainant(s) or person(s) providing information during an investigation are not exposed to any threats of violence, intimidation or personal risk. If any such situations are identified or have occurred, NIHD will proceed with the appropriate response, as advised by the Human Resources Department, legal counsel, security department or other appropriate professionals. Any NIHD employee found to have engaged in threatening behavior will be subject to disciplinary action up to and including termination, in accordance with NIHD's Workplace Violence Prevention Policy.

Investigative timeline

NIHD will make all reasonable efforts to initiate an investigation into the allegation(s) and conclude the investigation in a timely fashion, as appropriate.

Investigative tasks

The following steps should be undertaken as appropriate for the particular investigation:

Step	Action
1.	Obtain verbal and written statements from all parties involved, including the complainant and accused. Secure all publicly available reports from police or other agencies concerning the reporting (*if applicable*).
2.	Take photographs/video of any injury or damage (*if applicable*).
3.	Preserve all evidence, and secure the evidence in a locked location. Document all evidence obtained. The NIHD investigator will be responsible for maintaining the chain of custody for the evidence.
4.	Determine if there is a potential for risk occurrence. If there is a potential, take all measures appropriate to protect employees, visitors and property.
5.	Complete an investigation report, and provide all relevant and necessary information, including findings.

Documentation of findings

Based on the investigation, NIHD investigator(s) should determine whether the allegation(s) were founded, unfounded or inconclusive. This determination should be documented in writing and made part of the investigative report. The determinations are as follows:

- **Violation found.** Where a violation of NIHD policies or workplace rules is found to have occurred, the accused should be notified of the finding and of the specific or corrective actions to be taken. The accused employee's supervisor will also be notified if appropriate. No details about the nature or extent of disciplinary or corrective actions will be disclosed to the complainant(s) or witness (es) unless there is a compelling reason to do so (e.g., personal safety).

- **No violation found.** In this situation, the complainant and the accused should be notified that NIHD investigated the allegation(s) and found that the evidence did not support the claim.

- **Inconclusive investigation.** In some cases, the evidence may not conclusively indicate whether the allegation(s) was founded or unfounded. If such a situation occurs, the notification to the complainant and the accused should state that NIHD completed a thorough investigation but has been unable to establish the truth or falsity of the allegation(s). NIHD will take appropriate steps to ensure that the persons involved understand the requirements of NIHD's policies, and that NIHD will monitor the situation to ensure compliance in the future.

Disclosures to third parties

No NIHD employee or agent may make any disclosure to third parties (e.g., lawyers, investigators, insurance representatives, media reporters) regarding the particulars of any NIHD-initiated investigation without prior approval from legal counsel.

Retention of investigative records

Unless advised otherwise by legal counsel or the Human Resources Director, or their designee, NIHD will retain records relative to a NIHD-initiated investigation for a maximum of a period of five years or the minimum retention period required by law.

Release of investigative records

NIHD will not release any investigative files, including interviews and findings, unless authorized by the Director of Human Resources, legal counsel or pursuant to a court-authorized request (i.e., subpoena, court order).

Any information obtained and reported by third parties employed or engaged by NIHD concerning an employee's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living will be considered to be a "consumer report" under the Fair Credit Reporting Act. Accordingly, NIHD will provide notice to the employee that such reports have been received. The employee may request and obtain a copy of the consumer report.

Notice to government agencies

Before notifying any government agency concerning a NIHD-initiated investigation, legal counsel may conduct a full review of the investigation and determine what information, including documents, should be released to the government agency.

Approval	**Date**
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

MEMORANDUM

To: Board of Directors, Northern Inyo Healthcare District

From: Keith F. Collins, General Counsel

Date: December 1, 2020

Subject: Board of Director Access to Personnel Information

ISSUE PRESENTED

The District Board members find themselves hearing from amongst the community about personnel actions involving District staff, including one or more supposed terminations, about which they had no knowledge in their elected capacity. The Board wishes to know whether and to what extent they may be made aware of such personnel actions and the reasons therefor.

SUMMARY

Personnel information is confidential under California law. Accordingly, the Board may only be made aware of personnel information that the Board has a need to know and a right to know. This means that because the District has delegated personnel matters to District executive staff, there are only very limited instances where Board members can properly be made aware of personnel information.

RULE

The general rule of law in California government is that employee personnel records are confidential[1] and may be made known only to those who have a legitimate business-related necessity to inquire into these records. Under existing rules and practices, District employee personnel files are considered confidential and the District has a duty to protect those files from unnecessary disclosure. There are exceptions to this general rule, such as the right of the public to know of the compensation afforded public employees. But operationally the general rule governs, and access to information in employee personnel files is limited to a so-called "need to know and right to know" basis.

A variant of this rule is that one's "need to know and right to know" may not exist at one point in time but may accrue at another point in time. For instance, a governing body may have delegated personnel administration to a designated executive, in which case day-to-day personnel matters would not come before the governing body and the "need to know and right to know" would not routinely exist. Yet, locally adopted rules -- whether in an ordinance, adopted personnel rules or a labor agreement -- might designate the governing body as the level to which employee grievances or discipline would be taken for adjudication if not resolved at an earlier level of such processes. In such a scheme, the governing body's "need to know and right to know" would be triggered only at such time as an employee exercised his/her rights under the grievance and/or discipline processes.

[1] Cal. Const. Art. 1, Sec. 1; Cal. Gov. Code Sec. 6254(c).

And, finally, there may exist a “need to know and right to know” for certain limited and generally anonymous personnel information in furtherance of the role of the governing body in supervising and evaluating operational and executive performance.

ANALYSIS

Under existing NIHD rules and labor agreements, the Board of Directors is not a level to which grievances or disciplinary appeals are taken. Further, the duty of direct management and oversight of the services provided and the work performed by District employees is vested in the Chief Executive Officer (“CEO”). The Board of Directors of course supervises the performance of the CEO, but the Board does not directly perform that work; including as germane to this analysis, the personnel administration of the District work force.

Yet the Board can and does have a legitimate interest in being aware of and informed about how the CEO is performing his/her duties. But due to the confidentiality of personnel records, this interest of the Board in personnel administration would more appropriately be described as a need to know “what” is being done without need of knowing the “who” (i.e., the employee’s identity).

In practical terms, this could take the form of asking for a closed session briefing by the CEO regarding any significant personnel actions, perhaps to include discipline at or above the level of a lengthy suspension, demotion, or termination. Such a briefing would be done without identifying the concerned employee, thus protecting the confidentiality of personnel records while still providing the Board of Directors with an awareness of the “what” and the “why” of significant personnel actions while preserving the “who” of such actions. Additional personnel information shared with the Board would go beyond the Board’s “need to know and right to know” and would infringe on the employee’s privacy interest in his/her personnel information.

Another practical example where the Board may be made aware of additional personnel information is when a personnel action exposes the District to potential litigation that is discussed in a properly noticed closed session. In this situation, the Board would have both a “need to know and right to know” certain personnel information as it relates to assessing risk and deciding how to respond to potential litigation.

CONCLUSION

Board members can only be made aware of confidential personnel information when there is both a need to know and a right to know. Evaluating the performance of the CEO and assessing risk stemming from employee discipline are two such examples of when Board members may have a need and a right to know. Accordingly, Board members can respond to community inquiries about personnel matters by explaining that such matters are handled by District staff and Board members are only made aware in limited circumstances. Further, when confidential information is properly made known to Board members, members are also under the obligation to preserve its confidentiality.

MEMORANDUM

To: Board of Directors, Northern Inyo Healthcare District

From: Keith F. Collins, General Counsel

Date: December 8, 2020

Subject: General Principles of Board Governance

ISSUE PRESENTED

What are the general rules that apply to how members of the Northern Inyo Healthcare District ("District") Board of Directors govern the District?

SUMMARY

There are several rules that govern the personal conduct of board members. For example, the Brown Act requires board members deliberate and take action in public meetings, and conflict of interest laws prohibit board members from participating in decisions that have an impact on their personal finances. Board members are also required to receive two hours of ethics training every two years and make required campaign and financial disclosures. However, in terms of how board members exercise their discretion to set District policy, there are no legal restrictions. Board members are only accountable to the voters for how they function in their official capacity, although a board member can be censured by the Board for conduct that the Board considers detrimental to the District. Board members should use good judgement when discussing matters in public meetings that may increase the exposure to liability for the District, and make such inquiries or comments outside the context of a public meeting.

ANANYSIS

The enclosed summary of the Brown Act, conflict of interest laws, and financial disclosure requirements provides a comprehensive review of the most commonly applicable rules governing the conduct of elected officials as it relates to their public service. While the summary is geared toward city councilmembers, the same rules generally apply to board members of special districts.

Regarding board member conduct during public meetings, rules of parliamentary procedure should be followed to conduct District business efficiently. Enclosed please find a summary of basic parliamentary procedure that should be followed by board members when conducting District business.

If a board member consistently violates these rules or engages in conduct that is otherwise detrimental to the District, the Board can vote to formally censure the offending member. Censure is accomplished by passing a resolution describing the offending conduct and any remedies the Board has power to impose, if appropriate.

In terms of how a board member exercises his/her discretion in deliberating and making official decisions, board members are only accountable to the voters. Under Health & Safety Code § 32125(a), the role the Board of Directors is to set broad policy for the District. The Board

delegates authority for day-to-day operations to executive staff and makes decisions that are properly brought to the Board in a noticed public meeting. While deliberations and decisions are to be conducted in public, board members should exercise discretion when deliberating or making staff inquiries during public meetings that may increase the exposure of the District to liability. Such deliberations and inquiries should be made privately to District staff or within a properly agendized closed session.

CONCLUSION

Board members should familiarize themselves with the laws governing their personal conduct as elected officials and take care to comply with each legal requirement. Board members are accountable to the voters for how they exercise their discretion in setting District policy and conducting District business, and should refrain from engaging in deliberations that might increase the exposure to liability for the District or "micromanaging" operational matters that have been delegated to executive staff.

Rosenberg's Rules of Order

REVISED 2011

Simple Rules of Parliamentary Procedure for the 21st Century

By Judge Dave Rosenberg

LEAGUE® OF CALIFORNIA CITIES

MISSION AND CORE BELIEFS

To expand and protect local control for cities through education and advocacy to enhance the quality of life for all Californians.

VISION

To be recognized and respected as the leading advocate for the common interests of California's cities.

About the League of California Cities

Established in 1898, the League of California Cities is a member organization that represents California's incorporated cities. The League strives to protect the local authority and automony of city government and help California's cities effectively serve their residents. In addition to advocating on cities' behalf at the state capitol, the League provides its members with professional development programs and information resources, conducts education conferences and research, and publishes Western City magazine.

About the Author

Dave Rosenberg is a Superior Court Judge in Yolo County. He has served as presiding judge of his court, and as presiding judge of the Superior Court Appellate Division. He also has served as chair of the Trial Court Presiding Judges Advisory Committee (the committee composed of all 58 California presiding judges) and as an advisory member of the California Judicial Council. Prior to his appointment to the bench, Rosenberg was member of the Yolo County Board of Supervisors, where he served two terms as chair. Rosenberg also served on the Davis City Council, including two terms as mayor. He has served on the senior staff of two governors, and worked for 19 years in private law practice. Rosenberg has served as a member and chair of numerous state, regional and local boards. Rosenberg chaired the California State Lottery Commission, the California Victim Compensation and Government Claims Board, the Yolo-Solano Air Quality Management District, the Yolo County Economic Development Commission, and the Yolo County Criminal Justice Cabinet. For many years, he has taught classes on parliamentary procedure and has served as parliamentarian for large and small bodies.

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Introduction

The rules of procedure at meetings should be simple enough for most people to understand. Unfortunately, that has not always been the case. Virtually all clubs, associations, boards, councils and bodies follow a set of rules — *Robert's Rules of Order* — which are embodied in a small, but complex, book. Virtually no one I know has actually read this book cover to cover. Worse yet, the book was written for another time and for another purpose. If one is chairing or running a parliament, then *Robert's Rules of Order* is a dandy and quite useful handbook for procedure in that complex setting. On the other hand, if one is running a meeting of say, a five-member body with a few members of the public in attendance, a simplified version of the rules of parliamentary procedure is in order.

Hence, the birth of *Rosenberg's Rules of Order*.

What follows is my version of the rules of parliamentary procedure, based on my decades of experience chairing meetings in state and local government. These rules have been simplified for the smaller bodies we chair or in which we participate, slimmed down for the 21st Century, yet retaining the basic tenets of order to which we have grown accustomed. Interestingly enough, *Rosenberg's Rules* has found a welcoming audience. Hundreds of cities, counties, special districts, committees, boards, commissions, neighborhood associations and private corporations and companies have adopted *Rosenberg's Rules* in lieu of *Robert's Rules* because they have found them practical, logical, simple, easy to learn and user friendly.

This treatise on modern parliamentary procedure is built on a foundation supported by the following four pillars:

1. **Rules should establish order.** The first purpose of rules of parliamentary procedure is to establish a framework for the orderly conduct of meetings.
2. **Rules should be clear.** Simple rules lead to wider understanding and participation. Complex rules create two classes: those who understand and participate; and those who do not fully understand and do not fully participate.
3. **Rules should be user friendly.** That is, the rules must be simple enough that the public is invited into the body and feels that it has participated in the process.
4. **Rules should enforce the will of the majority while protecting the rights of the minority.** The ultimate purpose of rules of procedure is to encourage discussion and to facilitate decision making by the body. In a democracy, majority rules. The rules must enable the majority to express itself and fashion a result, while permitting the minority to also express itself, but not dominate, while fully participating in the process.

Establishing a Quorum

The starting point for a meeting is the establishment of a quorum. A quorum is defined as the minimum number of members of the body who must be present at a meeting for business to be legally transacted. The default rule is that a quorum is one more than half the body. For example, in a five-member body a quorum is three. When the body has three members present, it can legally transact business. If the body has less than a quorum of members present, it cannot legally transact business. And even if the body has a quorum to begin the meeting, the body can lose the quorum during the meeting when a member departs (or even when a member leaves the dais). When that occurs the body loses its ability to transact business until and unless a quorum is reestablished.

The default rule, identified above, however, gives way to a specific rule of the body that establishes a quorum. For example, the rules of a particular five-member body may indicate that a quorum is four members for that particular body. The body must follow the rules it has established for its quorum. In the absence of such a specific rule, the quorum is one more than half the members of the body.

The Role of the Chair

While all members of the body should know and understand the rules of parliamentary procedure, it is the chair of the body who is charged with applying the rules of conduct of the meeting. The chair should be well versed in those rules. For all intents and purposes, the chair makes the final ruling on the rules every time the chair states an action. In fact, all decisions by the chair are final unless overruled by the body itself.

Since the chair runs the conduct of the meeting, it is usual courtesy for the chair to play a less active role in the debate and discussion than other members of the body. This does not mean that the chair should not participate in the debate or discussion. To the contrary, as a member of the body, the chair has the full right to participate in the debate, discussion and decision-making of the body. What the chair should do, however, is strive to be the last to speak at the discussion and debate stage. The chair should not make or second a motion unless the chair is convinced that no other member of the body will do so at that point in time.

The Basic Format for an Agenda Item Discussion

Formal meetings normally have a written, often published agenda. Informal meetings may have only an oral or understood agenda. In either case, the meeting is governed by the agenda and the agenda constitutes the body's agreed-upon roadmap for the meeting. Each agenda item can be handled by the chair in the following basic format:

First, the chair should clearly announce the agenda item number and should clearly state what the agenda item subject is. The chair should then announce the format (which follows) that will be followed in considering the agenda item.

Second, following that agenda format, the chair should invite the appropriate person or persons to report on the item, including any recommendation that they might have. The appropriate person or persons may be the chair, a member of the body, a staff person, or a committee chair charged with providing input on the agenda item.

Third, the chair should ask members of the body if they have any technical questions of clarification. At this point, members of the body may ask clarifying questions to the person or persons who reported on the item, and that person or persons should be given time to respond.

Fourth, the chair should invite public comments, or if appropriate at a formal meeting, should open the public meeting for public input. If numerous members of the public indicate a desire to speak to the subject, the chair may limit the time of public speakers. At the conclusion of the public comments, the chair should announce that public input has concluded (or the public hearing, as the case may be, is closed).

Fifth, the chair should invite a motion. The chair should announce the name of the member of the body who makes the motion.

Sixth, the chair should determine if any member of the body wishes to second the motion. The chair should announce the name of the member of the body who seconds the motion. It is normally good practice for a motion to require a second before proceeding to ensure that it is not just one member of the body who is interested in a particular approach. However, a second is not an absolute requirement, and the chair can proceed with consideration and vote on a motion even when there is no second. This is a matter left to the discretion of the chair.

Seventh, if the motion is made and seconded, the chair should make sure everyone understands the motion.

This is done in one of three ways:

1. The chair can ask the maker of the motion to repeat it;
2. The chair can repeat the motion; or
3. The chair can ask the secretary or the clerk of the body to repeat the motion.

Eighth, the chair should now invite discussion of the motion by the body. If there is no desired discussion, or after the discussion has ended, the chair should announce that the body will vote on the motion. If there has been no discussion or very brief discussion, then the vote on the motion should proceed immediately and there is no need to repeat the motion. If there has been substantial discussion, then it is normally best to make sure everyone understands the motion by repeating it.

Ninth, the chair takes a vote. Simply asking for the "ayes" and then asking for the "nays" normally does this. If members of the body do not vote, then they "abstain." Unless the rules of the body provide otherwise (or unless a super majority is required as delineated later in these rules), then a simple majority (as defined in law or the rules of the body as delineated later in these rules) determines whether the motion passes or is defeated.

Tenth, the chair should announce the result of the vote and what action (if any) the body has taken. In announcing the result, the chair should indicate the names of the members of the body, if any, who voted in the minority on the motion. This announcement might take the following form: "The motion passes by a vote of 3-2, with Smith and Jones dissenting. We have passed the motion requiring a 10-day notice for all future meetings of this body."

Motions in General

Motions are the vehicles for decision making by a body. It is usually best to have a motion before the body prior to commencing discussion of an agenda item. This helps the body focus.

Motions are made in a simple two-step process. First, the chair should recognize the member of the body. Second, the member of the body makes a motion by preceding the member's desired approach with the words "I move … "

A typical motion might be: "I move that we give a 10-day notice in the future for all our meetings."

The chair usually initiates the motion in one of three ways:

1. **Inviting the members of the body to make a motion,** for example, "A motion at this time would be in order."
2. **Suggesting a motion to the members of the body,** "A motion would be in order that we give a 10-day notice in the future for all our meetings."
3. **Making the motion.** As noted, the chair has every right as a member of the body to make a motion, but should normally do so only if the chair wishes to make a motion on an item but is convinced that no other member of the body is willing to step forward to do so at a particular time.

The Three Basic Motions

There are three motions that are the most common and recur often at meetings:

The basic motion. The basic motion is the one that puts forward a decision for the body's consideration. A basic motion might be: "I move that we create a five-member committee to plan and put on our annual fundraiser."

The motion to amend. If a member wants to change a basic motion that is before the body, they would move to amend it. A motion to amend might be: "I move that we amend the motion to have a 10-member committee." A motion to amend takes the basic motion that is before the body and seeks to change it in some way.

The substitute motion. If a member wants to completely do away with the basic motion that is before the body, and put a new motion before the body, they would move a substitute motion. A substitute motion might be: "I move a substitute motion that we cancel the annual fundraiser this year."

"Motions to amend" and "substitute motions" are often confused, but they are quite different, and their effect (if passed) is quite different. A motion to amend seeks to retain the basic motion on the floor, but modify it in some way. A substitute motion seeks to throw out the basic motion on the floor, and substitute a new and different motion for it. The decision as to whether a motion is really a "motion to amend" or a "substitute motion" is left to the chair. So if a member makes what that member calls a "motion to amend," but the chair determines that it is really a "substitute motion," then the chair's designation governs.

A "friendly amendment" is a practical parliamentary tool that is simple, informal, saves time and avoids bogging a meeting down with numerous formal motions. It works in the following way: In the discussion on a pending motion, it may appear that a change to the motion is desirable or may win support for the motion from some members. When that happens, a member who has the floor may simply say, "I want to suggest a friendly amendment to the motion." The member suggests the friendly amendment, and if the maker and the person who seconded the motion pending on the floor accepts the friendly amendment, that now becomes the pending motion on the floor. If either the maker or the person who seconded rejects the proposed friendly amendment, then the proposer can formally move to amend.

Multiple Motions Before the Body

There can be up to three motions on the floor at the same time. The chair can reject a fourth motion until the chair has dealt with the three that are on the floor and has resolved them. This rule has practical value. More than three motions on the floor at any given time is confusing and unwieldy for almost everyone, including the chair.

When there are two or three motions on the floor (after motions and seconds) at the same time, the vote should proceed *first* on the *last* motion that is made. For example, assume the first motion is a basic "motion to have a five-member committee to plan and put on our annual fundraiser." During the discussion of this motion, a member might make a second motion to "amend the main motion to have a 10-member committee, not a five-member committee to plan and put on our annual fundraiser." And perhaps, during that discussion, a member makes yet a third motion as a "substitute motion that we not have an annual fundraiser this year." The proper procedure would be as follows:

First, the chair would deal with the *third* (the last) motion on the floor, the substitute motion. After discussion and debate, a vote would be taken first on the third motion. If the substitute motion *passed*, it would be a substitute for the basic motion and would eliminate it. The first motion would be moot, as would the second motion (which sought to amend the first motion), and the action on the agenda item would be completed on the passage by the body of the third motion (the substitute motion). No vote would be taken on the first or second motions.

Second, if the substitute motion *failed*, the chair would then deal with the second (now the last) motion on the floor, the motion to amend. The discussion and debate would focus strictly on the amendment (should the committee be five or 10 members). If the motion to amend *passed*, the chair would then move to consider the main motion (the first motion) as *amended*. If the motion to amend *failed,* the chair would then move to consider the main motion (the first motion) in its original format, not amended.

Third, the chair would now deal with the first motion that was placed on the floor. The original motion would either be in its original format (five-member committee), or if *amended*, would be in its amended format (10-member committee). The question on the floor for discussion and decision would be whether a committee should plan and put on the annual fundraiser.

To Debate or Not to Debate

The basic rule of motions is that they are subject to discussion and debate. Accordingly, basic motions, motions to amend, and substitute motions are all eligible, each in their turn, for full discussion before and by the body. The debate can continue as long as members of the body wish to discuss an item, subject to the decision of the chair that it is time to move on and take action.

There are exceptions to the general rule of free and open debate on motions. The exceptions all apply when there is a desire of the body to move on. The following motions are not debatable (that is, when the following motions are made and seconded, the chair must immediately call for a vote of the body without debate on the motion):

Motion to adjourn. This motion, if passed, requires the body to immediately adjourn to its next regularly scheduled meeting. It requires a simple majority vote.

Motion to recess. This motion, if passed, requires the body to immediately take a recess. Normally, the chair determines the length of the recess which may be a few minutes or an hour. It requires a simple majority vote.

Motion to fix the time to adjourn. This motion, if passed, requires the body to adjourn the meeting at the specific time set in the motion. For example, the motion might be: "I move we adjourn this meeting at midnight." It requires a simple majority vote.

Motion to table. This motion, if passed, requires discussion of the agenda item to be halted and the agenda item to be placed on "hold." The motion can contain a specific time in which the item can come back to the body. "I move we table this item until our regular meeting in October." Or the motion can contain no specific time for the return of the item, in which case a motion to take the item off the table and bring it back to the body will have to be taken at a future meeting. A motion to table an item (or to bring it back to the body) requires a simple majority vote.

Motion to limit debate. The most common form of this motion is to say, "I move the previous question" or "I move the question" or "I call the question" or sometimes someone simply shouts out "question." As a practical matter, when a member calls out one of these phrases, the chair can expedite matters by treating it as a "request" rather than as a formal motion. The chair can simply inquire of the body, "any further discussion?" If no one wishes to have further discussion, then the chair can go right to the pending motion that is on the floor. However, if even one person wishes to discuss the pending motion further, then at that point, the chair should treat the call for the "question" as a formal motion, and proceed to it.

When a member of the body makes such a motion ("I move the previous question"), the member is really saying: "I've had enough debate. Let's get on with the vote." When such a motion is made, the chair should ask for a second, stop debate, and vote on the motion to limit debate. The motion to limit debate requires a two-thirds vote of the body.

NOTE: A motion to limit debate could include a time limit. For example: "I move we limit debate on this agenda item to 15 minutes." Even in this format, the motion to limit debate requires a two-thirds vote of the body. A similar motion is a *motion to object to consideration of an item.* This motion is not debatable, and if passed, precludes the body from even considering an item on the agenda. It also requires a two-thirds vote.

Majority and Super Majority Votes

In a democracy, a simple majority vote determines a question. A tie vote means the motion fails. So in a seven-member body, a vote of 4-3 passes the motion. A vote of 3-3 with one abstention means the motion fails. If one member is absent and the vote is 3-3, the motion still fails.

All motions require a simple majority, but there are a few exceptions. The exceptions come up when the body is taking an action which effectively cuts off the ability of a minority of the body to take an action or discuss an item. These extraordinary motions require a two-thirds majority (a super majority) to pass:

Motion to limit debate. Whether a member says, "I move the previous question," or "I move the question," or "I call the question," or "I move to limit debate," it all amounts to an attempt to cut off the ability of the minority to discuss an item, and it requires a two-thirds vote to pass.

Motion to close nominations. When choosing officers of the body (such as the chair), nominations are in order either from a nominating committee or from the floor of the body. A motion to close nominations effectively cuts off the right of the minority to nominate officers and it requires a two-thirds vote to pass.

Motion to object to the consideration of a question. Normally, such a motion is unnecessary since the objectionable item can be tabled or defeated straight up. However, when members of a body do not even want an item on the agenda to be considered, then such a motion is in order. It is not debatable, and it requires a two-thirds vote to pass.

Motion to suspend the rules. This motion is debatable, but requires a two-thirds vote to pass. If the body has its own rules of order, conduct or procedure, this motion allows the body to suspend the rules for a particular purpose. For example, the body (a private club) might have a rule prohibiting the attendance at meetings by non-club members. A motion to suspend the rules would be in order to allow a non-club member to attend a meeting of the club on a particular date or on a particular agenda item.

Counting Votes

The matter of counting votes starts simple, but can become complicated.

Usually, it's pretty easy to determine whether a particular motion passed or whether it was defeated. If a simple majority vote is needed to pass a motion, then one vote more than 50 percent of the body is required. For example, in a five-member body, if the vote is three in favor and two opposed, the motion passes. If it is two in favor and three opposed, the motion is defeated.

If a two-thirds majority vote is needed to pass a motion, then how many affirmative votes are required? The simple rule of thumb is to count the "no" votes and double that count to determine how many "yes" votes are needed to pass a particular motion. For example, in a seven-member body, if two members vote "no" then the "yes" vote of at least four members is required to achieve a two-thirds majority vote to pass the motion.

What about tie votes? In the event of a tie, the motion always fails since an affirmative vote is required to pass any motion. For example, in a five-member body, if the vote is two in favor and two opposed, with one member absent, the motion is defeated.

Vote counting starts to become complicated when members vote "abstain" or in the case of a written ballot, cast a blank (or unreadable) ballot. Do these votes count, and if so, how does one count them? The starting point is always to check the statutes.

In California, for example, for an action of a board of supervisors to be valid and binding, the action must be approved by a majority of the board. (California Government Code Section 25005.) Typically, this means three of the five members of the board must vote affirmatively in favor of the action. A vote of 2-1 would not be sufficient. A vote of 3-0 with two abstentions would be sufficient. In general law cities in

California, as another example, resolutions or orders for the payment of money and all ordinances require a recorded vote of the total members of the city council. (California Government Code Section 36936.) Cities with charters may prescribe their own vote requirements. Local elected officials are always well-advised to consult with their local agency counsel on how state law may affect the vote count.

After consulting state statutes, step number two is to check the rules of the body. If the rules of the body say that you count votes of "those present" then you treat abstentions one way. However, if the rules of the body say that you count the votes of those "present and voting," then you treat abstentions a different way. And if the rules of the body are silent on the subject, then the general rule of thumb (and default rule) is that you count all votes that are "present and voting."

Accordingly, under the "present and voting" system, you would **NOT** count abstention votes on the motion. Members who abstain are counted for purposes of determining quorum (they are "present"), but you treat the abstention votes on the motion as if they did not exist (they are not "voting"). On the other hand, if the rules of the body specifically say that you count votes of those "present" then you **DO** count abstention votes both in establishing the quorum and on the motion. In this event, the abstention votes act just like "no" votes.

How does this work in practice?
Here are a few examples.

Assume that a five-member city council is voting on a motion that requires a simple majority vote to pass, and assume further that the body has no specific rule on counting votes. Accordingly, the default rule kicks in and we count all votes of members that are "present and voting." If the vote on the motion is 3-2, the motion passes. If the motion is 2-2 with one abstention, the motion fails.

Assume a five-member city council voting on a motion that requires a two-thirds majority vote to pass, and further assume that the body has no specific rule on counting votes. Again, the default rule applies. If the vote is 3-2, the motion fails for lack of a two-thirds majority. If the vote is 4-1, the motion passes with a clear two-thirds majority. A vote of three "yes," one "no" and one "abstain" also results in passage of the motion. Once again, the abstention is counted only for the purpose of determining quorum, but on the actual vote on the motion, it is as if the abstention vote never existed — so an effective 3-1 vote is clearly a two-thirds majority vote.

Now, change the scenario slightly. Assume the same five-member city council voting on a motion that requires a two-thirds majority vote to pass, but now assume that the body **DOES** have a specific rule requiring a two-thirds vote of members "present." Under this specific rule, we must count the members present not only for quorum but also for the motion. In this scenario, any abstention has the same force and effect as if it were a "no" vote. Accordingly, if the votes were three "yes," one "no" and one "abstain," then the motion fails. The abstention in this case is treated like a "no" vote and effective vote of 3-2 is not enough to pass two-thirds majority muster.

Now, exactly how does a member cast an "abstention" vote? Any time a member votes "abstain" or says, "I abstain," that is an abstention. However, if a member votes "present" that is also treated as an abstention (the member is essentially saying, "Count me for purposes of a quorum, but my vote on the issue is abstain.") In fact, any manifestation of intention not to vote either "yes" or "no" on the pending motion may be treated by the chair as an abstention. If written ballots are cast, a blank or unreadable ballot is counted as an abstention as well.

Can a member vote "absent" or "count me as absent?" Interesting question. The ruling on this is up to the chair. The better approach is for the chair to count this as if the member had left his/her chair and is actually "absent." That, of course, affects the quorum. However, the chair may also treat this as a vote to abstain, particularly if the person does not actually leave the dais.

The Motion to Reconsider

There is a special and unique motion that requires a bit of explanation all by itself; the motion to reconsider. A tenet of parliamentary procedure is finality. After vigorous discussion, debate and a vote, there must be some closure to the issue. And so, after a vote is taken, the matter is deemed closed, subject only to reopening if a proper motion to consider is made and passed.

A motion to reconsider requires a majority vote to pass like other garden-variety motions, but there are two special rules that apply only to the motion to reconsider.

First, is the matter of timing. A motion to reconsider must be made at the meeting where the item was first voted upon. A motion to reconsider made at a later time is untimely. (The body, however, can always vote to suspend the rules and, by a two-thirds majority, allow a motion to reconsider to be made at another time.)

Second, a motion to reconsider may be made only by certain members of the body. Accordingly, a motion to reconsider may be made only by a member who voted in the majority on the original motion. If such a member has a change of heart, he or she may make the motion to reconsider (any other member of the body — including a member who voted in the minority on the original motion — may second the motion). If a member who voted in the minority seeks to make the motion to reconsider, it must be ruled out of order. The purpose of this rule is finality. If a member of minority could make a motion to reconsider, then the item could be brought back to the body again and again, which would defeat the purpose of finality.

If the motion to reconsider passes, then the original matter is back before the body, and a new original motion is in order. The matter may be discussed and debated as if it were on the floor for the first time.

Courtesy and Decorum

The rules of order are meant to create an atmosphere where the members of the body and the members of the public can attend to business efficiently, fairly and with full participation. At the same time, it is up to the chair and the members of the body to maintain common courtesy and decorum. Unless the setting is very informal, it is always best for only one person at a time to have the floor, and it is always best for every speaker to be first recognized by the chair before proceeding to speak.

The chair should always ensure that debate and discussion of an agenda item focuses on the item and the policy in question, not the personalities of the members of the body. Debate on policy is healthy, debate on personalities is not. The chair has the right to cut off discussion that is too personal, is too loud, or is too crude.

Debate and discussion should be focused, but free and open. In the interest of time, the chair may, however, limit the time allotted to speakers, including members of the body.

Can a member of the body interrupt the speaker? The general rule is "no." There are, however, exceptions. A speaker may be interrupted for the following reasons:

Privilege. The proper interruption would be, "point of privilege." The chair would then ask the interrupter to "state your point." Appropriate points of privilege relate to anything that would interfere with the normal comfort of the meeting. For example, the room may be too hot or too cold, or a blowing fan might interfere with a person's ability to hear.

Order. The proper interruption would be, "point of order." Again, the chair would ask the interrupter to "state your point." Appropriate points of order relate to anything that would not be considered appropriate conduct of the meeting. For example, if the chair moved on to a vote on a motion that permits debate without allowing that discussion or debate.

Appeal. If the chair makes a ruling that a member of the body disagrees with, that member may appeal the ruling of the chair. If the motion is seconded, and after debate, if it passes by a simple majority vote, then the ruling of the chair is deemed reversed.

Call for orders of the day. This is simply another way of saying, "return to the agenda." If a member believes that the body has drifted from the agreed-upon agenda, such a call may be made. It does not require a vote, and when the chair discovers that the agenda has not been followed, the chair simply reminds the body to return to the agenda item properly before them. If the chair fails to do so, the chair's determination may be appealed.

Withdraw a motion. During debate and discussion of a motion, the maker of the motion on the floor, at any time, may interrupt a speaker to withdraw his or her motion from the floor. The motion is immediately deemed withdrawn, although the chair may ask the person who seconded the motion if he or she wishes to make the motion, and any other member may make the motion if properly recognized.

Special Notes About Public Input

The rules outlined above will help make meetings very public-friendly. But in addition, and particularly for the chair, it is wise to remember three special rules that apply to each agenda item:

Rule One: Tell the public what the body will be doing.

Rule Two: Keep the public informed while the body is doing it.

Rule Three: When the body has acted, tell the public what the body did.

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BASIC LAWS GOVERNING BOARD MEMBERS

BROWN ACT – CONFLICTS OF INTEREST SUMMARY – AB 1234

I. THE BROWN ACT

1. INTENT

The Ralph M. Brown Act ("Brown Act" or "Act") is found at Government Code Section 54950, et seq. It requires that all meetings of the "legislative bodies" of local public entities be open and public. It also states that every person is permitted to attend any such meeting, except in certain very limited situations.

The intent of the law is to require public agencies to deliberate openly, and to take all of their actions openly, so that the public can remain adequately informed.

2. WHO IS COVERED BY THE BROWN ACT?

Only a member of a "legislative body" is required to comply with the Brown Act.

The term "legislative body," however, has been defined very broadly to include the Board of Directors, and any commissions, committees, boards or other bodies of a local agency, whether permanent or temporary, decision-making, or advisory, created by charter, ordinance, resolution or other formal action of the city council. Thus, it covers most bodies in the District. **The term also covers those persons who have been elected to a legislative body, but who have not yet assumed office.**

The only thing that is clearly not covered by the Act is an "ad hoc" advisory committee that is composed solely of less than a quorum of members of the legislative body. If there is any question as to whether or not the Brown Act applies, General Counsel should be consulted. Otherwise it is best to assume that the Brown Act applies.

3. WHAT CONSTITUTES A "MEETING"

The Brown Act only applies if the members of a legislative body are actually engaged in a "meeting," as that term is defined under the Act.

The term "meeting" includes any gathering of a majority of the legislative body at the same time and location, no matter how informal, when the business of the body is discussed or transacted, or information regarding the business of the body is received. The term is defined very broadly to

include study sessions, group discussions, informational meetings, fact finding meetings, pre-meetings, lunch meetings, emails, texts, phone calls, informal meetings or retreats, so long as a majority of the members participate. Recently, this prohibition was extended to sharing or liking another Board Member's social media posts.

4. PROHIBITION

The general rule states that "[a] majority of the members of a legislative body shall not, outside a meeting authorized by this chapter, use a series of communications of any kind, directly or through intermediaries, ***to discuss, deliberate, or take action*** on any item of business" within the body's jurisdiction. Cal. Gov't Code § 54952.2(b)(emphasis added). In other words, the Brown Act will be violated in any situation where it can be shown that a majority of the legislative body "met" to discuss or deliberate on any issue within their jurisdiction, unless the discussion took place during a publically agendized meeting.

Direct communications among a majority of the legislative body are clearly prohibited. But so is the use of personal intermediaries or technological devices by a majority to discuss, deliberate or take action on an item outside of a publically noticed meeting. These indirect avenues of communications are called **"serial meetings."**

Thus, even if a single communication will only involve two members (or three members on a seven-member body), the Brown Act will be violated if a series of single communications *together* will involve a majority of the body in the discussion.

Caution is needed, because serial communications can arise in a variety of contexts. For example, a telephone call from one member to another member may create a violation, if one of the participants decides to call a third member to discuss the content of his call. Emails and texts can also create problems, due to the ease with which messages can be sent back and forth between multiple parties. If emails or texts are exchanged between a majority of the members of a body, discussing an item, it would likely result in a violation.

Another area of concern involves the use of internet blogs and social networking sites such as Facebook. In both instances, violations may occur if a majority of the body enters into a "discussion" concerning an item in their jurisdiction on a blog or on a social networking site. So caution is encouraged whenever those kinds of sites are used.

5. EXCEPTIONS

The Brown Act states that there are certain kinds of situations which will not be considered to be a violation. These statutorily defined exceptions state that the following contacts are permissible:

a. Individual contacts or conversations between a member and any other person.

b. The attendance of the majority of the members of the legislative body at a conference or similar gathering, which is open to the public or members of the community, and involves issues of interest to the public or to public agencies of the type represented by the body, so long as the members do not discuss subject matter under the jurisdiction of the body other than as part of the scheduled program.

c. Attendance of a majority of the members of the legislative body at any public gathering, organized by a person or organization other than the local agency, to address a topic of local community concern, provided that members do not discuss amongst themselves issues specifically related to subject matter under the body's jurisdiction.

d. The attendance by a majority of the members of the legislative body at a purely social or ceremonial occasion, so long as members do not discuss amongst themselves issues specifically related to the subject matter under the jurisdiction of the body.

e. The attendance of a majority of the members of a legislative body at a meeting of another committee or legislative body, so long as members do not discuss, amongst themselves, issues specifically related to the subject matter under the jurisdiction of the body.

f. The attendance of a majority of the members of a legislative body at an open and noticed meeting of a standing committee of that body, provided that the members of the legislative body who are not members of the standing committee attend only as observers.

g. Video teleconference meetings conducted according to specified procedures listed in the Brown Act.

h. Emergency exceptions for security briefings permitted by Executive Order during pandemic or other statewide emergency.

6. OTHER MEETING REQUIREMENTS

a. Meeting Location.

All meetings must occur within the District's boundaries, except under certain limited circumstances. The exceptions include but are not limited to the following situations: (1) where real or personal property is being inspected and it is inconvenient to bring the property into the jurisdiction; (2) where the meeting takes place at a facility owned by the agency located outside the city, but discussion must be limited to items related to the facility; (3) at a meeting between multiple public agencies, where the meeting is held in one of the agency's jurisdictions; (4) a meeting held with federal or state officials to discuss local issues, but only where a local meeting would be impractical; (5) to comply with state or federal law or a court order; or (6) a meeting at the office of the District's legal counsel for a closed session on pending litigation, when to do so would reduce legal fees or costs.[1]

Meetings cannot be held at a place where racial discrimination or other discrimination is practiced or which is not accessible to disabled persons, or where a fee must be paid for the public to attend.

b. Compensation Disclosure.

In certain situations, public disclosure of compensation may be required at the beginning of a Board meeting, if it that meeting would involve a joint meeting of another public entity whose membership constitutes a quorum of the Board. The specific rule states that a convened Board meeting whose membership constitutes a quorum of any other legislative body may convene a meeting of the subsequent legislative body, simultaneously or in serial order, **only** (subject to certain exemptions) if a clerk or member of the convened Board meeting verbally announces the amount of compensation, if any, that each member will be entitled to receive as a result of convening the simultaneous or serial meeting of the subsequent legislative body. The verbal announcement must state that the compensation is provided as a result of convening a meeting for which each member is entitled to collect compensation. Government Code section 54952.3.

c. Agenda Requirements.

[1] Under current Executive Order, the in-person meeting requirement is temporarily suspended due to the need to maintain social distancing. Likewise, a provision which would require notice and posting at a legislator's location for such meetings is currently suspended.

All meetings must have an agenda. An agenda is to be a brief general description of each item of business to be transacted or discussed at the body's meeting. The **agenda for all regular meetings must be posted at least 72 hours prior** to the time of the meeting in a conspicuous location that is freely accessible to members of the public, and also on the local agency's Internet Web site if the local agency has one.

A special meeting may occur after giving 24 hour notice, but only the items listed on the agenda may be discussed. No additional items can be brought before the body.

Emergency meetings can be held with at least one hour notice, but a closed session can only be held if approved by a 2/3 vote of the membership (or unanimous voter of those present if less than 2/3 of the membership is present). An emergency is considered a crippling disaster, work stoppage, or other activity which severely impairs the public health and/or safety.

d. Items Open for Discussion.

Once the agenda has been posted, the general rule is that the body is not allowed to discuss any item not appearing on the agenda.

Items may only be added to the agenda at a regular meeting where two thirds of the body determines (or by a unanimous vote if less than two-thirds of the body is present) that: a) there is a need for immediate action which cannot wait until the next regular meeting of the body; and b) the need came to the attention of the body after the agenda had already been posted. An item can also be added in certain statutorily defined "emergencies," upon a majority vote. In addition to the above, members of the body or staff are permitted to **very briefly** respond to issues not appearing on the agenda in the following limited ways:

1) To briefly respond to questions or statements made by the public during the meeting;
2) To ask questions for clarification;
3) Ask staff for other factual information, or ask staff to report back on an issue at a subsequent meeting;
4) Request that an item be agendized for some future meeting;
5) Brief announcements by members of the body or by staff, and brief reports on their activities.

e. Disclosure of Documents.

Generally, any materials provided to a majority of the committee or legislative body during a meeting, or in advance of a meeting, in connection with a matter subject to discussion at a meeting, is a public document subject to disclosure. Such documents must be made available for public inspection, unless they involve legal advice from the General Counsel or a closed session item.

7. PUBLIC PARTICIPATION

There must be an opportunity for the public at every regular public meeting of the body to address the body as a whole on items not on the agenda and to address each agendized item, before or during the body's consideration of an item, except where the body previously considered an item, members of the public were given an opportunity to comment, and no substantial changes have been made to the item since that time. Comment on closed session items should be allowed prior to adjournment to closed session. At a specially called meeting, the public also must be given an opportunity to address each agendized item, however they are not required to be given an opportunity to speak on items not on the agenda.

However, the body may adopt reasonable rules and regulations to limit the functioning of the meetings with regard to the time, place and manner of those public comments. For instance, the body may limit the total time of testimony on particular issues and for each individual speaker.

Any person attending a public meeting has the right to record the meeting, unless the body finds that such action is a disruption to the proceedings. If any tape recording is made at the meeting the public may have access to that tape for up to 30 days after the meeting. The District has the right to destroy the tape 30 days after the recording.

8. CLOSED SESSIONS

A closed session may occur, but only under very limited circumstances authorized by the Brown Act. Prior to a closed session meeting a representative of the body must announce the items that are going to be discussed on the agenda or orally. After the closed session, the body must reconvene in open session to report regarding any final decisions which were made.

The following are subjects which may be discussed in closed session under the Brown Act:

a. Consideration of the appointment, employment, evaluation of performance, discipline or dismissal of a particular employee, or to hear complaints or charges brought against the employee by another person or employee, unless the employee requests a public session. Employee includes an officer or an independent contractor who functions as an officer or an employee (such as the City Attorney), but does not include elected officials, members of a legislative body, or other independent contractors.

b. Consideration of charges brought against a public employee by another person or employee.

c. To confer with legal counsel regarding pending litigation, significant exposure to potential litigation based on existing facts and circumstances, or in response to a statement threatening litigation against a public agency. Closed sessions are also permitted to confer with legal counsel regarding initiating litigation against another party.

d. To meet with the body's negotiator regarding discussions with employee organizations and unrepresented employees regarding salaries, compensation, benefits or any matter within the scope of representation by a represented employee group.

e. Conduct of real property negotiations, including the purchase, sale, lease, or exchange of property by, or for, the body.

9. ENFORCEMENT OF THE BROWN ACT

Any member of a committee or legislative body who attends a meeting where action is taken in violation of the Brown Act, and the member intends to deprive the public of information to which the member knows or has reason to know the public is entitled, **may be guilty of a misdemeanor**. Disclosing closed session information without authorization by the legislative body is also a misdemeanor.

Generally, reliance upon the opinion of legal counsel that a closed meeting is proper is usually evidence to support that no wrongful intent to deprive the public of information has occurred.

Violations of the public meeting notice and agenda provisions may result in actions taken by that body being declared null and void. A written demand to cure the defect must be made prior to a lawsuit being brought, seeking to void actions of the body. Actions involving substantial

compliance with the provisions of the Brown Act are exempt. There are also other situations which are exempt, under certain circumstances.

A civil action, requesting injunctive, mandamus or declaratory relief, may be brought to prevent further or future violations.

The body may have to pay the attorney's fees of a person bringing a successful legal action relating to a violation by the body of the Act. The body may also be entitled to receive an award of attorney's fees if a challenge to its actions is deemed frivolous.

II. CONFLICT OF INTEREST RULES

There are two important statutes relating to conflicts of interest. The first is the Political Reform Act, and the other is Government Code section 1090. Each of these will be discussed in turn.

1. THE POLITICAL REFORM ACT

The first, and the most important, statute is the Political Reform Act (the "PRA"), which is found at California Government Code section 81000, *et seq*. The PRA controls conflicts of interests of public officials by requiring the officials to disclose their financial interests, and also by prohibiting them from participating in any decision in which the official knows (or has reason to know) he or she has a financial interest.

Exactly what constitutes a financial interest which would preclude involvement by an official shall be discussed in greater detail below.

The PRA is administered and enforced by the Fair Political Practices Commission (the "FPPC"). If there is ever any question as to whether or not a particular situation requires an officer to disqualify him or herself, the FPPC can be contacted for an opinion. The District's General Counsel can also be contacted.

A. General Rule

Under the PRA, the general rule is that public officials are prohibited from making, participating in, or in any way attempting to use their position to influence, a governmental decision in which they know (or have reason to know) they have a financial interest.

This includes not only financial interests held by the officials themselves, but also financial interests held by the official's spouse and/or his or her dependent family members.

B. What Constitutes a Financial Interest

The PRA states that a public official will be deemed to have a financial interest if it is reasonably foreseeable that the decision will have a material financial effect on: (a) the official; (b) a member of his or her immediate family, or (c) any of the following:

1) Any business entity in which the official has a direct or indirect investment of $2,000.00 or more;

2) Any business entity in which the officer is a director, officer, partner, trustee, employee or holds a management position;

3) Any real property in which the officer has a direct or indirect investment of $2,000.00 or more;

4) Any source of income (for the officer) which amounts to $500.00 or more within the 12 months prior to the decision.

(Note: Campaign contributions do not count as income under the PRA in most circumstances. However, there is also a separate conflict of interest rule in Government Code section 84308 covering campaign contributions. That section is discussed below.)

5) Any source of gifts to the officer, if the cumulative gifts value is $500.00 or more[2] within 12 months prior to the decision. The limit is updated biannually.

6) The personal expenses, income, assets or liabilities of the official or his or her immediate family. Almmediate family@ includes spouses, registered domestic partners recognized by state law, and dependent children.

One of the most common reasons for a conflict concerns an official's financial interests in real property. If the property that is the subject of the City's decision is located within 500 feet of the official's property, it is presumed to create a conflict of interest for the official. This is known as the "**500 Foot Rule**." If the property is located between 500 and 1000 feet from the official's property, it will create a conflict under specific circumstances. But if the official's property is located more than 1000 feet from the subject property, it is presumed not to be directly involved. In

[2] The limit is currently $500 up through December 31, 2020. The limit increases in January of odd-numbered years, and the new limit starting in January will be $520.

such case there will be no conflict, unless there are other specific facts demonstrating that a conflict exists.

In many situations a careful examination of the facts is necessary to determine if a conflict is present. Therefore, officials are encouraged to consult with either the General Counsel or with the FPPC if they have any questions about a particular situation.

In any circumstance where it is ultimately determined a public official has a conflict of interest, the official is required to do three things: a) publicly disclose the conflict on the record; b) not participate in the decision; and c) leave the dais/room[3] so that he/she cannot influence the decision in any way (with body language, expressions, or other intangible means).

C. Two Exceptions from the General Rule

Even if there is a conflict of interest under the PRA, there are two situations where an official can still participate in the decision. These are as follows:

1) **"Public Generally" Exception**. The official will not be disqualified, if the decision will affect the financial interests of the general public in the same manner it will affect the official's financial interests. The exception does not require that the entire general public be affected. It only requires that a "*significant segment*" of the population be affected in the same manner as the public official. What constitutes a "significant segment" of the population must be determined on a case by case basis. See Cal. Govt. Code § 87103.

2) **"Legally Required" Participation Exception**. An official will not be disqualified if his participation in the decision is "legally required." The fact that an official's vote is needed to break a tie does not make the official's participation "legally required." See Cal. Govt. Code § 87101.

D. Council Participation in Appointments to Outside Boards/Commissions.

Previously the FPPC had determined that members of an elected body could not lawfully participate in a vote upon their own appointment to non-agency boards or commissions, if the position paid compensation. In 2012 the FPPC amended its regulations to authorize a member's participation in these kinds of votes, provided the following requirements were met:

[3] This rule does not apply if an item is on the consent calendar and is not pulled for separate action. Any council member with a financial interest in such an item should abstain from voting on that item.

1) The Board must adopt and post on its website, on FPPC Form 806, a list of all existing appointed positions for which compensation is paid, the amount paid, the name of the Boardmember and alternate appointed, and the term of the position. Please note Form 806 must be posted *prior* to any vote being taken to make new appointments, and the form must be updated once new appointments are made.

2) The appointment must be one in which either the Boardmember's appointment (a) is as an officer of the body of which he or she is a member (e.g., appointment to the office of chair) OR (b) is to a committee, board, or commission of a public agency, a special district, a joint powers agency or authority, a joint powers insurance agency or authority, or a metropolitan planning organization; and

3) The Board must be one which is required to be made by the Council pursuant to either state or local law, or pursuant to the terms of a joint powers agreement (JPA).

E. Filing of Form 700.

Board members, other specified public officials, and all candidates for those offices, must file conflict of interest disclosure statements using the official FPPC Form 700. The form and explanatory regulations are available from the City Clerk or online at the FPPC website. It is important to check *every part* of the Form 700 to see if an interest is disclosable.

Form 700 must be filed on the occurrence of certain triggering events and dates. These include the following (certain exceptions may apply):

1) An "assuming office statement" must be filed within 30 days after an official assumes office.

2) Form 700 must be filed annually thereafter, while the official continues to hold office; must be filed no later than April 1; and

3) Form 700 must be filed within 30 days after leaving office.

2. SECTION 1090

In addition to the PRA, there is a separate prohibition set forth in Government Code section 1090 ("Section 1090").

The general rule under Section 1090 is that District officers and employees are prohibited from having a financial interest in contracts made by them, or by any board or body of which they are members.

One distinction between Section 1090 and the PRA is that Section 1090 only applies if there is a **contract** involved. The PRA, on the other hand, applies to all kinds of decisions. Another distinction is that conflicts under the PRA can be avoided by having the official recuse themself from the decision. That is not an option under Section 1090. If an elected official has a conflict under Section 1090, the District is prohibited from entering into the contract altogether. This is true regardless of whether the official recuses himself from the decision.

There are certain statutory exceptions to Section 1090, but they are narrowly defined. See Gov't Code §§ 1091, 1091.5. It is important to keep in mind that relatively minor or indirect financial interests in a contract could potentially result in a violation of Section 1090. Therefore each situation needs to be examined on a case by case basis with the General Counsel, to determine if there is a conflict.

When Section 1090 is violated, several serious penalties could be imposed. The maximum penalty for a willful violation is a felony conviction, with a fine of $1,000 or imprisonment in the state prison, and the official is "forever disqualified from holding any office" in California.

3. BIAS

The due process clauses in the federal and state constitutions require that in a quasi-judicial proceeding the decision maker must be fair and impartial. A quasi-judicial decision is one in which the Board must determine facts and apply local, state and/or federal law to those facts to determine whether to grant or take away a specific right.

When a public official has a personal interest or involvement in the outcome of a matter, or with any of the participants, he must disqualify himself from the proceedings. Fairfield v. Superior Court, 14 Cal. 3d 768 (1975). This rule does not preclude holding opinions, philosophies or strong feelings about issues or specific projects; it also does not prevent the public official from being able to express views about matters of importance in the community, particularly during an election campaign.

However, it would preclude participation by a decision maker who has been demonstrated to have a *completely closed mind*, and has a preconceived and unalterable view of the outcome of a particular adjudicatory proceeding before he/she has even heard the evidence. Cohan v. City of Thousand Oaks, 30 Cal. App. 4th 547 (1994).

In Nasha v. Los Angeles, 125 Cal. App. 4th 470 (2004), the Court of Appeal overturned a planning commission decision to deny a land use project, because one of the planning commissioners had previously authored an article opposed to the project. The court held that publishing the article prior to the public hearing gave rise to an unacceptable probability of actual bias, and was sufficient to preclude him/her from serving as a "reasonably impartial, non-involved reviewer."

In Woody's Group v. City of Newport Beach, 233 Cal. App. 4th 1012 (2015), the Court held that due process was violated and bias shown by a council member who appealed a Planning Commission decision to the City Council, based on his assertion that the decision was incorrect.

And, in a recent case, Petrovich Development Co., LLC v. City of Sacramento, 48 Cal. App. 5th 963 (2020), the Court of Appeal invalidated denial of a conditional use permit for a gas station because one of the Council Members had crossed the line into advocacy against the project, which if done by a person sitting as part of a quasi-judicial body, taints the hearing process and denies due process. Specifically, the court found the following behavior as evidence of bias:

- Evidence that the Council Member was counting, if not securing, votes against the gas station and communicating an update to the Mayor when he indicated he was "confident" he had a majority.

- Council Member's denial that he had spoken to all his colleagues functioned as an admission that he had spoken to less than all of them, which was confirmed by the final vote.

- Council Member's "talking points" amounted to a presentation against the gas station. Emailing these talking points to the Mayor and the Mayor's advisor suggested both behind-the-scenes advocacy, as well as organizing the presentation at the hearing to obtain a "no" vote on the gas station. The organization of opposition was further confirmed by the advisor's talking points, which reflected the Council Member's points.

- Council Member's talking points turned up in the substance of the project opponent's letters opposing the gas station sent to the other councilmembers, evidencing that the Council Member was coaching the opponent on how to prosecute the appeal.

- Council Member making the motion to deny the CUP evidenced his bias, which was compounded because the document prepared by the Mayor's advisor shows that this was the sequence planned beforehand.

4. GIFTS, HONORARIA AND CAMPAIGN CONTRIBUTIONS

A. Gifts.

1) Gifts in General. Local elected office holders, candidates for local elected office, and designated employees of a local agency, are prohibited from accepting any gift(s) from any single source, valued at more than **$500**[4], during any calendar year. Cal. Govt. Code § 89503; *See also* Cal. Code of Regs. § 18940.2. This limit is adjusted bi-annually.

There are a number of statutory exemptions where a gift is not subject to the annual limit, and is also not reportable on form 700 (Statement of Economic Interest). For example: 1) Gifts you return to the donor or which are given to a nonprofit 501(c)(3) within 30 days of receipt without claiming a deduction; 2) gifts from close family members; 3) gifts exchanged during holidays, if both gifts are of approximately equal value; 4) campaign contributions; 5) plaques or trophies of minor value; 6) free admission and food at an event where you give a speech or otherwise participate. There are also other exemptions. Therefore, you are encouraged to consult with the City Attorney's office if you have questions about a specific situation.

2) Gift Ticket Rules.

a) Tickets Received from City. District's are required to adopt a Ticket Distribution Policy. Tickets held/controlled by the District must be distributed pursuant to the policy and for a valid public purpose. The giver and user of the tickets must be disclosed on FPPC Form 802, and the form must be posted on the District's website. Often board members are given tickets to events to where they are serving a ceremonial role or function – **but this exception is limited**. If the abovementioned posting requirements are met, the tickets are not a gift, and the official does not have to report the tickets on their Form 700.

[4] See footnote 1.

b) Tickets Received Directly by the Official From a Third Party.

(1) General rule: Tickets received directly by a Board member to a nonprofit event must be reported on Form 700, but you only have to report the value of what was actually received (food/entertainment). Don't have to count portion constituting a donation. The $500 maximum applies to the receipt of tickets.

(2) Important Exception: Board members may receive up to two free tickets to events hosted by a 501(c)(3) nonprofit, so long as they receive the tickets directly from the nonprofit. FPPC says the two tickets are not a gift, and do not need to be reported on Form 700, but the actual value of the tickets cannot be greater than $500. Additional tickets are subject to general rule above.

(3) Board members may also receive up to two free tickets for political fundraising events, which don't need to be reported.

B. Honoraria.

No local elected office holder, candidate, or designated employee, may accept any honorarium. Cal. Govt. Code § 89501(a). "Honorarium" means payment in consideration for any speech given, article published, or attendance at any public or private conference, meeting or other similar gathering. It does not include income earned for personal services which are customarily provided in connection with the practice of a bona fide business or profession, unless the predominate activity of the business is making speeches. Cal. Govt. Code § 89502.

There are a few exceptions to the honorarium ban, which are similar to the exceptions for gifts above. If you have any questions consult with the General Counsel.

C. Disqualification Related to Campaign Contributions.

There are two prohibitions involving campaign contributions that officials need to be aware of. They apply to any officer who has been appointed to a city board or commission (e.g. planning commission, etc.). Members of the Board are specifically excluded from these prohibitions, except in situations where they are serving as a voting member of another board or commission (other than the Board or other body consisting solely of Board members).

The two prohibitions are as follows:

1) Contributions Related to Current Proceedings.

Public officials (excluding Board members)[5] are prohibited from receiving or soliciting campaign contributions of more than $250, from parties or persons financially interested in a proceeding before the official's body. The prohibition lasts for the duration of the proceeding and for three months thereafter.

2) Disqualification Where Contributions Previously Received.

Public officials must disqualify themselves from a decision if they received contributions of more than $250 during the previous 12 months from a person who is financially interested in the matter that is currently before the official. Cal. Govt. Code § 84308(c).

5. ENFORCEMENT

The PRA and Section 1090 are enforced by the Fair Political Practices Commission (FPPC), the Attorney General, and the District Attorney through criminal sanctions, civil liability and civil penalties. Criminal violations of the PRA are generally prosecuted as misdemeanors and violations of Government Code Section 1090 as felonies.

Good faith of the public official is relevant in determining criminal and civil liability, so it is particularly important that public officials seek advice from the General Counsel or the FPPC. On occasion it may also be possible to seek formal written opinions from the California Attorney General or the FPPC, to clarify how the law will apply to a particular set of facts.

III. AB 1234

AB 1234 applies to all members of a local legislative body who receive any type of compensation, or reimbursement for expenses incurred in the performance of his duties. It essentially requires two things:

1. MANDATORY ETHICS TRAINING.

[5] While the PRA exempts Board members from this rule, some agencies have their own local rules which do apply to campaign contributions.

AB 1234 states that public officials are *required to receive at least two hours of training in general ethics principles and laws every two years. New members are required to receive their first two hours of training within* ***one year*** of the day they first begin service for the agency. Thereafter, public officials are required to renew their ethics training every two years. An official serving on multiple boards, commissions or committees is only required to receive a total of two hours of training. Govt Code Sec. 53234 - 53235.2.

The ethics course must cover certain specified subjects. The General Counsel can teach this course. Officials are also permitted to take an approved online course or to attend an approved training elsewhere. District staff will inform officials when the next training is scheduled.

2. COMPLIANCE WITH REIMBURSEMENT POLICY.

Pursuant to AB 1234, the District has adopted a reimbursement policy. The policy explains when reimbursement is allowed for travel, meals, lodging and other actual and necessary expenses. Anyone who expects to seek reimbursement needs to be familiar with this policy. A copy can obtained from the District's finance department. All claims must be submitted on the District's expense report form. AB 1234 states that expense reports must be submitted within a reasonable period of time after the expense is incurred, and they **must be accompanied by receipts documenting each expense.**

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Stark Law Update: Determining Whether Compensation is Fair Market Value or Takes Into Account the Volume or Value of Referrals

By David L. Haron, Suzanne D. Nolan & Mercedes Varasteh Dordeski, Frank Haron Weiner, PLC, Troy, MI



Healthcare arrangements within the purview of federal Stark laws[1] require a careful analysis of the manner in which physicians are compensated. Over the past year, three significant court decisions have emerged which add another layer of complexity to the "compensation" issue. Therefore, any attorney reviewing an arrangement for compliance with Stark should be familiar with these decisions.

Background

Generally, the federal Stark laws prohibit any physician (or an immediate family member) who has a financial relationship with an entity from referring patients for the furnishing of designated health services (DHS) that will be paid for by a federally-funded healthcare program.[2] A "financial relationship" includes direct and indirect compensation arrangements, the latter of which exists if the referring physician receives aggregate compensation from the entity with which s/he has a financial relationship that varies with or otherwise reflects the volume or value of referrals or other business generated by the referring physician.[3]

Whether a transaction is within the scope of Stark can hinge on whether an indirect compensation arrangement exists – i.e., if a physician receives compensation that reflects the volume or value of referrals. Conversely, whether such compensation is fair market value (FMV), and is determined independently of the value or volume of referrals is a crucial element of qualifying for the indirect compensation exception to Stark. The indirect compensation exception provides that a financial relationship does not exist if (among other things) the compensation received by the referring physician is FMV for services and items actually provided, and is not determined in any manner that takes into account the value or volume of referrals.[4]

First, it is important to note that any "compensation" analysis differs depending on whether the indirect compensation *definition* or the *exception* is being evaluated. Notably, an assessment of FMV comes into play only when determining if a proposed arrangement satisfies the indirect compensation *exception*.

Next, attorneys should note that simply because compensation is set at a "fixed" amount or flat payment does not make it automatically comply with a Stark exception. Attorneys cannot rely on appraisals indicating that compensation is FMV without understanding whether the compensation was based on the volume and value of referrals. As the cases below illustrate, it cannot be assumed that a fixed fee meets the volume and value standard. These cases are especially

noteworthy because of the dearth of Stark cases, particularly those with in-depth discussions of FMV and the indirect compensation exception.

U.S. ex rel. Singh v. Bradford Regional Medical Center[5]

In *Bradford*, a medical practice owned by two physicians entered into an arrangement under which Bradford Regional Medical Center (BRMC) would sublease a nuclear imaging camera used to perform diagnostic tests (i.e., DHS). As part of the sublease, the physicians agreed to a covenant not to compete with the provision of nuclear cardiology services by BRMC for the term of the agreement. Although there was no explicit requirement that the physicians refer their own patients to BRMC for tests, it was clear that the parties anticipated such referrals would be made. Prior to acquiring the nuclear camera and offering imaging services in-house, the two physicians and their subtenant were responsible for ordering approximately forty-two percent of BRMC's nuclear medicine tests.

BRMC's monthly sublease payments, made to the physicians' group practice, consisted of a *fixed* "pass-through" amount to lease the camera (equal to the amount the physicians owned on the lease), and a *fixed* additional amount for the non-compete agreement.

The federal district court analyzed this arrangement as an indirect compensation arrangement[6] and tested the compensation relationship between BRMC and the practice (as it was the non-ownership or non-investment interest closest to the referring physicians).[7] The court concluded that the sublease agreement created an indirect financial relationship between the parties, because the fixed fee payments for the non-compete provision varied with the volume and value of referrals due to the manner in which it was calculated. Specifically, BRMC had based the fixed fee on the revenues BRMC expected to generate with the sublease in place, less the revenues it would generate *without* the sublease in place.

However, the court held that this arrangement did not qualify for the indirect compensation *exception* because "[BRMC's] analysis of whether the non-competition agreement represents a fair market value is based, in part, on anticipated referrals from the doctors."[8] In reaching this holding, the Court noted that the definition of FMV precluded such a value from being determined in a manner that takes into account the volume or value of anticipated or actual referrals.[9]

U.S. ex rel. Drakeford v. Tuomey[10]

Whether an indirect compensation arrangement existed was the central issue in *Tuomey*, a case in which a jury returned a verdict that defendant Tuomey Health System violated Stark. Facing competition from a nearby ambulatory surgical center and potentially from physicians creating in-office ancillary services lines, Tuomey Health System created a for-profit entity to own four specialty limited liability companies (Specialty LLCs) which employed part-time physicians to perform outpatient surgeries and procedures (i.e., DHS) at Tuomey Hospital. The physicians' employment agreements required them to perform all of their outpatient surgeries and procedures at Tuomey Hospital or other Tuomey facilities. The physicians received a base salary, productivity bonuses based on their collections and an incentive bonus for meeting certain quality goals. The amount paid to the physicians as compensation significantly exceeded the amount collected by the Specialty LLCs for the services that the physicians personally performed.

The parties agreed, because of the intervening LLCs, that if there was a financial relationship between the physicians and Tuomey, it would be an indirect relationship.[11] For each procedure that a physician personally performed, there was also a referral to Tuomey for the technical

component or facility fee associated with the procedure. Notably, CMS has stated in commentary that the technical components associated with such personally performed procedures are DHS.[12]

Each physician's compensation, because it was based on a percentage of collections, increased with the volume of the physician's personally performed procedures and with the concomitant increase in the volume of referrals for the associated technical components. Accordingly, the compensation paid to the physician varied with the volume or value of the physician's referrals for the associated technical components.

The government estimated Tuomey was losing $1 to $2 million per year, computed as the amount it received for the physicians' services less the amount it paid the physicians. In the government's view, no hospital would enter into such an arrangement unless it was to secure a revenue stream through referrals. Such an agreement would be commercially unreasonable in the absence of such a referral stream. Accordingly, the government concluded that Tuomey *must* be using the income from the technical components of the procedures performed by physicians to be able to pay the compensation. In support of this, the government presented evidence, including testimony from the designers of the compensation plan that the designers took the physician groups' outpatient referrals into account to determine a benchmark for compensation, and testimony of statements made by Tuomey's Chief Operations Officer representing to a physician that the physician would be *sharing* in Tuomey's facility fee.

Tuomey was decided by a jury verdict. Each party's Stark analysis and position on the same was set forth in various briefs filed to support or oppose summary judgment motions.[13] Given the jury verdict, attorneys do not have the benefit of a written opinion which would have analyzed each party's position. Accordingly, there is some uncertainty about the impact of *Tuomey*. This case is currently on appeal and the resulting appellate decision should clarify how Stark is applied in this situation.

U.S. v. Campbell, et al .[14]

In *Campbell*, Defendant Joseph Campbell, a cardiologist, entered into an employment agreement setting forth his compensation and duties as a part-time Clinical Assistant Professor with the University of Medicine and Dentistry of New Jersey (UMDNJ). Campbell personally performed cardiac procedures for the UMDNJ University Hospital. The federal district court held that the associated referrals for hospital services and facility fees for the personally performed procedures were referrals within the meaning of Stark. Importantly, the court reasoned that Campbell was not a *bona fide* employee because he was not actually required to and did not perform the duties set forth in the employment agreement Accordingly, the arrangement was not protected by the *bona fide* employee exception.[15] Thus, the court held that "the compensation could not be the fair market value for those services" and must serve some other purpose, such as compensation for patient referrals.[16] The holding precluded Campbell from arguing he qualified for other Stark exceptions.

Conclusion

Taken together, these cases indicate that "fixed" fee compensation may actually vary with the volume and value of referrals or other business if the compensation was determined in a manner that took into account the volume or value of referrals. Additionally, when evaluating an arrangement to determine whether it is within the purview of Stark or complies with an exception to Stark, technical components associated with services personally performed by a physician should be treated as referrals of DHS.

These cases (coupled with the ever-increasing emphasis on cutting healthcare costs by combating fraud and abuse), signify that the government will not only scrutinize the written agreement

memorializing an arrangement, but will also review the manner in which parties perform under the contract and the basis on which compensation is determined. Accordingly, courts will also subject transactions that potentially violate Stark and other laws to heightened scrutiny.

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1 42 U.S.C. §1399nn, *et seq*.

2 42 U.S.C. §1395nn(a).

3 42 C.F.R. §411.354(c)(2). Additionally, in order for an indirect compensation arrangement to exist, there must also be an unbroken chain of relationships linking the referring physician with the entity furnishing DHS, *and* the entity furnishing DHS must have actual knowledge of, or act in reckless disregard or deliberate ignorance of the arrangement.

4 42 C.F.R. §411.357(p).

5 2010 WL 4687739, __F.Supp.2d __ (W.D. Pa. Nov. 10, 2010).

6 This arrangement began before the regulations implementing the stand in the shoes doctrine went into effect on December 4, 2007. See 42 C.F.R §411.354(c)(2)(iv)(A).

7 42 C.F.R. §411.354(c)(2)(ii).

8 Id. at 19.

9 42 C.F.R. § 411.351. Litigation in *Bradford* is ongoing; the court will next address the issues of whether an Anti-Kickback Statute violation is present, and if the Stark violation gives rise to liability under the federal False Claims Act, 31 U.S.C. §3729 *et seq*. The court's November 10, 2010 decision has not been appealed.

10 *U.S. ex rel. Drakeford v. Tuomey,* 2010 WL 4000188, slip copy (D.S.C. 2010).

11 The government's backup argument was that the intervening LLCs should be ignored as the alter egos of Tuomey Hospital and the arrangement evaluated as a direct compensation arrangement.

12 66 Fed. Reg. 941 (Jan. 4, 2001); 69 Fed. Reg. 16054, 16063 or 16067 (March 26, 2004).

13 Tuomey is currently on appeal in the Fourth Circuit and the resulting appellate decision should clarify how Stark is applied in this situation. A date for oral argument has not been scheduled.

14 2011 WL 43013, Dkt. No. 08-1951, slip op. (D.N.J. Jan. 4, 2011).

15 42 U.S.C. §1395nn(e)(2).

16 *Campbell* at 8. *See alsoU.S. v. Rogan*, 459 F.Supp.2d 692, 723 (N.D. Ill. 2006).

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	Department: District Wide
Source: Emergency Dept Nurse Manager	Effective Date: 6/1/18

PURPOSE:
To provide a process for when a patient leaves against medical advice (AMA) or refuses a treatment or transfer.

POLICY:
An individual, except patients under police guard or an involuntary hold, has the right to leave the hospital against the advice of his physician. Any individual who has received treatment at Northern Inyo Healthcare District (NIHD) and then refuses further care or transfer will be informed of the benefits of further care versus the risk of no further care.

PROCEDURE:

A. If a patient, for any one of many reasons, desires to leave the hospital before his doctor thinks he is ready for discharge, refuses a certain treatment, test or intervention ordered, or transfer to another facility, every effort must be made to convince the patient to remain in this hospital or proceed with the tests/treatment or transfer.
    1. Notify physician of the situation
        a. The physician must attempt to provide the patient with information regarding the risks involved in leaving, benefits of continued stay in the hospital, and any other alternatives such as transfer to another facility or any other treatment.
    2. Patient's cause for discontent must be ascertained and solved if possible.
    3. Efforts should be also be made by the RN and shift supervisor to convince the patient to change his/her mind and all risks must be explained to the patient. This shall be well documented on the nurse's notes by the RN or shift supervisor.
    4. Patient's family and friends who may be concerned for his well-being should be enlisted to convince him to stay.
B. When all efforts have been made and the patient (or individual acting on their behalf) is still adamantly refusing further treatment and/or transfer and/or insists on leaving against medical advice, the informed refusal will be documented in writing on the appropriate form: (Available in English and Spanish)
    1. *Informed Consent to Refuse Treatment*
    2. *Leaving the Hospital Against Medical Advice*
    3. *Patient Refusal of Transfer*
C. No patient, other than patients under police guard or on involuntary psychiatric holds, can be forced physically to stay in the hospital against their will.
D. If a patient leaves undetected without signing the appropriate form, hospital staff should attempt to locate him/her and request that he/she return to the hospital so his /her signature may be secured on the form. Document all attempts and the results on the patient's chart.
E. Notify the following of AMA:
    1. Physician
    2. House Supervisor
    3. Department Manager
    4. Director of Nursing, if appropriate
    5. Police, if appropriate
    6. Administration, if appropriate
F. If all efforts to return the patient are unsuccessful and he/she cannot be located, document fully and precisely on nurse's notes.
G. If there is serious physician and staff concern regarding patient's well-being after he/she leaves AMA, an Unusual Occurrence Report (UOR) must be completed and turned in to Quality Analyst.

H. Regardless of whether it is believed the patient will sign or not, the release form must be offered to the patient (or the parent or guardian) for signature in the presence of at least one witness. It is a requirement that this procedure is followed:
   1. If the patient (or parent/guardian) refuses to sign, proceed as follows:
      a. In the space provided for the patient's signature, write the words "***patient refuses to sign***." Beneath this line, sign your name and enter the exact time, date and a brief notation concerning the circumstances of the refusal.
      b. All hospital personnel who were present when the release was offered, and refused, must sign as witnesses to the refusal. Each witness must write his/her complete name - no initials.

I. Refusal of Treatment for Minors
   1. A parent or other legal representative may not decline treatment where such a refusal may cause serious physical harm or illness to the minor.
   2. If a parent or legal representative refuses treatment to a minor, Child Protective Services (CPS) must be notified immediately.

REFERENCE:

1. California Hospital Association Consent Manual (2014), Ch. 5.5, Ch.9.2
2. California Code of Regulations Title 22 Division 5 (2014), Article 70707- Patients' Rights
3. EMTALA- A Guide to Patient Anti- Dumping Laws. (2018). Chapter 18, Patient refusal of stabilizing treatment or transfer.
4. California Hospital Association (CHA): Minors and Healthcare Law (2017). Chapter 6 Refusal of Treatment.

CROSS REFERENCE:

1. EMTALA Policy
2. Patient Rights
3. Child Abuse or Suspected Abuse or Sexual Assault Guidelines for Victim of

Approval	**Date**
CCOC	12/03/2020
Emergency Services Committee	11/09/2020
Med. Services/ICU	11/12/2020
Peri-Peds	10/27/2020
Surgery /Tissue	10/28/2020
MEC	12/01/2020
Board of Directors	
Last Board Review	

Revised/Reviewed: 12/96; 9/00; 2/01; 7/11as; 2/15as, 1/18 gr

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

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

TO: NIHD Board of Directors
FROM: Charlotte Helvie, MD, Chief of Medical Staff
DATE: December 1, 2020
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action item*)
   1. *Emergency Management Plan*
   2. *Administration of Drugs and Biologicals*
   3. *Cardiac Monitoring Policy*
   4. *Dead on Arrival*
   5. *Leaving Hospital Against Medical Advice Refusal or Treatment or Transfer*
   6. *Qualitative Fit Testing*
   7. *Safely Surrendered Baby Policy and Procedure*

B. Medical Staff and APP Staff Appointments (*action items*)
   1. David Plank, MD (*plastic surgery*) – Provisional Consulting Staff
   2. Sarah Starosta, PA-C (*RHC physician assistant*) – Advanced Practice Provider Staff

C. Medical Staff and APP Reappointments for Calendar Years 2021-2022 (*action item*)

	Practitioner	Credentials	Specialty	Category
1	Agarwal, Anu	MD	Cardiology	Telemedicine
2	Akinapelli, Abhilash	MD	Cardiology	Telemedicine
3	Amsalem, David	MD	Emergency Med	Active
4	Arndal, Lara Jeanine	MD	OB/GYN	Active
5	Boo, Thomas J	MD	Family Med	Active
6	Bourne, Sierra	MD	Emergency Med	Active
7	Cromer-Tyler, Robbin	MD	General Surgery	Active
8	Drew, Tracy	NP	Family Nurse Practitioner	APP
9	Engblade, Joy	MD	Internal Med	Active
10	Ercolani, Matthew	MD	Urology	Provisional Consulting
11	Fair, James	MD	Emergency Med	Active
12	Gasior, Anne	MD	Family Med	Active
13	Goshgarian, Anne	MD	Emergency Med	Active
14	Helvie, Charlotte	MD	Pediatrics	Active
15	Jeppsen, Samantha	MD	Emergency Med	Active
16	Joos, Jennifer	PA	Family Practice	APP
17	Karp, Felix	MD	Internal Med	Provisional Active
18	Kip, Katrinka	MD	Cardiology	Telemedicine
19	Landrito, Earl	MD	Radiology	Provisional Consulting
20	Leja, Catherine	MD	Family Med	Active
21	Loy, Bo	MD	Ortho Surgery	Active
22	Loy, Tamara	NP	Pediatric Nurse Practitioner	APP

23	Ludwick, Joseph	MD	Cardiology	Telemedicine
24	Mandal, Atashi	MD	Internal Med	Active
25	McEvoy, Colleen	NP	Pediatric Nurse Practitioner	APP
26	Mehrens, Monika	DO	Family Med	Active
27	Morgan, Jayson	MD	Cardiology	Telemedicine
28	Nicholson, David L	CRNA	Anesthesia	APP
29	Radulescu, Vlad	MD	Cardiology	Telemedicine
30	Robinson, Allison	MD	General Surgery	Active
31	Rudolphi, Anna	MD	Emergency Med	Active
32	Schneider, Jeanette	MD	Psychiatry	Consulting
33	Schunk, Stefan	MD	Internal Med	Active
34	Sharma, Uttama	MD	Family Med	Active
35	Siddiqi, Saif H	MD	Radiology	Telemedicine
36	Su, Daniel	MD	Urology	Provisional Consulting
37	Timbers, William	MD	Emergency Med	Active
38	To, Thomas-Duythuc	MD	Cardiology	Telemedicine
39	Wise, Matthew	MD	OB/GYN	Active (LOA)
40	Yolken, Mara	NP	Adult Nurse Practitioner	APP

D. Request for Extension of Appointment as per Bylaws Section 6.13.4 (*action items*)
   1. Arrash Fard, MD (*cardiology*) – Adventist Health, Telemedicine Staff
   2. Mark Robinson, MD (*orthopedic surgery*) – Active Staff
   3. J. Daniel Cowan, MD (*anesthesiology*) – Active Staff

E. Resignations (*action items*)
   1. Robert Nathan Slotnick, MD (*obstetrics/gynecology & genetics*) – effective 9/4/20
   2. Benjamin Ge, MD (*teleradiology – Quality Nighthawk*) – effective 9/2/20
   3. Joe Miller, MD (*urology*) – effective 11/2/20
   4. Tamara McBride, MD (*family medicine/hospitalist*) – effective 12/31/20
   5. Stuart Souders, MD (*diagnostic radiology*) – effective 12/31/20
   6. Jake Ichino, MD (*cardiology, Renown*) – effective 12/31/20

F. Medical Executive Committee Meeting Report (*information item*)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURES

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

POLICY:

Northern Inyo Healthcare District Emergency Operations Plan (EOP) follows the Hospital Incident Command System (HICS) format. Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the incident command system (ICS) design of the HICS~~Hospital Incident Command System (HICS)~~. HICS provides for an "All Hazards" approach to manage emergencies. HICS has a defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. ~~Northern Inyo Healthcare District~~ NIHD has identified nine leadership positions that may be activated when activate HICS plan. These include Incident Commander, Liaison, Safety Officer, Public Information officer (PIO), Medical Tech/Specialist, Operations Section Chief, Planning, Logistics and Finance Administrator. These positions will be filled with most appropriate staff member on duty when Hospital Incident Command System (HICS) is activated. These people will be relieved when senior healthcare district staff becomes available.

HICS materials including job action sheets, vests (found only on D-isaster Cart), organization chart and documentation forms are located in the Disaster Manual and Disaster Cart and brought to the Incident Command Center (ICC) upon activation of Code Triage.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

This Emergency Operations Plan (EOP) is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district.~~, Northern Inyo Hospital District (~~NIHD~~)~~ has adopted the National Incident Management System (NIMS) at an organization level. NIMS uses a system approach to integrate the best of existing processes and methods for a unified national framework for incident management. NIHD has incorporated the 17 elements of NIMS compliance into this Emergency Operations Plan.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo ~~Hospital~~ Healthcare District and ~~the Public Health Department.~~Toiyabe Indian Health Clinic. NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and/or medical supply vendors. Established Memorandums of Understanding (MOU) and/or Agreement (MOA) will be shared with local

emergency management prior to an incident occurring.

NIHD will participate in local, regional, and or state multidiscipline and multi-agency drills twice per year. Exercise activities will address internal and external communications, receiving, triage, treatment, and transfer of mass casualties, progression of causalities through the healthcare district system, resource management, security procedures, specialty lab testing, and or site/facility safety. Exercise will be conducted through drills, tabletop, functional, and or full scale exercises.

SCOPE:

The Emergency Operations Plan is designed to assure appropriate, effective response to a variety of emergency situations that could affect the safety of patients, staff, and visitors, or the environment of NIHD, or adversely impact upon the healthcare district's ability to provide healthcare services to the community based upon the Hazard Vulnerability Analysis. The Program is also designed to assure compliance with applicable codes and regulations.

This plan covers all healthcare district facilities (Main and All outbuildings and clinics) and its implementation is the responsibility of all personnel.

GOALS:

1. Adhere to the NIHD's mission statement.
2. Prevent or lessen the impact that an emergency may have on the institution and the community (mitigation).
3. Identify resources essential to emergency response and recovery and facilitate their access and utilization (preparedness).
4. Prepare staff to respond effectively to emergency situations that affect the environment of care response and test response mechanisms.
5. Plan processes for reestablishing operations after the incident (recovery).

OBJECTIVES:

EM 01.01.01

The critical access hospital engages in planning activities prior to developing its written Emergency Operations Plan. Note: An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a

type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions

EM .02.01.01

The critical access hospital has an Emergency Operations Plan. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

EM. 02.02.01

As part of its Emergency Operations Plan, the hospital has a plan for how it will communicate during emergencies

EM. 02.02.03

As part of its Emergency Operations Plan, the healthcare district prepares for how it will manage resources and assets during emergencies.

EM. 02.02.05

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage security and safety of staff, patients, visitors, volunteers and other individuals during an emergency.

EM. 02.02.07

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage staff during an emergency

EM.02.02.09

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage utilities during an emergency.

~~**EM.02.02.09**~~

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

~~As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage utilities during an emergency.~~

EM.02.02.13

During disasters, the critical access hospital may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

EM.02.02.15

During disasters, the critical access hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration. Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.

EM.03.01.01

The critical access hospital evaluates the effectiveness of its emergency management planning activities.

EM.03.01.03

The critical access hospital evaluates the effectiveness of its Emergency Operations Plan.

EM.04.01.01

If the critical access hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the critical access hospital participates in planning, preparedness, and response activities with the system.

ORGANIZATION AND RESPONSIBILITY

Medical Staff: The Emergency Department Physician on duty at the time of the emergency will be responsible for providing medical services for the “Immediate Care” area. Additional physicians may be called in depending on the number of casualties and the nature of their

injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The Medical Staff reviews the EOP Plan at the ~~Department and MEC.~~Medical Executive Committee (MEC).

~~Quality Improvement Committee~~Senior Leadership receives regular reports of the current status of the Emergency Management Program through the ~~Safety Committee~~Disaster Management Committee~~. Quality Improvement Committee~~ and ~~reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the ~~Safety Committee Chair~~Disaster Management Committee. The ~~MEDDM~~ committee makes recommendations to Senior Leadership for purchase of supplies and equipment necessary for the improvement of the emergency response capability.

The Manager of Emergency Department and Disaster Planning (MEDDP) works under the general direction of the Chief Nursing Officer (CNO), the Chief Medical Officer (CMO) and the ~~Administrator.~~Chief Executive Officer. The MEDDP, in collaboration with the ~~Resuscitation~~ Disaster Management Committee is responsible for managing all aspects of the Emergency Management Program. The Disaster Management ~~MEDDMP~~ Committee advises ~~the Safety Committee~~Senior Leadership regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

All Healthcare district personnel are considered essential to the operation of the healthcare district. HICS allows for easy expansion of the basic incident command structure to include additional personnel assignments designed to accommodate the needs of specific disaster situations. Designated staff have been assigned to fill HICS positions and trained to assume these rolls. In some emergencies, the Healthcare district may establish a personnel pool to supplement or staff essential response or operating functions. In those situations, employees may be assigned responsibilities commensurate with their abilities but outside their normal job responsibilities. Employees who are assigned key roles in the HICS are issued identification vests ~~and name badges, designed~~ to clearly identify their role in the response effort.

Department Directors and Managers are responsible to implement their departmental emergency duties and take whatever actions are necessary to maintain needed services including maintaining a current emergency call-back telephone list. Depending on the scope and nature of the emergency some departments may be asked to close and send all available employees to the labor pool to assist with more acute needs. Department Directors and Managers are also responsible for educating their staff regarding emergency procedures. In

addition, they are responsible to be familiar with the specific roles which may be assigned to them or their department should the function(s) be activated by the Incident Commander. Each department must complete and submit a status report to the Incident Command Center (ICC) immediately following Code Triage. ~~.~~ General guidance for emergency incidents is provided in the Management of the Environment of Care Manual for the immediate situation, i.e. Civil Disturbance, Bomb Threat, Earthquake Protocol, Utility Failures, etc. The Department Director will notify the Incident Command Center of additional staffing needs and request approval to utilize the call-back list to provide personnel necessary to cover necessary staff positions. Department Directors and Managers are responsible for determining the department level of response needed for the emergency, based upon such information as:

The nature and severity of the emergency;
Direction from the Incident Commander;
Number of victims;
Types of injuries;
Time of day;
Current staffing;
Conditions and availability of the healthcare district, its equipment and materials available.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the Emergency Preparedness Plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

HAZARD VULNERABILITY ANALYSIS (HVA)

The ~~Resuscitation~~ Disaster Management Committee, with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. The result of the HVA will be reviewed with Healthcare Coalition and a county HVA will also be developed. Both of these processes will be completed annually. Results will be shared with the ~~Safety~~ Disaster Management Committee, Department Heads, and the Board of Directors.

MITIGATION, PLANNING, RESPONSE AND RECOVERY

The job action sheet of HICS includes sections addressing mitigation, planning, response, and recovery.

- **The Mitigation Section** describes equipment and human activity designed to be put in place in advance to minimize the impact of an emergency.
- **The Planning Section** describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. These planning

descriptions include a list of available supplies and equipment and any required maintenance or inspection.

- **The Response Section** describes the command structure required to manage the plan after initiation, during the emergency situation, and sustaining operations during protracted disruptions.
- **The Recovery Section** describes the processes for moving from emergency operations back to normal operations, and the process for assessing and implementing a full recovery of the structure and all internal components and systems.

COMMUNICATIONS SYSTEMS

Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, an emergency phone system, ~~public and~~ satellite telephones, two-way radios, Ham radios, and cellular phones. The implementation of the emergency plan focuses on maintaining vital patient care communications.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plan language will be used in training and tested during drill exercises.

COMMUNITY-WIDE RESPONSE INVOLVEMENT

NIHD is part of Section VI (6). The Emergency Response Group works with local, county and state planning agencies to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

COMMAND STRUCTURE

NIHD has chosen to use the ICS (Incident Command System) model to manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately

available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.

COMMUNITY PLANNING

NIHD participates in the Inyo County Emergency Planning through the Unified Command and the Healthcare Coalition. The groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. The discussions of the group are used to guide the development of the NIHD Emergency Operations Plan and planning.

INITIATION OF EMERGENCY

The Administrator or Administrator on Call, and the Nursing Supervisor on Duty, have authority to activate the Incident Command Center (ICC) and initiate CODE TRIAGE, or other portions of the emergency plan whenever a defined emergency exists. The person activating the emergency plan and/or the EOC, serves as the Incident Commander until relieved by a senior Administrator, or relinquishes responsibility to another individual for breaks or rest periods. It is always better to activate the EOC, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events. Each Emergency Operations Plan (HICS) clearly states the process for implementation of the plan. The description includes the command structure for the plan, the conditions, or criteria requiring activation of the plan, and the individual(s) responsible for implementation of the plan. The simplest implementation procedure is immediate activation of the response using an equipment-activated alarm for the fire plan. More complex response procedures involving setting up a command center and ICS response team are required for most emergencies, including major utility failures and community-based emergencies.

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **An Advisory** is given when no system response is needed but the potential for a response exists.
- **An Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **An Activation** is given when a response is required.

The local Public Health Department or emergency management office will usually receive these notifications.

Important information to obtain as soon as possible should include but not be limited to:

- type of incident, including specific hazard/agent, if known
- location of incident
- number and types of injuries

- special actions being taken (e.g., decontamination, transporting persons)
- estimated time of arrival of first-arriving Emergency Medical Service units.

NIHD and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

NOTIFICATION OF CIVIL AUTHORITY

Whenever a situation adversely affects the Healthcare district's ability to provide services to the community, the Healthcare District notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIH maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Department of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Department of Health Services, Licensing and Certification Program.

STAFF NOTIFICATION

Staff is notified of EOP plan implementation in several ways: overhead page, landline telephone, cellular phones, pagers, or runners in the healthcare district. Telephone trees, electronic computer notification, cellular phones, social media, pagers and other means of communication are used to notify staff that are away from the healthcare district.

STAFF IDENTIFICATION

NIHD uses the regular staff identification badge to identify caregivers and other employees during mass casualty or major environmental disasters. Everyone coming into the facility needs to have a visible NIH ID in order to enter. Staff without ID's must go through Labor pool, be positively identified, and receive a temporary badge or other approved alternate.

Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title and as more senior staff become available, and during longer incidents, jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIH emergency identification or to determine what form of identification to each responding group will display.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURES

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

STAFF COVERAGE OF CRITICAL POSITIONS

The Emergency Operations Plan includes processes for the Incident Commander and Departments heads to communicate to determine staffing needs and to assign available staff to critical responder positions. Some response procedures assign departments or individuals specific roles automatically to assure timely and effective implementation. HICS includes organizational charts and processes to assure staff coverage.

MANAGEMENT OF PATIENT CARE ACTIVITY

There is an Emergency Operations Plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, for evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and about current patients for planning, patient management, and informing relatives and other; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

1. **very high-risk** – could only be cared for in an acute facility
2. **high risk** – could be transferred to an acute care facility
3. **moderate risk** – would be transferred to another facility
4. **low risk** – could be transferred home
5. **minimum risk** – could be discharged immediately

DISASTER CREDENTIALING (See Healthcare District Policy)

EMERGENCY LOCATIONS FOR PATIENT CARE

All patients will enter through Emergency Department, after triage outside, as appropriate. Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of the Code.

- **Triage Area -** Emergency Parking Lot beside Emergency Department
- **Immediate Care Area -** Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Pioneer Medical Building
- **MORGUE** – To be determined at the time of emergency

EMERGENCY LOCATIONS FOR NON-PATIENT CARE

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – 2nd floor Conference Room
- **Labor Pool** – Main Lobby

- **Family Center/Human Services Center** – Rehabilitation Building
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center** – Rehabilitation Building

Procedures also address the transportation and housing of staff that may not be able to get to or from the facility during an emergency or who may need housing and other services for their families to be available for service. A procedure is in place for incident stress debriefing. Staff who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals, social services or chaplain.

Arrangements are made with vendors and other services to assure availability of supplies, materials, food and water in a timely fashion.

Release of information to the news media follows the procedures developed by the Public Information Officer (PIO)[4] who would act as spokes persons for the organization. The PIO, along with information Technology can give updates through social media. The Incident Commander will release information as appropriate to the situation. In larger incidents, the local Emergency Operations Center of Inyo County may act as spokesperson for the overall emergency and healthcare district information.

STAFF AND FAMILY SUPPORT

Because all Healthcare district personnel are considered essential during emergency response situations, the Healthcare district recognizes its responsibility to provide meals, rest periods, psychological, and other personnel support. In addition, the Healthcare district recognizes that providing support, such as communication services and dependent care, to employees' families during emergency situations allows employees to respond in support of the essential functions of the Healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency child care
- Emergency transportation
- Staff/family lodging and meals
- Psychological and bereavement counseling
- Staff/family prophylaxis or immunization
- Animal and pet care

ETHICAL OPERATING PROCEDURES

In emergency situations, certain standing policies and procedures of the Healthcare district and rules and regulations of the Medical Staff may be waived by the Incident

Commander, the Medical Care Director or the other first-tier incident command center staff to ensure that essential patient care can be rendered and that the facility can be secured.

EVACUATION

A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the CEO or senior leadership available.

SURGE AND ALTERNATE CARE SITES

Surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; City Hall, Pine Street School Gym; and the Fairgrounds.

The Incident Command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

RECOVERY PLANS

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc) has been recorded for baseline

Documentation for ~~FMEA~~ FEMA assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of the emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and staff in all departments affected by the plans are trained as part of

organization wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the Emergency Operations Plan (HICS), and actual outages of utility systems.

CHEMICAL AND RADIOACTIVE ISOLATION AND DECONTAMINATION

The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

EDUCATION AND TRAINING

Each new staff member of NIHD participates in a general orientation that includes information related to the Emergency Operations Plan. Examples of such information include: the Emergency Operations Plan (HICS)s, job-specific roles, emergency communication plans, location of emergency supplies and equipment, and disaster management procedures.

The Human Resources Department conducts the general orientation program. The general orientation program is scheduled by the Human Resources Department, and records attendance for staff members who complete the general orientation program. They also track and reschedule staff members who did not to attend the general orientation program.

New staff members also receive a department-specific orientation. Each department manager provides new staff members with a department-specific orientation to their role in the Emergency Management Program. All staff members of NIH participate at least once each year in a continuing education Program. Information specific to the Emergency Management Program is included in the continuing education Program. The Safety Officer collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 ~~will be~~is available to all healthcare district personnel likely to have a leadership role in emergency preparedness,

incident management, and or emergency response during an incident; all directors and nursing supervisors.

PERFORMANCE OF DRILLS/EXERCISES

NIHD is a healthcare district that offers emergency services and has a defined role in community-wide emergency management therefore the emergency management plan is tested twice a year, in response to and actual or in a planned exercise. One exercise a year includes a communitywide exercise and an influx of actual or simulated patients.

During planned exercises, an individual(s) is designated whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise, documents opportunities for improvement. The following core performance areas are monitored during planned exercises: event notification including processes related to notification of external authorities, communication including the effectiveness of communication both within the healthcare district as well as with response entities outside of the healthcare district such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community, resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security, patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking processes.

All exercises are critiqued by a multi-disciplinary process that includes administration, clinical (including physicians), and support staff to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.
After a drill or exercise, a corrective action report will be created. In the corrective after action report, the following points will be addressed for each identified issue:

- The identified action to correct the issue or deficiency
- The responsible person or group of people to implement the action,
- The due date for completion of the action, and
- The resulting corrective action will be incorporated into plans and procedures once completed.

The EOP is modified in response to critiques of exercises. Future planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise. Note: When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements are put in place until final resolution. The strengths and weaknesses identified during exercises are

communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

The MEDDP maintains performance indicators to objectively measure the effectiveness of the Emergency Management Program. The MEDDP determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Personnel, equipment, and management performance are evaluated to identify opportunities to improve the Emergency Management Program. The performance measurement process is one part of the evaluation of the effectiveness of the Emergency Management Program. A performance indicator is established to measure at least one important aspect of the Emergency Management Program. The current performance indicators for the Emergency Management Program are:

HI1.25

1. # Drills
2. # actual implementation of HICS
3. # pts treated in ED requiring decontamination
4. # incidents of mass causality

In addition, all the objectives listed at the beginning of this plan are evaluated for effectiveness during the annual evaluation.

ANNUAL EVALUATION

The MEDEP is responsible for coordinating the annual evaluation of the seven functions associated with Management of the EC. The MEDEP is responsible for performing the annual evaluation of the Emergency Management Program.

The annual evaluation examines the objectives, scope, performance, and effectiveness of the Emergency Management Program and the Hazardous Vulnerability Analysis. The annual evaluation uses a variety of information sources including the reports from internal policy and procedure review, incident report summaries, Safety Committee Meeting minutes, Safety Committee reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation are presented in a narrative report supported by relevant data. The report provides a balanced summary of the Emergency Management Program's performance over the preceding 12 months. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer term future.

The annual evaluation is presented to the ~~Safety Committee~~Senior Leadership, Board of

Directors, and Medical Executive Committee who reviews and approves the report. The deliberations, actions, and recommendations of the Committee are documented in the minutes. The annual evaluation is also distributed to the ~~Chief Executive Officer, the Performance Improvement Committee, and other~~ Department Heads ~~as appropriate~~. Once the review is finalized, the MEDEP~~DONCCDM~~ is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~Request for 1135 Waiver~~REQUEST FOR 1135 WAIVER

The 1135 waiver allows reimbursement during an emergency or disaster even if providers can't comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or Children's Health insurance program (CHIP). The waiver applies to federal requirements only and nor state licensures.

Waiver requests can be made by sending an email to the CMS Regional Office in California. Information of the facility and justification for requesting the waiver is required. (See attachment for 1135 Waiver Request).
https://www.cms.gov/Medicare/Provider-EnrollmentCertification/SurveyCertEmergPrep/Downloads/CMS-Presentation-1135-Waivers.pdf

DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.

b. **Incident Planning Guides (IPGs)**: Plans that describe the specifics of how the organization plans to respond to specific emergency situations as identified by HVA and other analysis.

c. **Emergency Operations Plan (EOP)** – The Program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.

d. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the

organization or in the surrounding community that disrupt the organization's ability to provide care.

e. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIH or on the ability of NIH to conduct normal patient care and business activities.

REFERENCES

1. National Incident Management System (NIMS)
~~http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml~~
~~1.~~ https://training.fema.gov/nims/docs/nims.2017.instructor%20student%20learning%20materials.pdf

2. Federal Emergency Management Agency (FEMA), ICS-100: Introduction to Incident Command System, (2018)
https://training.fema.gov/emiweb/is/is100c/instructor%20guide/is0100c_ig.pdf
3. Joint Commission Resources, 3rd ed., (2016) Emergency Management in Healthcare: An All Hazards Approach.
4. Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), (2019) Emergency Management (EM), EM 0.01.01 - EM 04.01.01.

~~2. Appendix 1. NIMS Implementation Activities for Hospitals and Healthcare Systems~~
~~3. National Bioterrorism Hospital Preparedness Program (NBHPP)~~
~~4. Hospital Incident Command System (HICS) Manual http://www.emsa.ca.gov~~
~~5. LA County Hospital Regional Response Plan~~
~~6. Emergency Management (EM) Principles and Practices for Healthcare Systems~~
~~7.~~ 5. ~~Training of Hospital Staff to Respond to a Mass Casualty Incident~~
~~8. IS-242 Effective Communication~~
~~9. IS-702 National Incident Management System~~
~~10. CAMH's Manual EC 4.10 and EC 4.20~~
~~11. Los Angeles County Hospital Regional Response Plan Umbrella Health Care Entities agreement~~
~~12. Federal Emergency Management Agency, FEMA, Higher Education Project (Appendix: Select Emergency Management-Related Terms and Definitions - 501KB MS Word): http://training.fema.gov/EMIWeb/edu/hazdisusems.asp~~

Title: Emergency Management Plan	
Scope: Hospital Wide	Manual: Safety
Source: Disaster Planning/Safety	Effective Date: 8/2008

~~13. Federal Emergency Management Agency, FEMA, State and Local Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning: http://www.fema.gov/plan/gaheop.shtm~~
~~14. Department of Veterans Affairs. Emergency Management Program Guidebook. 2005: http://www1.va.gov/emshg/page.cfm?pg=114~~
~~15. NFPA 1600, Standard on Disaster/Emergency Management and Business Continuity Programs 2004 Edition: http://www.nfpa.org/assets/files/pdf/nfpa1600.pdf~~
Centers for Medicare and Medicaid Services (2009). 1135 Waivers and the Emergency
~~16.~~ Preparedness Rule

CROSS REFERENCES:
1. Evacuation Policy
2. HICS Organization Chart
3. Emergency: Internal/ External Disaster Plan
4. Credentialing Health Care Practitioners in the Event of a Disaster
5. Disaster Plan Perioperative Unit
6. Sterile Processing Disaster Plan
7. ~~Overcrowding in the Emergency department~~Emergency Room Overcrowding
8. Triage of Patients Suspected of Ebola*
9. Disaster Management Committee

Approval	**Date**
CCOC	~~1/29/18~~7/27/2020
Safety Committee	~~4/11/18~~10/14/2020
~~Resuscitation Committee~~Disaster management Committee	~~4/4/18~~6/8/2020
Emergency Services Committee	~~5/16/18~~9/11/2020
Medical Executive Committee	~~6/5/18~~12/1/2020
Board of Directors	6/20/18
Last Board of Director review	6/20/18

Developed:
Reviewed: 8/08; 8/09; 8/2010; 7/2011as
Revised: 10/07; 8/09; 7/2011as, 1/2018 gr, 6/20 gr
~~Supersedes: HI HICS_ Emergency Management Plan~~

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Administration of Drugs and Biologicals	
Scope: District Wide	Department: CPM - Medication (MED), Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 4-2010

PURPOSE:

To provide an accurate, safe, and efficient method of administering medications to patients.

To work cooperatively with Pharmacy to allow medications to be delivered and charged in a safe, timely and accurate manner.

POLICIES AND PROCEDURES:

ORDERING THE MEDICATIONS

All medication orders must be given by a licensed member of the medical staff or designee.
The order shall include:

Name of drug, dosage
Route of administration, if other than oral
Administration times or time interval between doses ("PRN" or "on-call" medications have indications or parameters indicated)
Date and time the order is written.
Signature of provider.

VERBAL ORDERS

May be received and recorded by a Pharmacist or licensed personnel lawfully authorized to administer drugs.

Ancillary services may take verbal orders for limited use in their specialty as approved by the medical staff.

All verbal orders must be confirmed, verified and signed in the EHR within 48 hours by the ordering Provider.

All verbal orders (telephone orders) ***must*** be confirmed by read back or by verbal reply.

All medications are administered by or under the supervision of appropriate medical personnel in accordance with applicable law and regulation governing such acts and in accordance with the approved medical staff rules and regulations.

PREDEFINED ORDER SETS, Patient Specific (Not standing orders)

Used for specific patients when authorized by a licensed member of medical staff. Eg. Post op Orthopedic Orders for Total Joint Patient or PCA & Epidural Orders for side effects.

Medication order sets will be initially approved and reviewed annually by the Pharmacy and Therapeutics Committee or the appropriate medical staff committee assigned to the patient care unit.

Title: Administration of Drugs and Biologicals	
Scope: District Wide	Department: CPM - Medication (MED), Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 4-2010

STAT MEDICATION ORDERS

STAT Orders are to be specifically noted and brought to the attention of the team leader and Pharmacy Department immediately. Any order received by the Pharmacy marked STAT will be addressed with highest priority.

RENEWAL AND AUTOMATIC CANCELLATION

All medication orders shall automatically be discontinued at time of surgery or whenever a patient has a change in the level of care.

CONTROLLED SUBSTANCES

(See Hospital Controlled Substances policy, in Administration Policy Manual)

All nursing departments will use the Omnicell system for retrieval and wastage of controlled substances.

PROCURING DRUGS AFTER PHARMACY HOURS

NIH on-call pharmacists are providing after hours pharmacy services. All orders should be entered as soon as possible so that the on-call pharmacist can verify. The on-call pharmacist will handle the orders just as if the pharmacy were open. Do not override medication from the Automated Dispensing Unit unless it is an emergent situation.
Only emergent medications should be overridden by staff nurses in the Automated Dispensing Unit, if emergent medications are not available on override, the staff nurses should contact the Nursing Shift Supervisor, who will follow appropriate policies and procedures to obtain medications. (Refer to "Access to Medications in the Absence of the Pharmacist" policy.

COMPOUNDING AND MIXING DRUGS

Only a pharmacist, or authorized Pharmacy personnel under the direction and supervision of a Pharmacist, may make labeling changes, or transfer medications to different containers. Only a Pharmacist or Provider may dispense medications, and only when an order has been made in the patient's medical record. All dispensed medications must be labeled in accordance with State and Federal requirements. For medications to be sent home with patients see Discharge Medication Policy.

Nurses will not compound or mix any drugs with the exception of the following:

Routine, simple admixture of IV medications, on a one time basis, in the absence of the Pharmacist, following the posted guidelines for preparation,

Mixing of injectables immediately prior to administration.

Reconstitution of dry, powdered oral medications, only in the absence of the Pharmacist, may be done only by the Nursing Supervisor for inpatient use, or the Emergency Room RN for ER patient use.

USE OF FILTERED NEEDLES

Filter needles are to be used for withdrawal of contents from reconstituted vials and ampules.
Discard filter needle post aspiration and, if a needle is required, change to the appropriate size standard needle for injection of medication.

VIALS FOR INJECTION AND IRRIGATION CONTAINERS

All vials should be **dated with 28 day expiration and initialed** when opened, unless discarded immediately after a single dose has been withdrawn (see below for exceptions). If reconstituted, the vial should be labeled with the concentration and the manufacturer's suggested expiration date, if applicable.

Single dose vials are always for single patient use only. Unless contraindicated by stability, a single use vial may be used, for a single patient, for the duration of the shift during which it was opened, provided the vial has been dated and initialed.

Multiple dose vials (i.e., containing bacteriostatic agents) are considered **single patient** vials again exceptions see below. A multiple dose vial may be used until the manufacturer's expiration date, but for one patient only, provided the vial has been dated and initialed. Insulin (not containing preservatives) is for single patient use.

Exceptions:

Skin test materials and vaccines containing preservatives may be used for multiple patients and kept until the manufacturer's expiration date, provided the vial has been dated and initialed.

Opened, unlabeled/undated/not initialed vials will not be used and they will be discarded appropriately.

Discontinued and outdated drugs, and containers with worn, illegible, or missing labels or labeling, are returned to the Pharmacy for proper disposition. Discarded medications should not be placed in the regular trash, but should be made inaccessible to further use.

Sterile irrigating solutions of sodium chloride and sterile water should be dated and initialed when opened and discarded after 24 hours.

EMERGENCY DRUG SUPPLY (CRASH CARTS AND DRUG BOXES)

The type of drugs, drug level and their location is determined by the Pharmacy and Therapeutics Committee with input from other appropriate committees.

(See Crash Cart and Emergency Medication policy)

BEDSIDE MEDICATIONS FOR SELF-ADMINISTRATION (~~Emergent/Palliative Only~~see policy *Administration of Drugs: Self-Administration*)

- Requires specific order of attending Provider "patient to self administer from bedside".
- Patient must be competent and capable of self-medication.
- All drugs dispensed from bedside must be charted in the EHR.
- Controlled substances may not be left at bedside.
- Medications are to be stored in the bedside table, in the possession of the patient.

ADMINISTRATION OF POTASSIUM (CONCENTRATION AND TELEMETRY)

(See Intravenous Potassium policy)

MEDICATION SAMPLES (SEE PHARMACY POLICY)

Use of drug samples in the hospital is not allowed, unless the Pharmacist has determined there is no other source and is essential to care. The drug sample will be stored in the Pharmacy and distribution/administration must conform to all appropriate hospital policies. Except for this single exception, drug samples may not be stored anywhere within the hospital.

PATIENT'S OWN MEDICATION

Drugs brought into the hospital by the patient are not administered unless the drug is unavailable through the hospital pharmacy and the patient's Provider indicates "patients may use own meds" in the order.
Drugs must be positively identified by the hospital pharmacist or Provider.(**A nurse cannot do this**)

If the drugs are not to be used during the patient's hospitalization, they are packaged, sealed and given to the patient's family or representative and documented on the Patient Admission Assessment.

If it is not possible to give the patient's medications to the family or representative, they are packaged, sealed, labeled in a valuables bag and given to the nursing supervisor to be locked in a specific cupboard. These are returned to the patient at the time of discharge unless denied by the Provider. A valuable medications label is

filled out with the patients name and is placed in the front of the patient chart to alert nursing personnel of locked medications.

DISCHARGING THE PATIENT

Upon discharge of the patient, any discontinued medications will be picked up by pharmacy.

Acetaminophen pediatric oral drops and suspension, and Ibuprofen pediatric suspension may be given to the patients caregiver to take home without a Provider order and do not need to be relabeled by the pharmacy.

NIHD does not operate a retail pharmacy and does not provide medications to go home (see Discharge Medication Policy).

Patients are given the choice of pharmacy desired for filling discharge medications.

Medication orders will be transmitted to the desired pharmacy.

TRANSFERS OF PATIENTS

Between Units:

All medication orders ~~are discontinued and then reordered~~will be reconciled if a patient relocates to a different level of care.

ADVERSE DRUG REACTIONS

Definition:
An Adverse Drug Reaction is any unintended and/or undesirable occurrence, associated with a drug, which occurs at doses normally used in man for prophylaxis, diagnosis or therapy of disease that results in one or more of the following:

1. Stopping the drug,
2. Initiating or prolonging the hospital stay,
3. Providing supportive treatment not ordinarily indicated,
4 Death.

Notify the Provider who ordered the medication immediately. The primary reporter should fill out a UOR in Comply Track for the acute care setting. Entry of the medication administered and the suspected drug reaction should be recorded in the patient's record in the EHR in the clinic setting.

Title: Administration of Drugs and Biologicals	
Scope: District Wide	Department: CPM - Medication (MED), Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 4-2010

NON-PUNITIVE REPORTING OF MEDICATION ERRORS / OCCURRENCES

Purpose:

To provide a non-punitive mechanism for the reporting of medication errors and occurrences in an effort to continuously improve the medication process and the quality of patient care. Comply Track is used for this purpose exclusively.

Medication Error Definition:

A medication error is any event that has caused or lead to inappropriate medication use. Such events may be related to professional practice, health care products, procedures, and systems, including assessment; prescribing; order communication/transcription; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Medication Occurrence Definition:

A medication occurrence is any event that may cause or lead to inappropriate medication use, but is intercepted by a healthcare professional or the patient prior to administration. Such events may be related to professional practice, health care products, procedures, and systems, including assessment; prescribing; order communication/transcription; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Policy:

Patient safety and quality improvement are important elements in the delivery of patient care at NIH. Reporting of medication errors and occurrences provides the opportunity to receive and analyze the data necessary to do this. With an emphasis on a non-punitive approach, focusing on performance improvement, it is expected that medication error/occurrence reporting will increase and provide the necessary data. All data will be collected, analyzed and reviewed in a confidential manner, subject to the terms of the hospital's policy on confidentiality and/or privacy of patient and employee information. It is the expectation that any employee of the hospital who believes a medication error/occurrence has occurred will report the error/occurrence

Non Punitive Action means that there will be no disciplinary action taken against an employee for a medication error/occurrence. Under this policy, no reference to the incident will be placed in the employee's permanent employment record or used during the performance appraisal process.
Continuing education, remedial training or an individualized action plan is not considered "punitive or disciplinary action" under this policy.

Exceptions to Non Punitive Action may include:

1. HIPAA violations.
2. Intentional or negligent acts by the employee in the administration of medications
3. The unlawful or inappropriate consumption of medications/controlled substances by the employee making the error/occurrence, at the time of the error/occurrence
4. Employees who knowingly fail to report a medication error/occurrence.
5. Acts resulting in the diversion of hospital medications.

If an error is made in the administration of a medication, the individual discovering the mistake will contact the nurse on duty, who will immediately assess the patient and notify the patient's Provider.

The incident and action taken should be noted in the patient's medical record, stating the medication given, strength, amount, time, date and initials of the nurse.

The Nursing leadership on duty will be notified and will verify that a UOR has been completed.

The Performance Improvement Coordinator and a pharmacist will be responsible for review of the report and the preparation for review at MAIC.

As a function of the MAIC Medication Administration Improvement Committee, aggregate medication error/occurrence information will be presented to a multidisciplinary team on a regular basis, in a confidential setting. The intent of the presentation will be to evaluate possible improvements in the medication process.

MEDICATION TIMES

Medications times have been established by departments, confirmed by committee and reviewed annually and live in the EHR.

QUESTIONING THE ORDER

If, in the nurse's professional judgment, a medication ordered by a Provider is in question, as to dosage, route or type of medication, the pharmacist will be consulted and/or the order will be clarified with the prescribing Provider. After clarification, the nurse or pharmacist will enter a clarification order in the patient's electronic medical record. If, in the nurse's judgment, the medication seems improper, the nurse will follow the "Guidelines for Resolving Differences of Opinion."

The Pharmacist on duty or "on-call" should be called for questions regarding a medication or compatibility.

Title: Administration of Drugs and Biologicals	
Scope: District Wide	Department: CPM - Medication (MED), Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 4-2010

PREPARING AND ADMINISTERING THE MEDICATION

Wash hands and use a clean surface area to set up medications for administration.
A drug is administered as soon as possible after the dose has been prepared, particularly a medication prepared for parenteral administration shall be administered within 1 hour (pursuant to USP 797) by nursing. Do not mix doses in anticipation for another shift to give.

Before a drug is administered, check "5 rights".

1. Right name: The identification band is always checked.
2. Right drug.
3. Right dose.
4. Right time and frequency.
5. Right route.

Call the pharmacist regarding any dispensing discrepancies.

Consult with the Provider for any unclear orders or discrepancies.

Shake medications **in suspension** before pouring or drawing into syringe.

Check the chart and armband for allergies.

Must check 2 patient identifiers (ask patient their name and birth date)

Examine the drug itself - check expiration or reconstitution date. Check for discoloration or precipitation.

Try not to be interrupted by other staff members while assembling and measuring the drugs.

Remain with the patient until the drug has been taken. **Do not leave medications at the bedside** unless it is specifically ordered that way and meets the policies under "Bedside Medications for Self-Administration".

DOUBLE CHECKING MEDICATIONS

Please refer to the High Alert Medication Policy for medications requiring double checking,

Dose Checking:

Double checks of dosages, with a recognized dosing reference, should be considered for any patient with a lower than normal body weight or size, renal impairment and/or liver impairment, regardless of age.

Pediatric Dose Checking:

In addition to the checks referenced above, **all** doses for patients less than 13 years of age must be verified with a recognized pediatric dosage reference source by a second health care professional, (**This should be an independent check**) prior to administration of the first dose. The dosage check is documented in the nursing notes.

VERIFYING THE ORDER

Orders entered via CPOE are verified, modified, or replaced by the pharmacist in accordance with pharmacy practice and policy. Pharmacists will enter orders that have been written (faxed) or given verbally by provider..

During the time that the NIHD pharmacy is closed the medication orders not entered via CPOE are if necessary input EHR by the NIHD pharmacist on-call.

TIME OF MEDICATIONS

Medication times are selected during order entry and populate correctly in the EHR.

Discontinue Time: When a medication is discontinued it will convert from being active to discontinued in EHR

All pre-op orders are discontinued when the patient goes to surgery. At any change of level of care orders will be restarted as appropriate.

All orders are reviewed at the start of each nursing shift.

Injection sites must always be noted in the EHR using the clinical notes under the drug given area.

When an error in charting has been made or patient refuses the ordered medication documentation in the EHR

The nurse must document each dose administration on the EHR.

Combined medications

If there is more than one drug to be given together, "give with" is placed on both drug entries.

START AND STOP TIME REQUIREMENTS IV'S, PIGGYBACKS, AND BLOOD;

All intravenous infusions must have a start and stop time documented.

If IV, piggyback or blood is hung on one shift and completed on another shift the stop time should be charted under the original start time of the infusion.

CHECKING IV, IVPB AND PCA SOLUTIONS

Intravenous solutions, IVPBs and PCA solutions are reviewed by the nurse for correctness of solution, additive(s), rate of administration and pump settings on a regular basis, but always at the beginning of the shift.

IVPBs are inspected by the nurse at the end of the infusion to verify:

- that the complete dose has been infused,
- that the maintenance IV is infusing as ordered or
- the line is flushed, if no maintenance IV is ordered.

ADMINISTRATION OF MEDICATION THROUGH A NASOGASTRIC TUBE

Medication may be administered with feedings unless contraindicated. Check with the pharmacist prior to crushing or if questioning any drug that can be given via the tube. Do not crush time-release products, which will change their rate of absorption characteristics check with pharmacist to confirm.

Equipment:
Medication (diluted if necessary)
50cc irrigating syringe
Clamp
Lopez Enteral Valve (See following inset)

Procedure:
1. Explain procedure to patient.
2. Elevate head of bed unless contraindicated.
3. Aspirate tube before instilling water and medicine to check for placement and position. Observe contents for blood, previous feeding, or medicines. Report any unusual findings before proceeding.
4. Attach appropriate syringe to nasogastric tube or enteral valve and check tube for proper placement according to hospital policy.
5. Instill 20ml of water to flush the tube and clamp for 15-20 minutes.
   a. Reconnecting it to suction. If patient is on continuous or intermittent suction, observe contents suctioned out after reconnecting tube to suction **OR**
   b. Leave it clamped until next feeding or medication if patient is not on suction.

Title: Administration of Drugs and Biologicals	
Scope: District Wide	Department: CPM - Medication (MED), Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 4-2010

TUBERCULIN SKIN TESTING

Procedure for Reading Skin Tests:

Skin tests are all administered intradermally (intracutaneous) on the volar aspect of the forearm. 0.1 cc of the antigen is administered with a TB syringe. The amount of induration in millimeters is recorded on the reporting form (do not simply report "negative" or "positive").

PPD: Read between 48 and 72 hours (preferably closer to 72 hours).Sensitivity is indicated by induration. The widest diameter of distinctively palpable induration should be recorded in millimeters (mm).

Positive: Any palpable induration measuring l0mm or more.
(In exposed individual 5mm or more).
Negative: Induration 5mm or less.

Recording Skin Test Results:

Skin test results are recorded in the patients EHR for future retrieval..

Classification of the Tuberculin Skin Test Reaction

An **induration of 5 or more millimeters** is considered positive in -HIV-infected persons -A recent contact of a person with TB disease -Persons with fibrotic changes on chest radiograph consistent with prior TB -Patients with organ transplants -Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF-α antagonists)	An **induration of 10 or more millimeters** is considered positive in -Recent immigrants (< 5 years) from high-prevalence countries -Injection drug users -Residents and employees of high-risk congregate settings -Mycobacteriology laboratory personnel -Persons with clinical conditions that place them at high risk -Children < 4 years of age – Infants, children, and adolescents exposed to adults in high-risk categories	>An **induration of 15 or more millimeters** is considered positive in any person, including persons with no known risk factors for TB. However, targeted skin testing programs should only be conducted among high-risk groups.

Title: Administration of Drugs and Biologicals	
Scope: District Wide	Department: CPM - Medication (MED), Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 4-2010

REFERENCES:

1. Targeted Tuberculin Testing *MMWR* 2000; 49 (No. RR-6)
2. A Review of Verbal Order Policies in Acute Care Hospitals Joint Commission Vol 38 P24-33 1/1/12
3. Order set utilization in clinical order entry system Pub Med AMIA Annu 2003:819
4. Controlled Substance Policy DEA Drug Abuse and Control Act 1970
5. Pharmacy Security California State Board of Pharmacy
6. Filter needle Use AJN, 1/2001 vol. 101 page 75
7. Stability of Biological Parenteral Products AHS Pharmacists 2015:72:396-407
8. Preventable Adverse Drug Reactions US. *Drug Saf* 2000;23(1):87–93.
9. Pathways For Medication Safety American Hospital Assn Nov 6, 2002
10. Survey on Medication Safety Perception ISMP June 27, 2002
11. CDC https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

CROSS REFERENCES:

1. Controlled Substance Policy NIHD
2. Discharge Medication Policy NIHD
3. Access to Medication in Absence of Pharmacist NIHD
4. Automatic Dispensing Unit Policy NIHD
5. Crash Cart and Emergency Medication Policy NIHD
6. Intravenous Potassium Policy NIHD
7. High Alert Medication Policy NIHD
~~7.~~8. Administration of Drugs: Self-Administration

Approval	**Date**
CCOC	10/29/2020
Perinatal/Pediatrics Committee	11/30/2020
Pharmacy and Therapeutics	10/15/2020
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	

Revised: 9/2020fl
Reviewed: 1/18/17; 1/17/18

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager Acute/Subacute ICU	Effective Date: 1/17/17

PURPOSE:

1. To ensure all patients who have orders for telemetry receive cardiac monitoring by trained staff within the constraints of the physician orders

2. To standardize process for nursing management of the patient on the Acute Sub Acute unit caring for the telemetry patients, and for the nurse monitoring the patient in the Intensive Care Unit (ICU)

3. To guide appropriate placement of patients requiring cardiac monitoring in the Acute Sub Acute Services Department

4. To define required competency for registered nurses (RN) caring for patients on a cardiac monitor in the Acute Sub Acute Services Department and for the nurse monitoring the patient in the ICU

5. To define parameters for and delineate response to clinical alarms related to cardiac monitoring in the Acute Sub Acute Services Department

6. To ensure that accommodation and billing codes are accurate

POLICY:

1. A physician's order is required to place a patient on a cardiac monitor
    a. Patients who present with or develop the following conditions while being admitted to the Acute Sub Acute department may be monitored on telemetry without being transferred to ICU:
        i. Syncope of unknown origin
        ii. Uncomplicated congestive heart failure (CHF)
        iii. Chest pain without diagnostic ECG findings or elevated biomarkers
        iv. Hemodynamically stable post-acute myocardial infarction (MI)
        v. Non-life threatening arrhythmias
        vi. Chronic, rate-controlled atrial fibrillation
        vii. Postoperative/post-procedure monitoring for patients at low risk for cardiac arrhythmias
        viii. Newly placed permanent pacemakers
        ix. Renal insufficiency

    b. Patients who present with or develop the following conditions require cardiac monitoring in the ICU:
        i. Hemodynamic compromise requiring vasoactive or antiarrhythmic medications
        ii. Unstable angina
        iii. ECG changes or life-threatening arrhythmias
        iv. Acute MI
        v. Atrial fibrillation requiring intravenous medications or procedures not approved for Acute Sub Acute Services
        vi. Unstable postoperative course
        vii. If it has been determined that the above patient no longer needs ICU interventions, they may be transferred to lower level of care with a physician's order.

2. RNs caring for patients on a cardiac monitor ~~, or nurses monitoring the patient in the ICU,~~ will successfully pass a cardiac dysrhythmia test and demonstrate accurate dysrhythmia interpretation skills within 6 months of hire and every 2 years~~.~~

~~2.~~3. Nurses monitoring the patient in the ICU will successfully pass a cardiac dysrhythmia test and demonstrate accurate dysrhythmia interpretation skills within 1 months of hire and every 2 years

~~3.~~4. Any patient on telemetry monitoring will be assigned to a registered nurse (RN) with a patient ratio of 1:4 or fewer~~.~~

~~4.~~5. The Acute Sub Acute RN will ensure that Standards of Care for the Telemetry patient are met:
   a. The Acute Sub Acute RN will assess the patient a minimum of once every shift and more frequently as ordered by the physician and if the patient's condition changes~~.~~
   b. Vital signs will be measured and documented every 4 hours or as ordered by the physician~~.~~
   c. Patient weight will be measured and documented daily~~.~~
   d. Patent IV access will be maintained~~.~~
   e. Telemetry will be continuously monitored (except as ordered by physician) with 24-hour staffing of the central monitor by the central monitoring technician~~.~~
   f. The Acute Sub Acute RN will initial the rhythm strip, verifying interpretation, with the central monitoring technician, a minimum of once per shift, and as needed for verification of alarms~~.~~
   g. The Acute Sub Acute RN will notify the physician for any acute changes in rate or rhythm~~.~~

~~5.~~6. Cardiac monitor alarms will be on at all times, audible to and visible to the central monitoring technician.

~~6.~~7. The central monitoring ~~technician will~~technician will immediately notify the Acute Sub Acute RN of any new alarms, rate changes, or rhythm changes via telephone~~.~~

EQUIPMENT:

1. See Lippincott procedure "Cardiac monitoring"

PROCEDURE:

A. Initial Setup

1. Verify the physician's order for telemetry monitoring

2. Obtain equipment from ICU
3. Follow procedure in Lippincott "Cardiac Monitoring" for Five-lead placement

4. Electrodes must be changed at least every 48 hours~~. If one electrode becomes loose and needs to be changed, change all of the electrodes.~~

5. Electrodes and lead-wires may be placed by CNA with verification by the Acute Sub Acute RN~~.~~

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager Acute/Subacute ICU	Effective Date: 1/17/17

B. Monitoring:

1. On admission or start of cardiac monitoring:
    a. When all the electrodes are in place, attach the lead-wires and check for a tracing on the telemetry monitor at the nurses' station on the Acute Sub Acute department
    b. The RN will check with the central monitoring technician to ensure quality ECG tracing is being monitored~~.~~
    c. The central monitoring technician will coordinate changing the patient to the appropriate accommodation status~~.~~
    d. The Acute Sub Acute RN will notify the central monitoring technician of the patient's:
        i. Name
        ii. Room number
        iii. Diagnosis
        iv. Pertinent medications
        v. Pertinent labs
        vi. Pacemaker status
    e. The Acute Sub Acute RN will perform an initial head to toe admission assessment and additional assessments each shift, as stated in the standards of care~~.~~
    f. The central monitoring technician will select one of the available telemetry windows~~.~~
        i. In the patient window, select "Admit Patient"~~.~~
        ii. Input the medical record number
        iii. Ensure that all of the information entered is correct~~.~~

2. Throughout monitoring:
    a. The Acute Sub ~~Acute RN~~Acute RN ~~will analyze~~will analyze, review, and ~~initial the~~initial the printed rhythm strip once per ~~shift with~~shift with the central monitoring ~~technician .~~technician
    b. The central monitoring technician will analyze, review and initial the rhythm strip every 8 hours and will review the patient's rhythm every 4 hours~~.~~
    c. Temporary discontinuation of telemetry monitoring requires:
        i. Physician order stating patient may shower or bathe off telemetry
        ii. Physician order stating patient may be off telemetry for ordered tests and procedures~~.~~
        iii. Notification to the central monitoring technician when the patient is being taken off telemetry
        iv. Notification to the central monitoring technician when the patient is being returned to telemetry
    d. If the patient needs to go to a test on telemetry, an RN or cardiac arrhythmia qualified personnel will accompany the patient using the portable telemetry monitor
    e. The Acute Sub Acute RN will notify the central monitoring technician when the patient is being given medications that may affect the cardiac rate and rhythm
    f. Default alarm parameters will include:
        i. Heart rate lower than 50
        ii. Heart rate higher than 120
        iii. SVT defined as greater than 180 beats per minute for greater than 5 beats
        iv. Run of PVCs defined as greater than 2 PVCs in a row
        v. Ventricular rhythm defined as greater than 14 PVCs in a run

vi. Ventricular tachycardia defined as greater than 100 bpm with greater than 5 PVCs in a run
vii. Greater than 10 PVCs in one minute
viii. Atrial fibrillation
ix. Pause defined as 2 seconds without electrical activity
x. Asystole defined as greater than 4 seconds without electrical activity

g. Alarm parameters may be modified at the ICU central monitor as ordered by the physician, depending on baseline rate and rhythm in order to avoid alarm fatigue.
~~g.~~i. An example would be a patient with a heart rate greater than 120 that the physician allows the alarm limits to be set higher than 120.

h. The Acute Sub Acute RN will notify the physician of any acute changes in rate or rhythm.

3. On discharge or upon discontinuation of cardiac monitoring:
   a. An Acute Sub Acute RN, CNA, or department clerk will notify the central monitoring technician of discontinuation.
   b. An Acute Sub Acute RN, CNA, or department clerk will return telemetry unit to ICU for cleaning and storage.
   c. Upon discontinuation of cardiac monitoring, the central monitoring technician will coordinate changing the accommodation status of the patient.

C. Documentation

1. On admission or start of telemetry monitoring:
   a. If telemetry is started after the patient is already admitted, the central monitoring technician will assure that there is a physician's order and that the accommodation status of the patient is accurate.
   b. Acute Sub Acute RN will enter time of "Telemetry Start" in the EHR
   c. Acute Sub Acute RN will enter "Unit Telemetry Initiated" in the EHR
   d. Acute Sub Acute RN will document rate, rhythm, lead used with verification by the central monitoring technician, in the EHR
   e. Acute Sub Acute RN will document initial placement of electrodes in the EHR
   f. Acute Sub Acute RN will open care plan "Alteration in Cardiac Output"

2. Throughout monitoring:
   a. Acute Sub Acute RN will document above assessment in EHR every shift.
   b. Initialed rhythm strips will remain in ICU for 24 hours, then will be placed in patient's paper chart
   c. Acute Sub Acute RN will document any acute changes, including time notified by the central monitoring technician, and time of notification of physician in EHR
   d. Acute Sub Acute RN will document any response to PRN medications in the EHR
   e. Acute Sub Acute RN will verify once per shift that admission information was documented in EHR
   f. Acute Sub Acute RN will ensure electrodes are changed at least every 48 hours, and documented in EHR.

Title: Cardiac Monitoring*	
Scope: Acute Sub Acute Services, ICU	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Manager Acute/Subacute ICU	Effective Date: 1/17/17

~~f.~~i. Electrode changes may be delegated to CNA, with confirmation of placement ~~and documentation~~ by RN~~.~~

~~g.~~d. Acute Sub Acute RN will review care plan each shift and document progress towards goals~~.~~

~~3.~~4. On discharge or at the end of telemetry monitoring:

a. The central monitoring technician will ensure that the change in service will be processed with the time of the physicians written order
b. Acute Sub Acute RN will enter time of "Telemetry Stop" in EHR
c. Acute Sub Acute RN will complete Alteration in Cardiac Output care plan~~.~~

REFERENCES:

1. California Department of Public Health. (2007). *Changes to the minimum licensed nurse-to-patient ratios effective January 1, 2008*. Retrieved from http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-07-26.pdf

CROSS REFERENCE P&P:

1. Cardiac monitoring. (July 10, 2015). *Lippincott Procedures*. Retrieved on April 14, 2016 from http://procedures.lww.com/lnp/view.do?pId=3260727

Approval	**Date**
CCOC	~~8/27/18~~9/10/2020
MED/ICU	~~10/25/18~~10/1/2020
MEC	~~11/6/18~~12/1/2020
Board	11/14/18
Last Board of Director review	11/14/18

Developed: 4/10/16
Reviewed: 1/17 la
Revised: 8/18 JN, 9/20 JN
Supersedes:

1. Transfer to Medical-Surgical Intermediate Care/Telemetry
2. Telemetry Monitoring – Philips.
3. Med/Surg unit standards of care for patients on telemetry

~~Index Listings:~~

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Dead on Arrival	
Scope: Departmental	Department: Emergency Department
Source: Emergency Department Manager	Effective Date: 10/04/06

PURPOSE:
To provide the Emergency Department staff with current guidelines for managing patients who are dead on arrival.
Dead on arrival (DOA) being defined as a patient brought to the Emergency Department who is dead and for whom any resuscitation efforts would be futile.

POLICY:
Pre-hospital providers and law enforcement agencies who cannot determine death in the field, will bring patients to the Emergency Room to be pronounced legally dead by a physician. Please note that when death can be determined in the field by an agency, i.e., ALS/Paramedic, the coroner is then contacted to legally pronounce the patient. California Health and Safety Code 102850 does not allow any agency to transport directly to the morgue to be pronounced.

PROCEDURE:
1. The deceased should be placed in a private room.
2. The physician in the Emergency Department will examine the body.
3. Family members should be notified and shown to the waiting room or a quiet area.
4. The physician should speak with the family as soon as possible.
5. Authorities to be notified:
    a. If an accident or suicide, notify appropriate law enforcement agency.
    b. If a coroner's case, notify the coroner.
    c. Notify House Supervisor.
6. Forms to be completed by HS after pronouncement of the patient:
    a. Release of Body to Mortuary.
    b. Organ Procurement Notification.

CORONER CASES: (Refer to Coroner Cases Policy for Coroners case criteria)
1. Clothing, personal effects or valuables should not be removed before coroner arrives. Items already removed should be placed in a bag, labeled and given to the coroner. Personal effects should not be given to the family until released by the coroner. The body, the clothing and all personal property are under the jurisdiction of the Coroner and permission of the Coroner is required before any post-mortem handling. This prohibition applies to law enforcement agencies as well.
2. If the coroner orders an autopsy, family permission is not necessary.
3. If the family has no preference or there is no family, the coroner should specify to which mortuary the body would be removed.
4. Coroner should notify family of death if this has not already been done.
5. Coroner is responsible for identifying unknown D.O.A. He may authorize hospital to assist in this identification. All efforts to identify the decedent by hospital staff, law enforcement agencies or social service agencies should be well documented in the medical records.
6. UNDER NO CIRCUMSTANCES SHOULD PHYSICIANS OR HOSPITAL STAFF IMPLY TO FAMILIES THAT REFUSAL TO GRANT THE HOSPITAL PERMISSION TO AUTOPSY WILL AUTOMATICALLY BRING THE DEATH WITHIN THE JURISDICTION OF THE DEPARTMENT OF MEDICAL EXAMINER-

Title: Dead on Arrival	
Scope: Departmental	Department: Emergency Department
Source: Emergency Department Manager	Effective Date: 10/04/06

CORONER. CONVERSELY, NO FAMILY SHOULD BE TOLD THAT THE CORONER WOULD, IN FACT, BE PERFORMING AN AUTOPSY ON A PARTICULAR DECEDENT.

NON-CORONER CASES:

1. Mortuary
    a. The relatives should specify agent for disposal of body.
    b. If no relatives, coroner to specify mortuary.
    c. House Supervisor will call the appropriate mortuary after determination by coroner or relative.
2. Valuables
    a. Relatives sign for possessions.
    b. If no relatives, valuable are placed in Lost and Found for 90 days then disposed of.
3. If an autopsy is to be performed, a family member must sign authorization.
4. Agency picking up the body must sign "Release of Body to Mortuary".

STAFF RESPONSIBILITIES:

1. Provide emotional support.
2. Notify in-house Social Worker if available.
3. If possible, a nurse or social worker should accompany doctor when he notifies family.
4. Ask family if they wish assistance, i.e. minister, priest.
5. Where appropriate, Social Worker may arrange for community support follow-up for family.

DOCUMENTATION:

House Supervisor will complete documentation for release of body to mortuary and organ procurement agency. Emergency Department will document as necessary in Electronic Health Record.

References.

1. CDC Medical Examiners and Coroners Handbook on Death Registration and Fetal Death Reporting, 2003 https://www.cdc.gov/nchs/data/misc/hb_me.pdf
2. California HEALTH AND SAFETY CODE – HSC. DIVISION 102. VITAL RECORDS AND HEALTH STATISTICS. CHAPTER 6. Death Registration [102775 - 102925] Article 3. Responsibility of Coroner http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=102850.&lawCode=HSC
3. Los Angeles County, Medical Examiner Coroner. Retrieved from: https://mec.lacounty.gov/for-hospitals/#1525911578470-2fdfd45a-5458

Cross- References:

1. Organ Donation Policy
2. Coroners Cases policy

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Dead on Arrival	
Scope: Departmental	Department: Emergency Department
Source: Emergency Department Manager	Effective Date: 10/04/06

Approval	Date
CCOC	10/29/2020
Emergency Services	11/09/2020
Medical Executive Committee	12/01/2020
Board of Directors	
Last Board of Director review	

Initiated: 4/92
Reviewed: 4/17kp
Revised: 03/2000; 02/02, 03/05, 02/08 AS, 08/11 AS, 09/2020gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	**Department:** District Wide
Source: Emergency Dept Nurse Manager	**Effective Date: 6/1/18**

PURPOSE:
To provide a process for when a patient leaves against medical advice (AMA) or refuses a treatment or transfer.

POLICY:
An individual, except patients under police guard or an involuntary hold, has the right to leave the hospital against the advice of his physician. Any individual who has received treatment at Northern Inyo Healthcare District (NIHD) and then refuses further care or transfer will be informed of the benefits of further care versus the risk of no further care.

PROCEDURE:

A. If a patient, for any one of many reasons, desires to leave the hospital before his doctor thinks he is ready for discharge, refuses a certain treatment, test or intervention ordered, or transfer to another facility, every effort must be made to convince the patient to remain in this hospital or proceed with the tests/treatment or transfer.
    1. Notify physician of the situation
        a. The physician, or designee, must attempt to provide the patient with information regarding the risks involved in leaving, benefits of continued stay in the hospital, and any other alternatives such as transfer to another facility or any other treatment.
    2. Patient's cause for discontent must be ascertained and solved if possible.
    3. Efforts should be also be made by the RN and shift supervisor to convince the patient to change his/her mind and all risks must be explained to the patient. This shall be well documented on the nurse's notes by the RN or shift supervisor.
    4. Patient's family and friends who may be concerned for his well-being should be enlisted to convince him to stay.
B. When all efforts have been made and the patient (or individual acting on their behalf) is still adamantly refusing further treatment and/or transfer and/or insists on leaving against medical advice, the informed refusal will be documented in writing on the appropriate form: (Available in English and Spanish)
    1. *Informed Consent to Refuse Treatment*
    2. *Leaving the Hospital Against Medical Advice*
    3. *Patient Refusal of Transfer*
C. No patient, other than patients under police guard or on involuntary psychiatric holds, can be forced physically to stay in the hospital against their will.
D. If a patient leaves undetected without signing the appropriate form, hospital staff should attempt to locate him/her and request that he/she return to the hospital so his /her signature may be secured on the form. Document all attempts and the results on the patient's chart.
E. Notify the following of AMA:
    1. Physician
    2. House Supervisor
    3. Department Manager
    4. Director of Nursing, if appropriate
    5. Police, if appropriate
    6. Administration, if appropriate
F. If all efforts to return the patient are unsuccessful and he/she cannot be located, document fully and precisely on nurse's notes.
G. If there is serious physician and staff concern regarding patient's well-being after he/she leaves AMA, an Unusual Occurrence Report (UOR) must be completed and turned in to Quality Analyst.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	**Department:** District Wide
Source: Emergency Dept Nurse Manager	**Effective Date: 6/1/18**

H. Regardless of whether it is believed the patient will sign or not, the release form must be offered to the patient (or the parent or guardian) for signature in the presence of at least one witness. It is a requirement that this procedure is followed:

1. If the patient (or parent/guardian) refuses to sign, proceed as follows:
    a. In the space provided for the patient's signature, write the words "***patient refuses to sign***." Beneath this line, sign your name and enter the exact time, date and a brief notation concerning the circumstances of the refusal.
    b. All hospital personnel who were present when the release was offered, and refused, must sign as witnesses to the refusal. Each witness must write his/her complete name - no initials.

I. Refusal of Treatment for Minors

1. A parent or other legal representative may not decline treatment where such a refusal may cause serious physical harm or illness to the minor. If a parent or legal representative refuses treatment to a minor in this instance, Child Protective Services (CPS) must be notified immediately.

~~2. If a parent or legal representative refuses treatment to a minor, Child Protective Services (CPS) must be notified immediately.~~

REFERENCE:

1. California Hospital Association Consent Manual (2014), Ch. 5.5, Ch.9.2
2. California Code of Regulations Title 22 Division 5 (2014), Article 70707- Patients' Rights
3. EMTALA- A Guide to Patient Anti- Dumping Laws. (2018). Chapter 18, Patient refusal of stabilizing treatment or transfer.
4. California Hospital Association (CHA): Minors and Healthcare Law (2017). Chapter 6 Refusal of Treatment.

CROSS REFERENCE:

1. EMTALA Policy
2. Patient Rights
3. Child Abuse or Suspected Abuse or Sexual Assault Guidelines ~~for ,~~ Victim of

Approval	**Date**
CCOC	09/02/2020
Emergency Services Committee	11/09/2020
Med. Services/ICU	11/12/2020
Peri-Peds	10/27/2020
Surgery /Tissue	10/28/2020
MEC	12/01/2020
Board of Directors	
Last Board Review	3/18/2020

Revised/Reviewed: 12/96; 9/00; 2/01; 7/11as; 2/15as, 1/18 gr

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Qualitative Fit Testing	
Scope: Respiratory Therapist	Department: Cardiopulmonary
Source: Cardiopulmonary Manager	Effective Date:

PURPOSE: The intended use of this product is to fit test any particulate respirator or gas/vapor respirator with a particulate prefilter. Qualitative Fit test will be performed, in place of the quantitative fit test, in an emergency situation when N95 mask supply is in short supply.

POLICY:

1. **To use the qualitative fit test method to ensure proper fit for respirator masks in accordance with manufacturer instructions, and to evaluate employees understanding of proper fit and how to take care to ensure employee is protected in an airborne precaution area of the hospital.**

PROCEDURE:

1. Preparation

a. Notify the subject that the testing solution contains Denatonium Benzoate (bitter) which is a chemical used to keep children from ingesting consumer products or sodium saccharin (sweet) and that they will be exposed to a fine mist.
b. The solutions are made up of sodium chloride, Denatonium Benzoate(bitter) and water or sodium saccharin(sweet) and water. If crystals are present hold closed, bottle under a warm stream of water or shake vigorously to dissolve the material.
c. Attach hood to collar by placing drawstring between flanges on collar. Tighten drawstring and tie with a square knot or bow.
d. Pour a ½ teaspoon of the **Sensitivity Test Solution** (#1) into the nebulizer labeled "#1 Sensitivity Test Solution."
e. Pour the same amount of **Fit Test Solution** "#2" into the second nebulizer labeled "#2 Fit Test Solution."
f. Immediately recap the bottles

2. Sensitivity Test

This test is done to assure that the person being fit tested can detect the bitter or sweet taste of the test solution at very low levels. The sensitivity test solution is a very dilute version of the fit test solution.

a. The test subject should not eat, drink (except water), or chew gum for 15 min before the test.
b. Have the test subject put on the hood and collar assembly without a respirator.
c. Position the hood assembly forward so that there is about 6 inches between the subjects face and the hood window.
d. Instruct the test subject to breathe through his/her mouth with tongue extended.
e. Using nebulizer #1 with the Sensitivity Test Solution (#1), inject the aerosol into the hood through the hole in the hood window. Inject 10 squeezes of the bulb, fully collapsing and allowing the bulb to expand fully on each squeeze. Both plugs on the nebulizer must be removed from the openings during use. The nebulizer must be held in an upright position to ensure aerosol generation.

f. Ask the test subject if he/she can detect the bitter or sweet taste of the solution. If tasted, note the number of squeezes as 10 and proceed to the Fit Test.
g. If not tasted, inject an additional 10 squeezes of the aerosol into the hood. Repeat with 10 more squeezes if necessary. Note whether 20 or 30 squeezes produced a taste response.
h. If 30 squeezes are inadequate, in that the subject does not detect a bitter taste the test is ended and another type of Fit Test must be used.
i. Remove the test hood and give the subject a few minutes to clear the taste from his or her mouth. It may be helpful to have the subject rinse his/her mouth with water.
j. Wipe the outside of nebulizer #1, Sensitivity Test Solution, with a grey top wipe between fit tests.

3. Fit Test

a. Have the test subject don the respirator and perform a user seal check per the instructions provided on the respirator package.
b. Have subject wear any applicable safety equipment that may be worn during actual respirator use that could interfere with respirator fit.
c. Have the subject put on and position the test hood as before, and breathe through his/her mouth with tongue extended.
d. Using nebulizer #2 with Fit Test Solution (#2), inject the Fit Test aerosol using the same number of squeezes as required in the Sensitivity Test (10, 20, or 30). A minimum of 10 squeezes is required, fully collapsing and allowing the bulb to expand fully on each squeeze. The nebulizer must be held in an upright position to ensure aerosol generation.
e. To maintain an adequate concentration of aerosol during this test, inject ½ the number of squeezes (5, 10, or 15) every 30 seconds during the duration of the fit test procedure.
f. After the initial injection aerosol, ask the test subject to perform the following test exercises for 60 seconds each:

    1. Normal breathing - in a normal standing position, without talking, the subject shall breathe normally.
    2. Deep Breathing – in a normal standing position, the subject shall breathe slowly and deeply, taking caution so as not to hyperventilate.
    3. Turning head side to side – standing in place, the subject shall slowly turn his/her head from side to side between the extreme positions on each side. The head shall be held at extreme momentarily so the subject can inhale on each side.
    4. Moving head up and down- standing in place, the subject should slowly move his or her head up and down. The subject shall be instructed to inhale in the up position (ie when looking toward the ceiling).

5. Talking- the subject should talk out loud slowly and loud enough so as to be heard clearly by the test conductor. The subject can read from a prepared text such as the rainbow passage, count backward from 100 or recite a memorized poem or song.
6. Bending over - the test subject should bend at the waist as if he or she were to touch his or her toes. Jogging in place may be substituted for this exercise.
7. Normal breathing

g. The test is terminated at any time the bitter or sweet taste of the aerosol is detected by the subject because this indicates and inadequate fit. Wait 15 min and perform the sensitivity test again.
h. Repeat the Fit Test after redonning and readjusting the respirator. A second failure may indicate that a different size or model respirator is needed.
i. If the entire test is completed without the subject detecting the bitter or sweet taste of the aerosol, the test is successful and respirator fit has been demonstrated.
j. Periodically check the nebulizer to make sure that it is not clogged. If clogging is found, clean the nebulizer and retest.

Cleaning
At the end of each session or at least every four hours, discard the unused solutions from the nebulizers. **DO NOT pour unused solutions back into bottles**. Rinse the nebulizers with warm water to prevent clogging and shake dry. Wipe out the inside of the hood with a grey top wipe to remove any deposited Test Solution before starting a new fit test. Clean non-disposable type respirator face pieces between fit tests.

REFERENCES:
1. 3M Guide to using the Qualitative Fit Test Kits (2010)

CROSS REFERENCE P&P:
1. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program

Approval	**Date**
CCOC	9/10/2020
Infection Control Committee	9/22/2020
Medical Services/ICU Committee	11/12/2020
Emergency Services Committee	11/09/2020
Medical Executive Committee	12/01/2020
Board of Directors	
Last Board of Directors Review	

Developed: 9/2020as
Reviewed:
Revised:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Safely Surrendered Baby Policy and Procedure	
Scope: NIHD	Department: **Emergency Dept, Perinatal, Social Services**
Source: Emergency Dept. Manager	Effective Date: 5/1/18

PURPOSE:
This intent of this policy is to meet the legal requirements of the Newborn Safe Surrender Law (Health and Safety Code1255.7).

POLICY:

1. NIHD shall post a sign in the Emergency Department utilizing a statewide logo that has been adopted by the State Department of Social Services that notifies the public of the location where a minor child 72 hours old or younger may be safely surrendered.

2. ~~The Emergency Department or~~ Aany personnel on-duty at a safe surrender site is authorized to accept physical custody of an infant who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who ~~1.~~ surrenders the child. When an infant is received in an area other than the ED, the ED must be notified. If a child appears older than 72 hours, we will accept the infant for surrender.

~~2. NIHD shall post a sign in the Emergency Department utilizing a statewide logo that has been adopted by the State Department of Social Services that notifies the public of the location where a minor child 72 hours old or younger may be safely surrendered.~~

~~3.~~2. A member of the ED Staff shall do the following:

a. Place a coded, confidential ankle bracelet on the child. The bracelet is found in the safe surrender kit, which are found in the emergency department and the perinatal unit.
b. Provide, or make a good faith effort to provide, to the parent or other individual surrendering the child a copy of unique, coded, confidential ankle bracelet identification in order to facilitate reclaiming the child. However, possession of the ankle bracelet identification, in and of itself, does not establish parentage or a right to custody of the child.
c. Provide, or make a good faith effort to provide, to the parent or other individual surrendering the child a medical information questionnaire, which may be declined, voluntarily filled out and returned at the time the child is surrendered, or later filled out and mailed in an envelope provided for this purpose. This medical information questionnaire shall not require any identifying information about the child or the parent or individual surrendering the child, other than the identification code provided in the ankle bracelet placed on the child. Every questionnaire provided pursuant to a safe surrender shall begin with the following notice in no less than 12-point type:

Notice: The baby you have brought in today may have serious medical needs in the future that we don't know about today. Some illnesses, including cancer, are best treated when we know about family medical histories. In addition, sometimes relatives are needed for lifesaving treatments. To make sure this baby will have a healthy future, your assistance in completing this questionnaire fully is essential. Thank You

d. Ensure that a medical screening examination and any necessary medical care is provided to the surrendered child as soon as possible without requiring consent of the parent or other relative to provide that care to the minor child pursuant to a safe surrender.

~~4.~~3. After the medical screening exam is complete and the newborn is determined to be stable, or is stabilized, the newborn will be placed in the Perinatal Department Nursery, for routine newborn care.

NORTHERN INYO HEALTHCARE DISTRICT
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~~5.~~4. A Nursing Supervisor shall be notified as soon as possible.
~~6.~~5. The Nursing Supervisor shall notify Social Services.
~~7.~~6. Social Services or the Nursing Supervisor shall notify Child Protective Services of the safe surrender as soon as possible, but no later than 48 hours after the physical custody of a child has been accepted.
~~8.~~7. Any medical information pertinent to the child's health, including, but not limited to, information obtained pursuant to the medical information questionnaire shall be provided to child protective services without obtaining a HIPAA release. However, any personal identifying information that pertains to a parent or individual who surrenders a child shall be blacked out from any medical information provided to child protective services or the county agency providing child welfare services.
~~9.~~8. Since child protective services will assume temporary custody of the child immediately on receipt of notice, NIHD employees will surrender physical custody of the child to the agency upon demand.
~~10.~~9. Should the person who surrendered the newborn request that the hospital return the newborn to him/her before child protective services assumes custody of the child, then, NIHD personnel will either return the child to the parent or individual or contact the child protective agency if NIHD personnel know or reasonably suspect that the child has been the victim of child abuse or neglect. The voluntary surrendering of a child is not in and of itself a sufficient basis for reporting child abuse or neglect. The child will not be returned to the requesting person if the hospital has been notified that a dependency petition has been filed in juvenile court.
~~11.~~10. The person requesting the return of the newborn must present positive identification or evidence that the requesting person is the person who surrendered the child.

PROCEDURE:

1. At the time of the presentation, attempt to verify the age of the newborn by physically examining the infant, specifically looking for presence of umbilical cord.
2. When the newborn is ~~surrendered~~ received in ~~to~~ the Emergency Department, staff ~~they~~ will immediately call the Perinatal Unit and the ED physician and notify them that they have a surrendered newborn and request their assistance.
3. The Perinatal nurse will bring a radiant warmer and ID bands to the Emergency Department.
4. The ED physician will perform a “medical screening examination”.
5. Notify the Supervisor and Social Service Worker of the surrendered newborn.
6. Place an identification bracelet on the infant’s wrist and ankle.
7. Make a duplicate bracelet with identical numbers to give to the person surrendering the baby in case the person wants to reclaim the child at a later date.
8. The identification band will contain the following information:
    a. The infant’s name or baby boy/girl Doe if no name.
    b. Tag number
    c. Sex of infant
    d. Date and time of birth, or the admit date and time if birth data is unknown
9. Ask the person surrendering the newborn to complete a family medical history questionnaire.
10. Admit the newborn to the Perinatal Department Nursery.
11. Notify the on-call pediatrician of the admission.
12. The admitting nursery nurse will follow policy and procedure for *Admit Newborn to Nursery*.

NORTHERN INYO HEALTHCARE DISTRICT
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DOCUMENTATION:

1. The confidential identification will be handled per medical records guidelines.
2. The medical screening examination, treatment and transfer from the Emergency Department will be the usual documentation.
3. Discharge documentation: Social Services obtain release of minor documentation, and CPS credentials.
4. The nurse will document according to department procedure in the electronic health record (EHR).

REFERENCES:

1. California Health and Safety Code, Division 2.Chapter 2, Article 1-1225.7. (2010) Retrieved from: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1255.7
2. California Health and Safety Code, An act to amend Section 1255.7 of the Health and Safety Code, (2013) relating to child protection. Retrieved from: http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1001-_1050/ab_1048_bill_20100930_chaptered.pdf
3. California Department of Social Services. (2006). *Safely Surrendered Baby Law* Retrieved from http://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby

CROSS REFERENCE P&P:

1. California Children Services Referral
2. Standardized Procedure for Admission of the Well Newborn
3. Child Abuse Neglect Policy

Committee Approval	**Date**
Clinical Consistency Committee	~~1/29/18~~9/10/2020
Emergency Services Committee	11/09/2020
Medical Executive Committee	12/01/2020
Board of Directors	
Last Board of Director review	02/18/2020

Initiated: 01/2001
Reviewed: 2/15as, 7/2020gr
Revised: 12/17gr

CALL TO ORDER	The meeting was called to order at 5:30 pm by Jean Turner, District Board Chair.
PRESENT	Jean Turner, Chair Robert Sharp, Vice Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Topah Spoonhunter, Member at Large Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer William Timbers MD, Interim Chief Medical Officer Allison Partridge RN, MSN, Chief Nursing Officer Charlotte Helvie MD, Chief of Staff Keith Collins, General Legal Counsel, Jones and Mayer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner announced 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 30 minutes being allowed for all public comment 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 that item is considered. No comments were heard.
NEW BUSINESS RE-ORDERING OF MEETING AGENDA	Interim Chief Executive Officer (CEO) and Chief Operating Officer Kelli Davis, MBA requested that agenda item 10, *Financial and Statistical reports as of September 30 2020* be re-ordered to become item 3C under the New Business section of this meeting. The re-ordering of the agenda was requested in order to allow Financial Consultant Vinay Behl to present financial information early in the meeting in order to avoid a scheduling conflict.
STRATEGIC PLANNING UPDATE	Ms. Davis stated that due to the recent surge in Covid-19 cases, the November 20 and 21st Northern Inyo Healthcare District (NIHD) in-person Strategic Planning sessions will be re-scheduled for some time in the spring of 2021.
APPROVAL OF INTERIM CEO CONTRACT	NIHD Human Resources Director Charity Dale called attention to a proposed *Northern Inyo Healthcare District Interim Chief Executive Officer Agreement* with Kelli Davis for the term July 1 2020 through June

30 2021. The agreement allows for a base salary of $263,600 annually with eligibility for quarterly bonuses, and a benefits and pension package equal to that of other District managers. Following review of the information provided it was moved by Robert Sharp, seconded by Jody Veenker and unanimously passed to approve the proposed *Interim Chief Executive Officer Agreement* with Kelli Davis as presented, with housekeeping changes being made including the correction of gender references included in the document.

FINANCIAL AND STATISTICAL REPORTS AS OF SEPTEMBER 30, 2020

NIHD Financial Consultant Vinay Behl called attention to approval of the Financial and Statistical Reports as of September 30 2020, including the following:

- Overview of revenue fluctuations relating to the Covid-19 pandemic
- Review of budget projections compared to actual performance
- Notation that NIHD's financials show a strong comeback since the March onset of the Covid-19 pandemic
- Update on collection of the District's Accounts Receivable backlog

District Legal Counsel advised the Board that detailed questions on the financial reports from members of the public should be addressed by District staff at a later time, rather than being addressed during the meeting. It was moved by Mr. Sharp, seconded by Topah Spoonhunter, and unanimously passed to approve the Financial and Statistical Reports as of September 30 2020 as presented.

PUBLIC COMMENT POLICY AND PROCEDURE APPROVAL

NIHD General Legal Counsel Keith Collins called attention to a proposed Policy and Procedure titled *Northern Inyo Healthcare District Board of Directors Meeting Public Comment Policy*. The purpose of the Policy is to help ensure the orderly conduct and efficient handling of District business during Board meetings, while protecting the ability of the public to participate meaningfully in such business. The only significant change to previous public comment practices is the limiting of cumulative public comment to 30 minutes total, allowing for deviation or extension of the total time allowed at the Board Chair's discretion. The proposed Policy specifies that public comment is intended for members of the public to address the Board of Directors directly, but it is not intended to allow for dialog with District staff during meetings. It was moved by Ms. Veenker, seconded by Mr. Spoonhunter and passed by a 4 to 0 vote to approve the proposed *Northern Inyo Healthcare District Board of Directors Meeting Public Comment Policy* with one (1) abstention being entered by Mary Mae Kilpatrick.

NIHD MEDICAL STAFF BYLAWS AD HOC COMMITTEE UPDATE & ACTION REGARDING REVISED MEDICAL STAFF BYLAWS

Directors Turner and Sharp provided an update on NIHD Board Ad Hoc Committee meetings on the subject of approval of revised NIHD Medical Staff Bylaws, noting that at this point in the process the Board must vote to approve or disapprove the revised Bylaws that have been submitted for their consideration. Both Directors acknowledged the significant amount

of time and effort that has been dedicated to this process by the NIHD Medical Staff, stating their belief that the framework for the revised Bylaws is good, however it is their recommendation that a few minor changes be made which will first require the Board's rejection of the current draft version. It was additionally noted that the Ad Hoc Committee's proposed changes would bring the Bylaws into alignment with California Hospital Association recommended Bylaws examples, and they would also memorialize and clarify the development of the Chief Medical Officer (CMO) role which was established at the request of the NIHD Medical Staff. It was then moved by Mr. Sharp, seconded by Ms. Veenker and unanimously passed to reject the current version of the revised draft NIHD Medical Staff Bylaws, in order to allow for further discussion and possible revisions being made.

CHIEF OF STAFF REPORT

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

POLICY AND PROCEDURE APPROVALS

1. *Infection Control in OR/PACU Environment*
2. *Adult Oxygen Protocol*
3. *Informed Consent Policy – Practitioner's Responsibility*

It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve Policies and Procedures 1 through 3 as presented.

MEDICAL STAFF APPOINTMENTS

Doctor Helvie also reported the Medical Executive Committee recommends approval of the following NIHD Medical Staff appointments:

1. Jason Phillips, MD (*urology*) – Provisional Consulting Staff
2. Lindsey Ricci, MD (*pediatrics*) – Provisional Active Staff
3. Kelly O'Neal, MD (*general surgery*) – Locums/Temporary Staff

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

MEDICAL STAFF CREDENTIALING BY PROXY, TELEMEDICINE

Dr. Helvie also stated the Medical Executive Committee recommends the Medical Staff Credentialing by Proxy as per the approved Telemedicine Physician credentialing and Privileging Agreement, and as outlined by 42CFR 482.22. The Medical Staff recommends the following practitioner for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions:

1. Snow Peterson, MD (*sleep medicine*) – Distant Site: Adventist Health, St. Helena

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the Telemedicine Credentialing by Proxy of Snow Peterson MD as requested.

MEDICAL STAFF ADVANCEMENT

Dr. Helvie additionally stated the Medical Executive Committee recommends the following Medical Staff advancement:

1. David Amsalem, MD (*emergency medicine*) – Advancement from Provisional Staff to Active Staff

It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and unanimously passed to approve the Medical Staff advancement of David Amsalem MD as requested.

PLASTIC SURGERY PRIVILEGE FORM (NEW)

Doctor Helvie also stated the Medical Executive Committee recommends approval of the following:

- *Plastic Surgery Privilege Form*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the *Plastic Surgery Privilege Form* as presented.

INTERNAL MEDICINE PRIVILEGE FORM (UPDATED)

Doctor Helvie also reported the Medical Executive Committee recommends approval of the following updated form:

- *Internal Medicine Privilege Form*

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the updated *Internal Medicine Privilege Form* as presented.

PHYSICIAN ENGAGEMENT SURVEY RESULTS

Doctor Helvie also reported there is no further update on the results of the NIHD Physician Engagement Survey at this time, and that the Medical Executive Committee will work with District Administration on follow-up based on the results of that survey. Director Kilpatrick complimented Interim Chief Medical Officer William Timbers MD on recent successes in the area of physician recruitment.

CONSENT AGENDA

Ms. Turner called attention to approval of the following Consent Agenda items:

- *Approval of minutes of the October 21 2020 regular meeting*
- *Interim Chief Executive Officer report*
- *Interim Chief Medical Officer report*
- *Chief Nursing Officer report*
- *Eastern Sierra Emergency Physicians quarterly report*
- *Cerner Implementation update*
- *Compliance Department quarterly report*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all seven Consent Agenda items as presented, with Directors Spoonhunter and Sharp abstaining from the vote on approval of minutes of the October 21 2020 regular meeting.

BOARD MEMBER COMMITTEE REPORTS

Ms. Turner asked if any members of the Board of Directors wished to report on attendance at any District Committee meetings. Director Kilpatrick reported she recently attended NIHD Medical Surgical and Operations Team meetings, as well as a Pioneer Home Health Home Board of Directors meeting. She additionally reported that the NIHD

Foundation Board of Directors is planning a retreat in the near future. Director Sharp stated that he has enjoyed attending Ad Hoc Committee meetings with representatives of the NIHD Medical Staff, and thanked Medical Staff members for their time and countless hours of work and effort dedicated to revising the Medical Staff Bylaws. Director Turner reported on information submitted to the Association of California Healthcare Districts (ACHD) Advocacy Committee on the subject of the impact of Telehealth at NIHD. No other Committee reports were heard.

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Ms. Turner also asked if any members of the Board of Directors wished to comment on any items of interest. Director Kilpatrick congratulated NIHD Language Services Manager Jose Garcia on his election to serve as a member of the Bishop City Council. She also praised Kathryn Erickson RN for providing wound care services for District patients, and requested that physician listings in area Yellow Pages be updated. No other comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 6:48 pm Ms. Turner announced that the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with legal counsel, existing litigation (*pursuant to Gov. Code Section 54956.9(d)(1*). Name of case: Robin Cassidy v. Northern Inyo Healthcare District.
B. Conference with legal counsel, anticipated litigation/significant exposure to litigation (*pursuant to Paragraph 2, subdivision D of Government Code Section 54956.9*), 3 cases.

Ms. Turner additionally noted that that the Board did not anticipate that any reportable action would be reported out following the conclusion of Closed Session.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 7:12 pm the meeting returned to Open Session. Ms. Turner reported that the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 7:12 pm.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

Overview: Billed charges are ahead of budget in October, and this is continuing the trend from Q1 FY2021.
We have not experienced the decrease in gross revenue that was expected from the impacts of COVID-19.

	Charges	Budget
October 2019	14,719,335	14,095,678
November 2019	13,286,763	13,640,980
December 2019	13,880,182	14,095,678
January 2020	16,271,574	14,095,678
February 2020	13,886,140	13,186,280
March 2020	12,141,181	14,095,678
April 2020	6,887,085	13,640,980
May 2020	10,687,793	14,095,678
June 2020	13,443,103	13,640,980
July 2020	14,939,822	11,862,737
August 2020	13,989,077	11,533,455
September 2020	14,652,230	10,715,581
October 2020	14,539,677	12,487,777

Gross Accounts Receivables in Athena total $39,988,328, down from over $48M at the end of August.
Gross Legacy AR is at $2,009,293, with most of that being uncollectible due to the age of the AR.

Salaries and Wages for hospital operations were up 1.04% over September and is trending within Q1 levels.

	Salaries & Wages	Cost Per Day
October 2019	2,285,326	73,720
November 2019	2,260,215	75,341
December 2019	2,235,031	72,098
January 2020	2,169,008	69,968
February 2020	2,144,412	73,945
March 2020	2,306,958	74,418
April 2020	1,999,126	66,638
May 2020	2,082,141	67,166
June 2020	2,130,598	71,020
July 2020	2,244,335	72,398
August 2020	2,263,144	73,005
September 2020	2,142,762	71,425
October 2020	2,227,959	71,870

October 2020 Financial Results: Revenues continued to trend higher than budget, which continued from Q1.
Direct costs were slightly higher than budget in October, while G&A expenses were under budget.

FY2021

Unit of Measure	July 2020	August 2020	September 2020	October 2020
Cash, CDs & LAIF Investments	56,272,847	55,214,586	52,965,190	53,539,618
Days Cash on Hand	226	225	220	218
Gross Accounts Receivable	46,949,619	48,287,230	45,195,462	39,988,328
Average Daily Revenue	481,930	466,595	473,708	472,527
Gross Days in AR	97.42	103.49	95.41	84.63
Key Statistics				
Acute Census Days	263	275	232	203
Swing Bed Census Days	42	44	34	8
Observation Days	44	32	46	48
Total Inpatient Utilization	349	351	312	259
Avg. Daily Inpatient Census	11.3	11.3	10.4	8.3
Emergency Room Visits	691	639	581	624
Emergency Room Visits Per Day	22	21	19	20
Operating Room Inpatients	23	18	28	18
Operating Room Outpatient Cases	120	85	82	79
RHC Clinic Visits	2,670	2,614	2,535	2,730
NIA Clinic Visits	1,792	1,794	1,918	1,681
Outpatient Hospital Visits	4,431	3,558	4,139	3,560
Hospital Operations				
Inpatient Revenue	3,201,903	3,105,168	3,469,234	2,495,776
Outpatient Revenue	10,836,050	10,143,216	10,036,379	10,848,725
Clinic (RHC) Revenue	901,868	740,693	1,146,616	1,195,178
Total Revenue	14,939,822	13,989,076	14,652,230	14,539,679
Revenue Per Day	481,930	451,261	488,408	469,022
% Change (Month over Month)		-6.36%	8.23%	-3.97%
Salaries	2,244,335	2,263,143	2,142,762	2,227,959
PTO Expenses	221,460	234,078	225,291	249,855
Total Salaries Expense	2,465,795	2,497,221	2,368,053	2,477,814
Expense Per Day	79,542	80,556	78,935	79,929
% Change		1.27%	-2.01%	1.26%
Operating Expenses	6,681,333	6,598,376	6,443,189	6,700,067
Operating Expenses Per Day	215,527	212,851	214,773	216,131
Capital Expenses	118,728	243,872	146,626	47,518
Capital Expenses Per Day	3,830	7,867	4,888	1,533
Total Expenses	8,056,147	7,962,211	7,811,638	7,971,619
Total Expenses Per Day	259,876	256,846	260,388	257,149
Gross Margin	2,200,258	1,770,841	1,569,390	1,411,167
Gross Margin Per Adjusted Day				
Debt Compliance				
Current Ratio (ca/cl) > 1.50	1.51	1.49	1.47	1.47
Quick Ratio (Cash * Net AR/cl) > 1.33	1.41	1.38	1.36	1.37
Days Cash on Hand > 75	226	225	220	218

	July 2020	August 2020	September 2020	October 2020
Total Net Patient Revenue	8,881,591	8,369,217	8,239,709	8,111,234
Cost of Services				
Salaries & Wages	2,244,335	2,263,143	2,142,762	2,227,958
Benefits	1,285,813	1,444,212	1,418,815	1,486,044
Professional Fees	1,729,883	1,641,804	1,519,996	1,734,533
Pharmacy	176,452	304,490	373,754	268,114
Medical Supplies	373,322	237,452	307,119	362,431
Hospice Operations	-	-	-	-
Athena EHR System	85,401	86,356	129,219	145,890
Other Direct Costs	592,164	492,312	420,847	475,097
Bad Debt	193,962	128,607	161,285	-
Total Direct Costs	6,681,333	6,598,376	6,473,796	6,700,067
Gross Margin	2,200,258	1,770,841	1,765,913	1,411,167
Gross Margin %	24.77%	21.16%	21.43%	17.40%
General and Administrative Overhead				
Salaries & Wages	341,944	326,215	323,043	340,706
Benefits	280,576	230,351	242,620	273,351
Professional Fees	182,344	187,479	170,202	172,012
Depreciation and Amortization	348,949	350,898	350,981	351,061
Other Administrative Costs	196,201	195,246	152,383	134,422
Total General and Administrative Overhead	1,350,014	1,290,188	1,239,230	1,271,552
Net Margin	850,244	480,653	526,683	139,614
Net Margin %	9.57%	5.74%	6.39%	1.72%
Financing Expense	121,150	119,676	114,676	134,694
Financing Income	56,337	56,337	56,337	56,337
Investment Income	49,812	29,010	34,393	52,775
Miscellaneous Income	91,226	52,266	51,822	35,727
Net Surplus	926,469	498,589	554,560	149,759

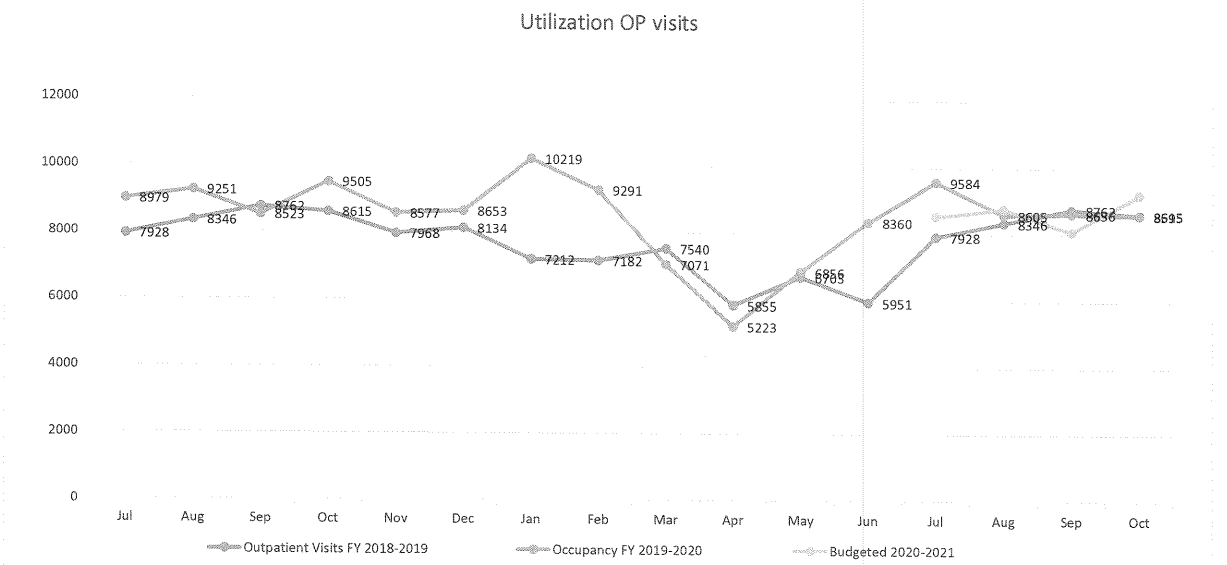
	October 2020
Assets	
Current Assets	
Cash and Liquid Capital	6,709,747
Short Term Investments	45,796,181
PMA Partnership	667,978
Accounts Receivable, Net of Allowance	18,734,824
Other Receivables	829,598
Inventory	2,197,454
Prepaid Expenses	1,608,376
Total Current Assets	76,544,157
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,193,799
Short Term - Restricted	2,502,303
Limited Use Assets	
LAIF - DC Pension Board Restricted	681,935
DB Pension	18,895,468
PEPRA	5,338
Total Limited Use Assets	19,582,741
Revenue Bonds Held by a Trustee	3,653,211
Total Assets Limited as to Use	26,932,055
Long Term Assets	
Long Term Investment	1,770,911
Fixed Assets, Net of Depreciation	75,373,245
Total Long Term Assets	77,144,156
Total Assets	180,620,368
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	1,771,774
Accounts Payable	4,323,087
Accrued Payroll and Related	8,163,208
Accrued Interest and Sales Tax	565,685
Notes Payable	8,927,628
Unearned Revenue	21,404,650
Due to 3rd Party Payors	2,341,874
Due to Specific Purpose Funds	(25,098)
Other Deferred Credits - Pension	3,045,446
Total Current Liabilities	50,518,255
Long Term Liabilities	
Long Term Debt	39,441,126
Bond Premium	426,589
Accreted Interest	14,846,849
Other Non-Current Liability - Pension	39,817,345
Total Long Term Liabilities	94,531,909
Suspense Liabilities	(148,455)
Uncategorized Liabilities	242,063
Total Liabilities	145,143,772
Fund Balance	
Fund Balance	33,658,245
Temporarily Restricted	1,668,591
Net Income	149,759
Total Fund Balance	35,476,596
Liabilities + Fund Balance	180,620,368

	Budget 10/31/2020	Actual 10/31/2020	Budget Expense as a % of Revenue 10/31/2020	Actual Expense as a % of Revenue 10/31/2020
Total Net Patient Revenue	6,868,277	8,111,234	100.00%	100.00%
Cost of Services				
Salaries & Wages	2,314,870	2,227,958	33.70%	27.47%
Benefits	1,461,377	1,486,044	21.28%	18.32%
Professional Fees	1,605,803	1,734,533	23.38%	21.38%
Pharmacy	194,757	268,114	2.84%	3.31%
Medical Supplies	356,587	362,431	5.19%	4.47%
Hospice Operations	44,596	-	0.65%	0.00%
Athena EHR System	122,255	145,890	1.78%	1.80%
Other Direct Costs	195,746	475,097	2.85%	5.86%
Bad Debt	-	-		
Total Direct Costs	6,295,991	6,700,067	91.67%	82.60%
Gross Margin	572,286	1,411,167		
Gross Margin %	8.33%	17.40%	8.33%	17.40%
General and Administrative Overhead				
Salaries & Wages	479,602	340,706	6.98%	4.20%
Benefits	370,780	273,351	5.40%	3.37%
Professional Fees	252,622	172,012	3.68%	2.12%
Depreciation and Amortization	395,855	351,061	5.76%	4.33%
Other Administrative Costs	67,892	134,422	0.99%	1.96%
Total General and Administrative Overhead	1,566,752	1,271,552	22.81%	15.98%
Net Margin	(994,465)	139,614		
Net Margin %	-14.48%	1.72%		
Financing Expense	233,676	134,694		
Financing Income	200,519	56,337		
Investment Income	43,419	52,775		
Miscellaneous Income	27,631	35,727		
Net Surplus	(956,572)	149,759		

Management Discussion and Analysis

- Overall Net Patient Revenue Increased by $ 1.2 M due to higher inpatient visits offset lower Outpatient visits.
  Budgeted Outpatient visits were 9217 and actual were 8595.
  Budgeted Inpatient visits were 162 and acutal were 259. Overall revenue also increased due to higher value of outpatient surgeries.
- Salaries and wages were in line with Pre covid levels due to ramp up in revenues and corresponding efficiencies
- Other direct costs increased compared to budget Higher utility expenses, property insurance,
  repairs and maintenance and non medical supplies, mal practice insurance
- Overall direct costs as a % of revenue are tracking pre covid levels at 82% of revenue as against budgeted at 92%

- Administrative salaries and wages are lower due to vacancies in positions
- Overall administrative costs are 18% of revenue very much in line with Pre COVID levels due to higher revenues
- Financing Expense and Income are lower due to change in method of accouting
- Provision for bad debts is under stated and may have an impact on profitiability levels
- COVID testing may result in huge direct costs and impact on liquidity if state funding is not received


Utilization OP visits
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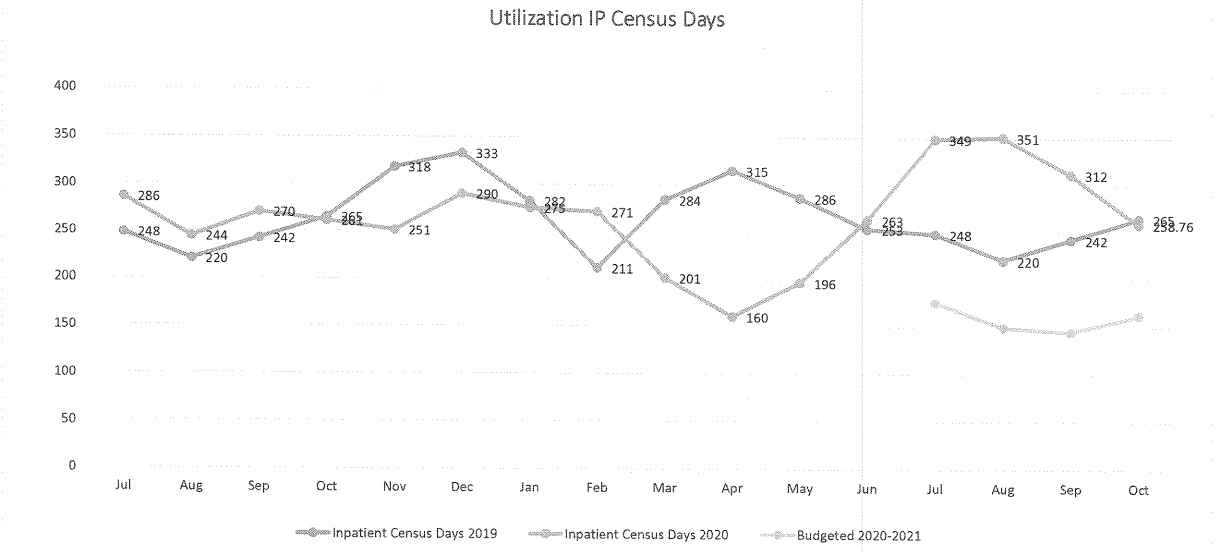
Outpatient Visits FY 2018-2019
Occupancy FY 2019-2020
Budgeted 2020-2021


Utilization IP Census Days
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Inpatient Census Days 2019
Inpatient Census Days 2020
Budgeted 2020-2021

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

Date: December 4, 2020
Title: **CERNER PROJECT UPDATE**

Narrative

In the month of December, we will transition from the Data Collection phase and move into the Validation phase. Cerner has already begun to configure our instance of their applications to meet our distinct needs. Configuration settings are based on data they have collected from us (e.g., pharmacy formulary, item master, charge master, patient room numbers, tax ID number). In addition, Cerner led us through design decisions during the Workflow and Integration event on November 2 through 5. Our design decisions where based on two project core principles: 1) adopting industry best practices, and 2) applying standardization to our processes. During the validation phase, we will begin to review the system build configuration and validate that what we provided is what Cerner configured and what we need.

As mentioned in last month's report, NIHD and Cerner continue to monitor the latest developments of the COVID-19 pandemic. We will adjust accordingly for future events in 2021 that typically would be held onsite in a non-COVID world. The next potential event that may be impacted is the first Integration Testing event on February 2 through 4 and February 9 through 11.

Top Accomplishments for this Reporting Period

1. **Project Communication:** The communication team provides an update to the department managers at their monthly meeting. In this month's update, we provided a general update along with an appeal to the managers to have conversations with their SMEs and SUs about the tasks they are working on and meeting commitments they have. We also provided the calendar of events for the large Cerner events as a way to generate communication between managers/SMEs/SUs about these events.

   In a separate communication, the managers received an Excel spreadsheet that contains a list of the 90+ meeting invitations for the Train the Trainer event along with who is scheduled to attend each meeting. It is the communication team's hope that the information provided to the managers along with the appeal to have conversations with their SMEs/Sus, that the managers are well informed on project activities

2. **Workflow and Integration Event:** We completed the Workflow and Integration event the week of November 2. During this event, Cerner sought to understand our current workflows. They provided industry best practice advice on which workflows will need to change and what each change looks like. Cerner is a very integrated system. Data that is entered upstream impacts the staff that need to use it downstream. During this event, we made numerous design decisions that affect multiple departments. Representatives from all impacted departments were present and their voice was registered prior to making a final decision. This was a very collaborative effort.

3. **Network and Wireless Network Assessment:** Cerner has completed an assessment of our wired and wireless network. The assessment identifies any deficiencies in network equipment and wireless reception. The assessment report has been provided to the IT staff who will begin to upgrade or enhance some of our technology.

4. **Order Sets:** We have submitted more than 75 order sets to date, which is phenomenal. Cerner will build about a dozen order sets prior to the Train the Trainer event so that they can train on how the order sets work. The goal is to have all order sets built prior to integration testing.

Changes in Scope of Work

1. **Batch Scanning:** Cerner has two different options for document scanning. For low-volume scanning, documents can be scanned at the location where they are obtained. For example, the registration staff will scan insurance cards during the registration process. Cerner also has a high-volume document scanning module. This module is used by the Health Information Management (HIM) department. We did not purchase the Batch Scanning module with our initial agreement. HIM leadership has determined that there is a need for and a value to the organization to have this module. A request will be made in the near future to approve the purchase of this modules. Details are still being worked out at the time of this report.

Issues or Concerns the Board of Directors Should Be Aware Of

1. **Staff Availability:** We have had and are currently experiencing a few staff changes in our Lab department. Larry Weber and his team have expressed concern regarding their Cerner assignments and meeting commitments. Larry feels we are two to three weeks away from having temporary staff up to speed to backfill for our SMEs and SUs. Meredith, the project manager from Cerner, reported per Bridget (Blood Bank) and Lauren (Micro), they have seen pretty significant delays in getting data collection gathered. In turn, this has hindered their ability to begin building out the system. An issue we've seen thus far is being able to coordinate call times where the lab techs for each lab venue are available. Aligning extra resources was one of the mitigation steps we put in place, but it doesn't appear these extra resources have had the bandwidth to assist.

Upcoming Events or Milestones

1. **Train the Trainer:** The Train the Trainer (TTT) event is scheduled for December 15 through 17. We have distributed 90+ meeting invitations to all participating staff. We have also provided managers with a list of the scheduled events along with who is invited to attend each session.

2. **IT Prep Workshop:** Subject Matter experts have their calendars blocked on Tuesday, December 8 from 11:00 to 3:00 pm to participate in this workshop. During the workshop, Cerner will walk us through the process for developing our test scripts.

3. **Integration Testing Rounds 1, 1.5, and 2.** Cerner is a highly integrated system. We perform end to end testing of our most common patient scenarios using integrated test scripts. We will begin our integration testing on February 2, 2021. We will have three days of concentrated testing. SMEs, Sus, and providers will be extensively involved with exercising our test scripts. All departments except billing will be involved in this event from February 2 through 4. Beginning February 9 through 11, the billing team will pick up where the scripts ended the previous week and finish testing the billing and claims functions.

Prepared by: _Daryl Duenkel, Project Manager, Wipfli__
Name and Title

Reviewed by: _____
Name
Title of Chief who reviewed

Approved by: _____
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

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

An Internal NIHD Communication

November 24, 2020

NEWSLETTER

Produced bi-weekly during The NIHD Cerner Implementation

Top 5 P1

Results of Trick or Treat with Cerner P2

Upcoming Events and Activities P3

Training Corner P3

Project Timeline P4

"As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them."

-- John F. Kennedy, 35th U.S. President

Overview of our Top 5 most recent accomplishments

By: Daryl Duenkel, *Wipfli*

1. Workflow and Integration: We successfully completed the workflow and integration event. During this event Cerner sought to understand our current workflows and, in some cases, recommended industry best practice changes. We also had numerous integrated discussions bringing together multiple departments to make design or workflow decisions that impact multiple departments. Our staff was energetic, engaged, and enthusiastic about how Cerner can work for us. No doubt our team still has many questions and have only received a small portion of education to date. So likely their excitement is tempered by uncertainty. This is to be expected. Like the implementation process, the learning activity and comfort level is incremental. Our team will become more educated and more comfortable with each passing event and each passing week. We should expect that some staff will not be completely comfortable until after go-live, and that's okay. Some staff are comfortable trusting a process and some are more prone to trust results. We should be aware and embrace this perspective and support our peers wherever they are on their comfort level.

2. Momentum and Pace is Picking up for our Teams:

Continued on page 2

SME & SU Schedule

		SMEs	SUs
IT Prep Workshop	Dec. 8	Yes PM	
Train The Trainer	Dec. 15-17		Yes
IT 1 Clinical	Feb. 2-4	Yes	Yes
IT 1 Financial	Feb. 9-11	Yes (B)	Yes (B)
IT 1.5 Clinical	March 2-4	Yes	Yes
IT 1.5 Financial	March 9-11	Yes (B)	Yes (B)
IT 2 Clinical	April 6-8	Yes	Yes
IT 2 Financial	April 13-15	Yes (B)	Yes (B)
Training Dates	April 15-May 14 *	Yes	
Go-Live Daily Meetings	May 17-28	Yes	Yes
Go-Live End User Support	May 17-28		Yes

*SME- Subject Matter Experts SU - Super User (B) - Billing * - Specifics to come*

Sierra Cerner Newsletter

Published every two weeks during the implementation of the Cerner EMR system

Communications Team

Daryl Duenkel, Wipfli
Barbara Laughon
Linda Ramos
Sarah Yerkes

Early Data Collection: Several departments participated in early data collection activities including: Lab, Pharmacy, Charge Services, Supply Chain, Diagnostic Imaging, Patient Accounting, HIM, and Interfaces. They each provided information like; charge master, formulary, and department tests. The early data collect tasks are nearly complete.

Weekly Department Solution Calls:
All weekly department solution calls have been scheduled and our team is working closely with their Cerner counterparts. The weekly calls will include education opportunities, assigning data collection workbook assignments, and unit testing.

Network Assessment: Cerner has completed an assessment of our wired and wireless network. The assessment identifies any deficiencies in network equipment and wireless reception. The assessment report has been provided to the IT staff who will begin to upgrade or enhance some of our technology.

Order Sets: We have begun the work of collecting order sets for NIHD review and Cerner build. We already provided Cerner with more than 50 order sets. We celebrate this large volume this early in the project. Congratulations to all who helped achieve this milestone! We will build a small quantity of order sets prior to the Train the Trainer event. This will provide us with the ability to train on how to use order sets in Cerner. The goal is to have all order sets built prior to integration testing.

Communication is *Every* Team Member's Responsibility

SMEs and SUs: We need your help!

Email is an essential project communication tool. Our Cerner consultants use this tool as their primary communication tool outside of their weekly department call to communicate with department SMEs and SUs. SMEs and SUs are responsible for checking email frequently to expedite knowledge sharing and responding to requests or questions. It is expected that the SMEs and SUs are checking email at a minimum once per day for each day they work.

Department Leaders: We need your help!

We encourage you to check in with your department SMEs and SUs frequently to ensure that you are staying abreast of what they are working on, which meetings they are scheduled to attend, and any challenges they may be facing.
You may want to schedule a weekly 15-minute weekly meeting to touch bases.

UPCOMING EVENTS & ACTIVITIES

1. **The Train the Trainer** (TTT) event is scheduled for Dec. 15 – 17. Cerner has sent out each of the 90+ meeting invitations to all participating staff. Department leaders received that includes who from their department will attend. We encourage the department leaders, SMEs and SUs to discuss their involvement and any staffing backfill requirements.

2. **IT Prep Workshop:** Cerner will lead an IT Prep Workshop on Dec. 8. During the workshop we will learn how to review the sample Cerner test scripts and modify them for our unique needs. Staff will receive an assignment to create between 35 – 45 test scripts that cover 80 percent of our most frequent patient encounter types.

3. Integration Testing Round 1: We will begin our integration testing on Feb. 2, 2021. We will have three days of concentrated testing. SMEs, SUs and providers will be extensively involved with exercising our test scripts. All departments except billing will be involved in this event from Feb. 2 – 4. Beginning on Feb. 9 through Feb. 11 the billing team will pick up where the scripts ended the previous week and finish testing the billing and claims functions.

TRAINING CORNER
with Marjorie Routt

NIHD's Train the Trainer session draws closer

Train the Trainer is right around the corner for our SMEs and Super Users; occurring Tuesday, Dec.15th through Thursday, Dec. 17th. Schedules for these virtual training sessions have been sent out.

This is the reminder for those scheduled to attend our December dates, please complete stages 1-3 of your Learning Journey paths prior to the start of Train the Trainer. Doing so will set you and the team up for successful virtual training as you begin the hands on portion.

Learning journeys are meant to be an introduction into the content and workflows.

They may not cover all NIHD role specific needs, please prepare questions as you work through you journeys for your Cerner team members during Train the Trainer.

Please reach out to Marjorie Routt, District Education Coordinator, ext. 2019, or via email at marjorie.routt@nih.org with questions or needs.

Board-Exec Admin-Physicians Meeting
Tuesday, September 22, 2020, 6:00-8:00pm

Attending: Interim CEO Kelli Davis, Interim CMO Will Timbers, Board of Directors Vice-Chair Robert Sharp, Immediate Past Chief of Staff Stacey Brown, Chief of Staff Charlotte Helvie, and Board of Directors Chair Jean Turner

Dr. Timbers began with opening comments framing the discussion around friction points between medical staff, administration and/or Board. Kelli Davis added by emphasizing the need for Medical Staff, Board and Administration to work cohesively and collaboratively together for the best interests of the District and that there is a strong desire for alignment between Administration and Medical Staff toward the mission, vision and values of the District.

Dr. Helvie presented a three-page written list of bulleted comments, concerns, and issues. (attached)

Discussion began with comments on the current week's webinars presented as part of Gallagher Consulting Symposium.

Robert reflected that he was hearing concerns about relationships and communication, business concerns versus emotional concerns, and healthcare district concerns.

Dr. Brown brought the issues of distrust as well as physician burnout into focus and the wear and tear from managing COVID this year.

Dr. Helvie commented that while communication is key, we should be mindful of behind-the-back communication and be careful. She stressed the importance of bringing along our Medical Staff on various issues.

There was much information provided by Drs. Brown and Helvie about how few physicians have been willing to do the extra tasks that have arisen in recent times with the changing landscape of healthcare, along with necessary tasks this year around COVID. The group reviewed, from a high level, the differences in roles of providers, directors, CMO and COS, while acknowledging the ever-evolving roles over time particularly in the area of increased administrative tasks.

The group discussed the use of engagement surveys with physicians as well as the entire workforce, and agreed to share engagement survey tools between medical staff and executive team.

Robert queried the group about their views on biggest priority for the Board and best opportunity for the Board. In response,

*Dr. Helvie discussed the importance of strategic planning with District financial planning tied into that. She stressed the importance of the Board staying focused on the big picture and avoid micromanaging.
*Dr. Brown talked about the priority of the Board motivating people and creating high profile perceptions of what's happening in the District, and being the face of the District. He also cautioned against micromanaging.
*Dr. Timbers articulated his thoughts about the Board providing direction and getting feedback independent of the CEO, CMO and CFO, perhaps from an outside group, to ensure oversight and regulation.
*Kelli Davis indicated the need for a clear strategic plan, clear and public expectations of the CEO for staff and community. She wants the Board to ask tough questions and heavily scrutinize issues and decisions.

Jean referenced the media article in which both Drs. Brown and Helvie were mentioned by name, and offered her apology, as Board Chair, to both Drs. Brown and Helvie for not reaching out to them personally following that article.

Next steps agreed upon by all:

1) Board follow-up with COS on Medical Staff by-laws concerns or questions
2) Move forward on workforce engagement surveys and assessment of the results
3) Dr. Timbers will set up meetings with additional Medical Staff to also have the opportunity to meet with Jean, Robert, Kelli and Dr. Timbers.

Board/Med Staff Meeting: 9/22/2020 (Turner/Sharp/Brown/Helvie/Davis/Timbers)
*(DR. HELVIE'S NOTES)

I do not currently have enough information from the medical staff to represent them as Chief of Staff. These concerns I present as a long time medical staff member and medical director.

What do you think the friction points are?
What relationships do you envision between the Board and the Medical Staff?
What is the current community attitude? How do you solicit this information?
What do you hope to get from this meeting?

Expectation for relationship between the Board and the Medical Staff:

- Board represents the community
- CEO represents the employees
- COS represents the medical staff
- Joint conference committee added to new bylaws to help with communication between the three branches
- Medical staff should not be coming to Board members directly with concerns because the Board doesn't have a process to address this and it is not their role (except CEO complaint which should then go through a standardized complaint process)
- Board needs to solicit information from medical staff (along with many other groups) to help develop the strategic plan. (Examples may be a medical survey along with burnout/engagement assessment)
- Medical directors work for the CEO/CMO but are also medical staff members. Medical directors help carry out the strategic plan and work with administration to provide adequate staffing and equipment in their departments.
- Medical directors should be asked for feedback by the BOD about the CEO/CMO who is their boss
- Consider how to make gestures of appreciation more personal but also keep in mind they are not expected and can seem insincere if medical staff are not feeling supported/heard.
- Consider meeting with new providers to discuss the strategic plan and how they fit in.
- Since the Board represents the community consider asking the community to write in with staff or provider praise and reading these comments at board meetings. We love to hear back from the community when we have done well and the Board could facilitate this praise and help make it more public.

Governance:

- Everyone needs more clarity about responsibilities
- Need to develop a procedure for the appropriate evaluation of complaints against the CEO with feedback to all parties involved.
- Redirect concerns from medical staff or employees to appropriate leaders
- Redirect toxic public comment

- Encourage constructive public participation in Board meetings. Address topics brought up during public comment on a later agenda or redirect to the appropriate department. Consider encouraging the public to send email public comments.
- What would the Board find helpful from the COS report?
- When there is an inadvertent error in Brown Act procedure make a correction at the next meeting.

Concerns:

- Covid crisis, changes in leadership and financial concerns have taken a toll. Many providers are feeling under appreciated. I am working on a brief provider survey to further assess these concerns and the current level of provider resilience. I'm also concerned about clinical staff who are stressed by the changes brought on directly and indirectly by Covid.
- Years of building up a patient base by providing improved access and quality of care has contributed to our rapid rebound in outpatient visits but this takes a lot of work to maintain and will a require proactive approach
- Decades of recruitment problems improved over the last few years and just now we are at a time when all major services are fully staffed but there is concern from providers that this struggle has been forgotten and we could easily backtrack with threats of change in compensation, and decreased engagement which needs to be further assessed
- We need to work with providers to optimize services delivered and maintain our patient base in order to support the number of providers here and maintain revenue.
- We need to optimize provider engagement starting with a validated tool to assess our baseline.
- Relying on and expanding plans put in place over the past several years to recruit patients, is especially important post surge to maintain revenue. (eg, Valley Health)
- Huge effort put into work flows to provide safe patient care during Covid does not directly generate RVUs but does generate revenue by helping to get patients back into the system for services and maintain patient confidence in the system
- Ongoing discussion about change in contracts but without a clear plan is disconcerting.
- Challenges of determining contract changes at the same time as RVUs change with new CPT coding in 2021 needs to be taken into account. (as seen in the Gallagher webinar)
- CMO should be able to focus time on ensuring that the district is enabling providers to provide quality care. Like keeping Covid info up to date. Like developing policies or updating old policies. Contracts should not be taking up all his time, outside expertise should and medical staff input should be included in this decision making process.

Financial:

- Board oversees finances as they relate to the strategic plan and decides how to allocate money to support a strategic plan.
- We need a fiscal plan as this helps drive the strategic plan. It is not clear from the Board meetings what the current fiscal plan is only that we are no longer following the old fiscal plan.

- Just like with the strategic plan, all the recent changes make this a great time to develop a forward-thinking fiscal plan.
- Concern about sudden changes in financial information leading to sense of insecurity and lack of transparency
- Concern about ROI committee being a financial ROI not a healthcare ROI.
- It appears to the public listening in on the Board meetings that the Board makes significant financial decisions with very little information presented during Board meetings to understand how those decisions are being made. Questions and discussion from Board members help clarify the decision making process.

Strategic Plan:

- The medical staff need to have an idea as to what they are working toward and where they fit in.
- It will be very helpful to have a strategic planning session coming up. Thank you.

Investigation:

- Problems inherent to closed session meetings which even when handled well lead to mistrust.
- Never talked to KF to hear his side of the accusations.
- Picture yourself in his shoes (he put is heart and sole into his work here and now his career is ruined and he doesn't even know why) and now picture yourself in the shoes of those who appreciated his work here (motivated to work hard for healthcare in the community, following his example of dedication, watching the district grow and our patient care improve significantly and now "going in a new direction" that no one can describe or has even talked about). It is not the experience for everybody but it was the experience of many.
- Hardest working most dedicated employee fired at will makes everyone left feel very vulnerable (external view for those of us on the outside of the closed session).
- Information leaked about check writing policy and other accusations further contribute to feeling of mistrust (not only can you be fired at anytime you can also be smeared by the press and not be able to do anything about it)
- Refusal to release the forensic accountant report after the investigation was closed also fuels mistrust about the process involved.
- Response to the Sheet article targeting Dr Brown and myself was very disappointing The lack of support from the Board has further undermined trust. Even one private note from someone/anyone in leadership saying that all my years of hard work and dedication to the district are appreciated would have gone a long way.

NIHD Board Directors' Ad Hoc Committee Meeting
To Address Board Concerns with Draft Medical Staff ByLaws
September 30, 2020

Attending: Jean Turner, NIHD Board Chairperson
Robert Sharp, NIHD Board Vice-Chairperson
Kelli Davis, NIHD Interim CEO

This was a very initial discussion, acknowledging there was a lot to read. Committee members were interested in the statewide work done on Medical Staff By-Laws by the California Hospital Association (CHA) and that group's 2019 "Model By Laws" on their website for local hospital use.

The group initially re-acknowledged, as had come up in the September Board of Directors' meeting, concerns about:

1) the omission of the opening governance statement and relationship between medical staff and the governing board;
2) the Preamble's mention of "independent self-governance" without further clarification; and
3) omission of any language or acknowledgement about the Chief Medical Officer (CMO) role and relationship with medical staff.

All committee members wanted more time to review the By Laws and then anticipated a joint problem-solving meeting with Medical Executive staff.

Board-Exec Admin-Physicians Meeting
Sunday, October 4, 2020, 4:00-6:00pm

Attending: Interim CEO Kelli Davis, Interim CMO Dr. Will Timbers, Board of Directors Vice-Chair Robert Sharp, Board of Directors Chair Jean Turner, Dr. Jeanine Arndal, Dr. Martha Kim

Kelli began with opening comments about providing an opportunity for medical staff to meet with Board and Executive Team around concerns or ideas for moving forward together.

Dr. Kim talked about the importance of quality regional patient care for women and the importance of the physician team to make that possible. Dr. Arndal added that although physicians were hired by the District as individual doctors, the time, energy and communication of their team is what makes the quality care for each patient.

Dr. Arndal articulated how unsettling the year has been with all of the change in a short period of time. She discussed her own history with various former NIHD CEOs, and how Dr. Flanigan had been "one of us," as physicians. She encouraged the Board to move forward with strategic planning and come up with our top priorities for the next few years, and consider sending Dr. Flanigan a personal letter of support.

Dr. Kim stressed the importance of physicians feeling like they were being listened to, and expressed concerns about that not happening in the past. Dr. Arndal continued that the Board did not defend two physicians who were named in a media article, and felt that those colleagues need to be validated in a public forum.

Kelli Davis informed the group about an upcoming Engagement Survey, and that discussions with Chief of Staff and Past Chief of Staff proposed the use of such a survey to ensure all voices were heard. She further informed all about the Board's intent to have further physician meetings with Board's Ad Hoc committee. Kelli also explained that a Strategic Planning session with David Sandberg is scheduled for early November.

There was much discussion about the challenges of being a physician in a particular specialty working in a small, rural community without the benefit of additional medical resources, including other similar specialists – in a manner that physicians in larger communities experience.

Dr. Arndal expressed concern about how the current NIHD financial picture is being presented. Discussion continued with Jean and Robert both expressing appreciation for the vast increase in financial transparency in recent months. Dr. Timbers added that the financial efforts underway currently are an attempt to "right the ship" so we can re-invest in patient care.

Further discussion included messaging/promoting our OB/GYN team and services with a goal of letting the public know that no one should have to leave the area for such care. Many operational ideas and thoughts were exchanged, with the group agreeing to increase communication between the OB team and the Executive team.

Dr. Kim described how her team is what keeps her going and motivates her. Dr. Arndal explained the two things that motivate her include getting to see the babies grow up in the community, along with the great team she is fortunate to work with.

CALL TO ORDER

The meeting was called to order at 5:35 p.m.

PRESENT

Jean Turner, NIHD Board of Directors Chair
Robert Sharp, NIHD Board of Directors Vice Chair
Charlotte Helvie, MD
Stacey Brown, MD
Will Timbers, MD, Interim CMO
Kelli Davis, Interim CEO
Dianne Picken, Medical Staff Support Manager

DISCUSSION ON PROPOSED MEDICAL STAFF BYLAWS

Kelli Davis reviewed the current status of the draft bylaws which have been approved by the Medical Staff and are awaiting decision by the Board of Directors.

MEDICAL STAFF AND BOARD RELATIONSHIP AND ACCOUNTABILITY

Jean Turner expressed concerns with the lack of clarity in language specific to the relationship between the Medical Staff and Board of Directors in the drafted Preamble and referenced the 2019 CHA Model Bylaws "Purpose" as an example of preferred bylaws text. Dr. Helvie reported that the body of the bylaws describes in detail the authority of the Board to act in situations when the Medical Staff fails to act in due diligence or when there are concerns to quality of care. It was also agreed that a Preamble may no longer be common in newer model bylaws.

CMO ROLE IN THE BYLAWS

Robert Sharp expressed concerns about the lack of delineation of the Chief Medical Officer (CMO) role in the bylaws text. Dr. Helvie reported that the CMO role is new and at the time the bylaws were drafted there was no active CMO. It was agreed that defining the CMO role in the bylaws is important but more time is needed to determine how best to incorporate role in the bylaws. It was also noted that the proposed draft bylaws do not preclude the CMO's ability to carry out his or her duties in relation to Medical Staff committees, and that it would be the intent of the Bylaws committee to make revisions regarding the CMO language and have further discussion with the Board to clarify the Medical Staff-Board relationship.

CONCLUSION

The Board members thanked the participation of the Bylaws committee members and reported they will be taking this information back to the Board of Directors for discussion and vote.

ADJOURNMENT

The meeting was adjourned at 6:37 p.m.

Board-Exec Admin-Physicians Meeting
Wednesday, December 2, 2020, 5:30-7:30pm

Attending: Interim CEO Kelli Davis, Interim CMO Dr. Will Timbers, Board of Directors Vice-Chair Robert Sharp, Board of Directors Chair Jean Turner, Dr. Robbin Cromer-Tyler, Dr. Joy Engblade

Dr. Timbers and Kelli Davis began with opening comments about providing an opportunity for medical staff to meet with Board and Executive Team around concerns or ideas for moving forward together.

This robust discussion predominantly focused on, and kept returning to, communication issues: stylistic differences, misunderstanding, lapses. There was a shared concern that there currently is a sense of different "camps", instead of one team at NIHD, and agreement that this is a primary issue. Part of that includes clarifying "feeling heard" versus "disagreeing."

Additionally, a few more concrete concerns were identified:

1) Acknowledging that 2020 required a more detailed look at finances, there now is a need to simplify the financial information presented at Board meetings, keeping in mind that the general public must be able to understand the information and feel confident in the stability of the District. This would mean things like bulleted summaries of key points, use of color coding, and keeping the information brief enough that our participating audience will in fact read it and understand it.
2) One of the challenges with the Medical Staff Bylaws is that some on the medical staff feel the need to establish in the bylaws that the medical staff is an independent body, and as an independent body, the Med staff information/concerns shall carry equal importance to the Board as information/concerns of the CEO.
3) The provider compensation issue is a source of great angst.

All expressed a desire for resolving tensions and improving communications. Dr. Timbers is in the process of bringing the provider compensation consultants to an upcoming Board meeting to provide high-level information about the process, industry standards, and other relevant information. He also acknowledged Dr. Brown's tremendous and on-going help with the current compensation analysis.
Dr. Timbers further reminded the group, of the commitment the Board and Leadership Team have made to continue meeting with providers to work collaboratively through issues.