Northern Inyo Hospital

May 17 2017 Regular Meeting

May 17 2017 Regular Meeting - May 17 2017 Regular Meeting

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

May 17, 2017 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. Old Business
   A. Proposed Budget Assumptions Update (*information item).*
4. New Business
   A. Approval of Nursing Department Policies and Procedures (*action items*):
      - *Outpatient Infusion Charge Descriptions*
      - *Charge Sheet and Charge Description in the PACU*
      - *Dress Code in the OP PACU*
   B. Hospital Wide Policy and Procedure annual approvals, Attachment A to Agenda (*action item*).
   C. Joint Commission Lab Survey results (*information item*).
   D. State Survey, NIHD Rural Health Clinic (*information item*).
   E. EHR Next Steps (*information item*).
   F. Proposal for vendor change as Benefits Manager (*information item*).
   G. Northern Inyo Healthcare District inpatient charges comparison to State of California and competitors, 2010 to 2015 (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the March 1, 2017 special meeting
6. Approval of minutes of the April 19, 2017 regular meeting
7. Approval of minutes of the May 5, 2017 special meeting
8. 2013 CMS Validation Survey Monitoring, May 2017

9. Financial and Statistical Reports for the period ending March 31, 2017
10. Hospital Wide Pillars of Excellence quarterly report, July 1 2016 to June 30 2017

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11. Patient Experience Committee report (*information item*).
12. Workforce Experience Committee report (*information item*).
13. Compliance Officer Report (*information item*).
14. Compliance Policy and Procedure update, *False Claims Act Employee Training and Prevention Policy* (*action item*).
15. Chief of Staff Report; Joy Engblade, MD:
    A. Policies/Procedures/Protocols/Order Set approvals (*action items*):
        - *Venous Blood Collection*
        - *Insulin Continuous Subcutaneous Infusion Self Management of the Patient in the Acute Setting*
        - *Consent Form: Videotaping, Voice Recording, and Photography in the Perinatal Unit*

    B. Perinatal Critical Indicators 2017 (*action item*)

    C. Medical Staff Appointment/Privileges (*action item*)
        - Temporary Staff: John Franklin, MD (*internal medicine – temporary assignment until 12/31/17*)

    D. Additional Privileges (*action item*)
        - Richard Meredick, MD (orthopedic surgery) – additional surgical privileges granted:
            - Biopsy
            - Excision Biopsy Tumors (including ganglion etc.)
            - Pathological Fracture Fixation
16. Reports from Board members (*information items*).
17. Adjournment to closed session to/for:
    A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).

    B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 4 matters pending (*pursuant to Government Code Section 54956.9*).

    C. Discuss trade secrets, new programs and services (estimated public session date for

discussion yet to be determined) (*Health and Safety Code Section 32106*).

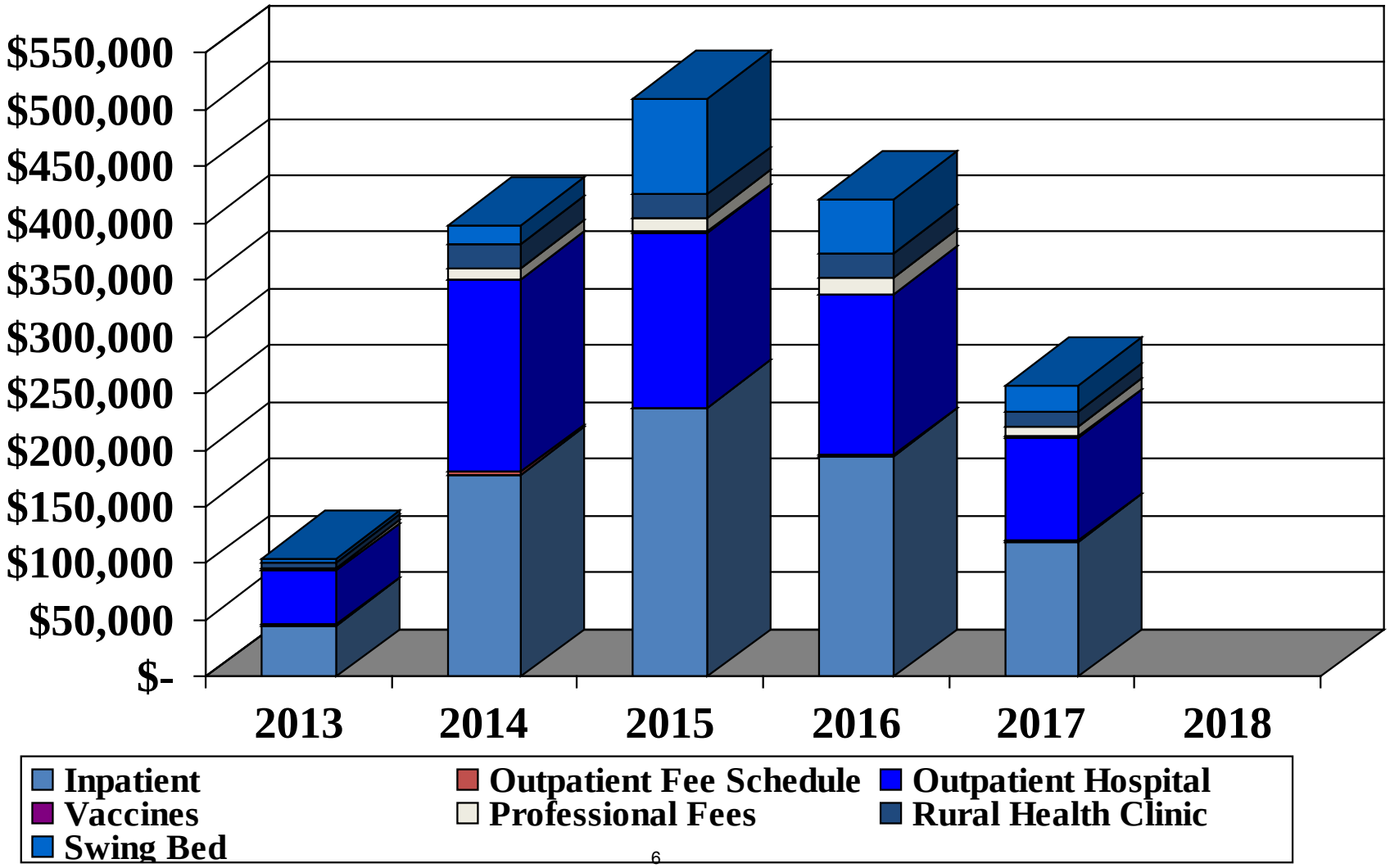
18. Return to open session and report of any action taken in closed session.
19. Adjournment.

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.

We Need Congress to Pass a New Budget

- The on-going process of passing continuing resolutions is not addressing the issue that sequestration guarantees that NIH loses money each year serving Medicare patients in every patient care setting
- There is at least one bill before Congress that would be incorporated into the Fiscal 2018 budget which would eliminate sequestration for Critical Access Hospitals, Rural Health Clinics and Community Health Centers
- The sequestration reductions are averaging $450,000 per year for NIH and by the end of Fiscal 2017 will total nearly $1,950,000 over the last five fiscal years since they started in late Fiscal 2013.
- Part of the challenge for Northern Inyo Health Care District to have a positive margin is sequestration

Medicare Sequestration Reductions



NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

PURPOSE: To delineate use of the Outpatient (OP) charge sheet to ensure appropriate charges are made.

POLICY: All OP patients will be charged for the OP procedure and medications by computer or on the charge sheet.

PRECAUTIONS: Coordination with other units / departments such as the OR, and the Pharmacy is necessary to avoid missing charges or double charging on some items (like pre-operative medication, local anesthetics, etc.). Nursing care, medication administration, and times for all procedures and medications (including IV medications) must be accurately documented in order for the charges to be made correctly.

PROCEDURE:

- The outpatient procedure includes time, room, monitors and in some cases supplies but does not generally include medications or IV solutions. There is a description of outpatient procedures called: "Descriptions of Charges". Any questions should be referred to the Outpatient Nurse Manager or the OP Clerk.
- Procedures are charged for electronically through Order Management in Paragon.
- There is an Infusion "hierarchy" when multiple drugs are administered. Only **one initial service code can be reported for a given date** unless the protocol requires two separate IV lines. If an injection or infusion is of subsequent or concurrent nature even if it is the first infusion or IV injection of the group it should be reported as subsequent or concurrent. For example: the first IV push given to an initial one hour infusion is reported as a subsequent IV push – even if it was given prior to the one hour infusion. The initial infusion is the primary reason for the encounter. The hierarchy is as follows: Chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services. IV push is primary to hydration services. IM and SQ injections are not in the hierarchy but IM or SQ injections of the same drug are given a "same drug" injection code.

CHARGE DESCRIPTIONS

CHEMOTHERAPY

Chemotherapy Injection, SQ/IM Non-hormonal: CHM96400

Administration of a chemotherapy (antineoplastic) medication administered by subcutaneous or intramuscular route.
Includes: supplies, nursing expertise and time, room and monitors as needed.
Charge separately for: Medication administered.
Note: Only 1 injection charged for when an ordered medication is given in divided doses to a patient during one visit.

Chemotherapy Injection, SQ/IM Hormonal: CHM96402

Administration of a hormonal chemotherapy (antineoplastic) medication administered by subcutaneous or intramuscular route. (examples are Faslodex, Zoladex, and Lupron)
Charge separately for: Medication administered.
Note: Only 1 injection charged for when an ordered medication is given in divided doses to a patient during one visit.

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Chemotherapy IV Injection (IVP) / IV Infusion lasting 15 minutes or less: CHM96409

Administration of a chemotherapy (antineoplastic) medication by syringe as a "push", with or without the use of a syringe pump or IV infusion of a chemotherapy (antineoplastic) medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, an IV catheter, or IV tubing.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Charge separately for: Medications administered.
Note: fluids used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately. Pharmacy will charge for pharmacy items such as premedications, chemotherapy medications.
Note: Only 1 injection charged for when an ordered medication is given in divided doses to a patient during one visit.

Chemotherapy Sequential IV Injection (IVP) / IV Infusion lasting 15 minutes or less: CHM96411

Administration of a sequential (subsequent different) chemotherapy (antineoplastic) medication by syringe as a "push", with or without the use of a syringe pump or IV infusion of a sequential (subsequent different) chemotherapy (antineoplastic) medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, an IV catheter, or IV tubing.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Charge separately for: Fluids and medications.
Note: fluids used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately. Pharmacy will charge for pharmacy items such as premedications, chemotherapy medications.
Note: Charge for each subsequent (sequential) chemotherapy medication administered but only 1 injection charged for when an ordered medication is given in divided doses to a patient during one visit.

Chemotherapy IV Infusion lasting 90 minutes or less: CHM96413

Administration and monitoring of an intravenous chemotherapy (antineoplastic) medication through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration.
Chemo infusion time is defined as the time from the start of the primary chemotherapy medication until the infusion of that particular medication has finished.
Chemotherapy infusions that last longer than 90 minutes are charged additional chemotherapy infusion time for each hour or part of an hour after the first 90 minutes of infusion time.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Fluids and medications are billed separately, except for fluids (NS or D5W) used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately. Pharmacy will charge for pharmacy items such as premedications, chemotherapy medications

Chemotherapy IV Infusion Other Unlisted lasting 90 minutes or less: OPD96549 (Concurrent Chemotherapy Infusions)

Administration and monitoring of an two intravenous chemotherapy (antineoplastic) medications through a primary or secondary IV tubings into veins or catheters concurrently. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration.

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Chemo infusion time is defined as the time from the start of the primary chemotherapy medication until the infusion of that particular medication has finished.
Chemotherapy infusions that last longer than 90 minutes are charged additional chemotherapy infusion time for each hour or part of an hour after the first 90 minutes of infusion time.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Fluids and medications are billed separately, except for fluids (NS or D5W) used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately. Pharmacy will charge for pharmacy items such as premedications, chemotherapy medications

Chemotherapy IV, Additional Hour Infusion after Initial 90 minutes: CHM96415

Each additional hour or fraction of an hour of administration and monitoring of an intravenous chemotherapy (antineoplastic) medication through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration. Initial 90 minutes is charged as the chemotherapy infusion CHM96410.
Chemo infusion time is defined as the time from the start of the primary chemotherapy medication until the infusion of that particular medication has finished.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Fluids and medications are billed separately, except for fluids (NS or D5W) used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately. Pharmacy will charge for pharmacy items such as premedications, chemotherapy medications.

Chemotherapy IV, Sequential Infusion first hour: CHM96412

Infusion and monitoring of a sequential (subsequent different medication) intravenous chemotherapy (antineoplastic) medication through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration. Initial infusion (up to and including 90 minutes) is charged as CHM96413. Additional sequential infusion time (over1hour) will be charged as additional chemotherapy infusion: CHM96415 for each hour after the first sequential hour of infusion.
Sequential chemotherapy infusion time is defined as the time from the start of the sequential (subsequent) chemotherapy medication until the infusion of that particular medication has finished.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Fluids and medications are billed separately, except for fluids (NS or D5W) used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately. Pharmacy will charge for pharmacy items such as premedications, chemotherapy medications.

Chemotherapy Infusion- Initiation of Intravenous Infusion > 8 Hours: CHM96416

Setting up a pump for an infusion of antineoplastic medication that lasts more than 8 hours. May include infusion of chemotherapy medication by use of a portable pump such as those worn home by patients.
Includes: IV start supplies or access supplies for central venous access devices, IV tubings and use of pump, nursing expertise and time.
Note: Pharmacy will charge separately for the medication and a separate charge to refill the pump will be added for those infusions that require a second infusion bag.

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Refill/Maintenance of Portable Infusion Pump: CHM96521
Adding another infusion bag for a portable infusion pump or maintaining infusion pump such as clearing blocked or kinked tubing, changing pump settings, restarting pump that has shut off accidentally.
Includes: IV tubing, use of pump, flush solutions and supplies, nursing expertise and time.
Note: Pharmacy will charge separately for the medication that is being added to the pump.
Refill/Maintenance of Portable Infusion Pump applies to chemotherapy and non-chemotherapy infusions.
(Examples of non-chemotherapy infusions are TPN and Vancomycin.)

Bladder Instillation Antineoplastic: OPD32005
Administration of antineoplastic medication through a catheter into the bladder.
Includes: Catheterization supplies except for catheter itself, nursing expertise and time
Note: Pharmacy will charge separately for medication and the actual catheter itself will be charged separately.

INJECTIONS / INFUSIONS, NON-CHEMO

Injection, SQ / IM: 64401
Administration of medication either intramuscularly or subcutaneously for therapeutic or diagnostic purposes and subsequent observation for effect and/or sequelae, such as reduction of prior symptoms and/or allergic reaction.
Includes: Nursing time and expertise only.
Note: Only 1 injection charged when a single ordered dose of medication is given in divided syringes without an interval of monitoring or observation between injections.
Charge separately for: Medication(s) administered.

IV Injection, (IVP) / Infusion lasting 15 minutes or less: 64403
Administration of an IV medication by syringe as a "push" with or without a syringe pump or IV infusion of a medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, IV catheter or IV tubing.
Includes: IV start supplies, IV tubings, syringe pump, nursing expertise and time.
Charge separately for: Medication(s) administered.
Note: Only 1 injection charged for when a medication is given in divided doses (2 or more syringes) or multiple times (example might be two doses of Zofran for nausea).
Note: Fluids used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately.

Sequential IV Injection (IVP) / IV Infusion lasting 15 minutes or less: OPD90775
Administration of a sequential (subsequent different) diagnostic or therapeutic medication by syringe as a "push", with or without the use of a syringe pump or IV infusion of a sequential (subsequent different) diagnostic or therapeutic medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, an IV catheter, or IV tubing.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Charge separately for: Medication(s) administered.
Note: fluids used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately.

IV Infusion lasting 90 minutes or less: 64404

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Administration and monitoring of IV medications for diagnostic or therapeutic purposes, through a primary or secondary IV tubing into a vein or catheter. Includes an IVPB infusion lasting longer than 15 minutes. Additional time (after 90 minutes) will be charged (each hour) as an additional infusion hour. Infusion time is defined as the time an infusion is started until that particular infusion has finished.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Charge separately for: Medication(s) administered.
Note: Fluids used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately.

IV Infusion, Additional Hour after Initial 90 minutes: OPD90780
Each additional hour or fraction of an hour of infusion time for administration and monitoring of an intravenous diagnostic or therapeutic medication through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration. Initial 90 minutes is charged as the 64404 (IV Infusion 90 minutes or less).
Infusion time is defined as the time from the start of the primary medication until the infusion of that particular medication has finished.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Medication(s) administered are billed separately, except for fluids (NS or D5W) used to flush before and/or after medication administration, which are considered a part of the medication administration and are not billed separately.

Sequential IV Infusion first hour: OPD90781
Infusion and monitoring of a sequential (subsequent different medication) intravenous diagnostic or therapeutic medication through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration. Initial infusion (up to and including 90 minutes) is charged as 64404. Additional infusion time (over1hour) of a sequential infusion will be charged as additional IV infusion: (OPD90780) for each hour after the first sequential hour of infusion.
Sequential infusion time is defined as the time from the start of the sequential (subsequent) medication until the infusion of that particular medication has finished.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Medication(s) are billed separately by pharmacy. Fluids (NS or D5W) used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately.

Concurrent IV Infusion: (billed only once) OPD32006
Infusion and monitoring of an intravenous diagnostic or therapeutic medication given concurrently (at the same time as another intravenous diagnostic or therapeutic medication) through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration. This is a one time charge regardless of the total infusion time of the concurrent medication.
Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.
Note: Medication(s) are billed separately by pharmacy. Fluids (NS or D5W) used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately.

Hydration IV, 90 minutes or less: OPD32007

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Infusion and monitoring of administration of intravenous fluids specifically ordered by the physician for replacement of body fluid or for increased urine production / rapid elimination of potentially nephrotoxic or urotoxic chemicals.
Includes: IV start, supplies, tubings, and pump.
Note: This does not include "background" IV solutions such as NS or D5W that are used to maintain IV patency or flush medications through the tubing and these are not charged to the patient). Pharmacy will charge for the actual hydration fluid and additives.

Hydration IV, each additional hour: OPD32008

Each hour or fraction of an hour of IV hydration after the initial hour (which is 90 minutes) Hydration is the infusion and monitoring of administration of intravenous fluids specifically ordered by the physician for replacement of body fluid or for increased urine production / rapid elimination of potentially nephrotoxic or urotoxic chemicals.
Includes: IV start, supplies, tubings, and pump.
Note: This does not include "background" IV solutions such as NS or D5W that are used to maintain IV patency or flush medications through the tubing and these are not charged to the patient). Pharmacy will charge for the actual hydration fluid and additives.

Porta-Cath Blood Draw: OPD36543

Blood draw (for laboratory tests) by an RN through an implanted port (porta-cath or life-port). Also entails a final flush with sterile normal saline and/ or heparin. This charge number is linked (by billing) to the charge number: OPD36542 and to a lab draw charge.
Includes: Skin prep solution, non-coring needle, syringes, needles, sterile normal saline, test tubes, nursing time, and phlebotomist time.
Note: Does not include the heparin solution (which is a Pharmacy billed item) or the laboratory charge for the actual test performed on the blood.

Porta-Cath Flush: OPD96523

Flush (with normal saline and or heparin) by an RN through an implanted port (porta-cath or life-port) to maintain patency.
Includes: Skin prep solution, non-coring needle, syringes, needles, sterile normal saline, and nursing time.
Note: Does not include the heparin solution, which is a Pharmacy billed item.

Groshong Catheter Repair: OPD36575

Repair of a Groshong catheter in which a repair kit is necessary to splice the line aseptically or to secure a new female adapter at the end of the Groshong (so a needless cap can be secured).
Includes: Groshong catheter repair kit, nursing time and expertise, miscellaneous supplies such as sterile gloves, syringes and sterile normal saline for priming and flushing the catheter.
Note: Does not include medication(s) or infusion time for a scheduled outpatient infusion (for example a patient that is scheduled for an IV antibiotic administration daily and needs a catheter repair prior to the infusion).

OTHER OUTPATIENT PROCEDURES

Evaluation and Management – Level 1 (low Level): OPD99211

Low Level Interventions include:

- Clinical staff assessment (not by physician) vital signs, symptom assessment
- Specimen collection other than venipuncture, such as clean catch urine specimen (includes antiseptic wipes, sterile cup, explanation)
- Suture removal (suture removal kit)
- Use of room (includes cleaning and registration) not separately billable.
- Simple dressing change (cleaning and dressing of a single body area wound 26 cm or less, and small or medium dressing: no more than 6 packages of sterile gauze pads)

Includes: room, supplies, nursing time and expertise.
Charge separately for: Any extra supplies (specialized dressings) or pharmacy items used.

Evaluation and Management – Level 2 (Mid-Level): OPD99212

Mid-Level Interventions include:

- Administration of oral, topical, rectal, naso-gastric, or sublingual medication (s). (Does not include medication charges).
- Teaching up to ½ hour (syringes, needles, or dressings for demonstration) example; care of vascular access device or dressing changes for vascular access device.
- Assist physician with examination (pelvic exam, eye exam with slit lamp)
- Application of preformed splint(s), elastic bandages/slings, or immobilizer for non-fracture or non-dislocation injuries when not separately billable. (Includes splint).
- First aid procedures (control bleeding, ice, cool body, remove insect stinger)
- Monitoring / assessment as evidenced by two sets of vital signs including the initial set integral to the patient's condition.
- Blood draw though non-implanted vascular access device such as Groshong or PICC line. (Includes supplies and saline for flush)
- Care of non-implanted vascular access devices such as Groshong or PICC line (Includes assessment, flushing, and supplies such as Groshong caps, non-coring needles, sterile saline for flush, cleaning solution, and 2x2 gauze dressing).

Includes: room, supplies, nursing time and expertise.
Charge separately for: Any extra supplies (specialized dressings, etc.) or pharmacy items used.

Evaluation and Management – Level 3 (High Level): OPD99213

- Care of multiple catheters
- Fecal disimpaction – manual disimpaction or multiple enemas (includes enema supplies)
- Teaching (face to face) greater than 1 hour
- Frequent monitoring / assessment: more than 2 sets of vital signs (including initial set) integral to patient's condition

Includes: room, supplies, nursing time and expertise.
Charge separately for: Any extra supplies (specialized dressings) or pharmacy items used.

Contributory factors Level 1 to Level 2 or Level 2 to Level 3:

- Altered mental status
- Airway insertion
- Social service intervention
- Isolation

- Reporting to law enforcement

Evaluation and Management – Level 4 (Critical Level): OPD99214
Interventions/care for critically ill or critically injured patients (examples: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

- Assist in the induction/monitoring of pharmaceutical-induced coma
- Assist with rapid sequence intubation and/or airway management
- Code team/trauma team intervention
- Control of major hemorrhage such as exsanguination leading to hemodynamic instability
- Initiation, monitoring, and titration of thrombolytic agents and vasopressors
- Continuous reassessment of an unstable patient

Includes: room, supplies, nursing time and expertise.
Charge separately for: Procedures performed by a physician (such as intubation) that are chargeable, any extra supplies or pharmacy items used.

Central Line Insertion: OPD36556
Insertion of a non-tunneled central venous line for monitoring central venous pressure or for rapid administration of IV fluids. This charge would be used in addition to an Evaluation and Management Level IV (Critical Level) in the Outpatient Unit.
Includes: Room, nursing time and expertise, and monitors
Note: Charge separately for Pharmacy items (medications, IV fluids), CVC prep kit, and CVC

CVP Prep Tray: 59769
Charge for a CVP prep tray to go with the CVP insertion procedure (above)

PICC Line Insertion
PICC Line Insertion patient 5 years old or younger: OPD36568
PICC Line Insertion, patient older than 5 years: OPD36569
Charge for a PICC Line tray to go with the PICC Line insertion procedure (above)

Cardioversion - Outpatient: OPD92960
Administration of an electric shock to the patient's chest to regulate heart rhythms considered dangerous.
Includes: Quick Combo Patches, monitor, and nursing time
Charge separately for: any other equipment and pharmacy items.

Thoracentesis – Outpatient: OPD32000
Removal of a collection of fluid in a lung by puncturing through the space between the ribs and entering the lung. Fluid is then aspirated from the cavity of fluid collection in the lung tissue.
Includes: Thoracentesis tray, 2 evacuator bottles and nursing time.
Charge separately for: Local anesthetic agents and any additional evacuator bottles.

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Lumbar Puncture: OPD62270
Assist with placement of a needle in the spinal column for the purpose of collecting specimens for testing and/or checking Cerebral Spinal Fluid Pressure.
Includes: Lumbar puncture tray and nursing time.
Charge separately for: Gertie Marx needle.

Paracentesis: OPD49080
Insertion of a needle or catheter into the abdominal and withdraw fluid for diagnostic and/or therapeutic purposes.
Includes: Paracentesis tray, 2 evacuator bottles and nursing time.
Charge separately for: Anesthetic agents and additional bottles.

Phlebotomy 1 Unit: OPD99195
A venipuncture performed to remove a unit of blood from a patient for therapeutic reasons (polycythemia, hemochromatosis etc.).
Includes: Phlebotomy bag, 1% Lidocaine for SQ use, dressing supplies, room, monitors, and nursing time
Charge separately for: Any other Pharmacy items or supplies used.

LASERS
Argon Laser / Indirect Laser: OPD32002
Use of the Argon or Indirect laser (sometimes both lasers are used for the same procedure) for ophthalmic procedures such as: pan-retinal photocoagulation.
Includes: Use of lenses, miscellaneous supplies such as sterile Q-tips, retrobulbar needles, eye patches and shields
Note: does not include eye drops, Goniosol, injectable anesthetics such as Lidocaine – which are charged separately by Pharmacy

Epidural Blood Patch: OPD62273
Injection of a small amount of the patient's blood into the epidural space by a physician to provide relief from headaches that may occur as a complication of an epidural injection done previously for another reason (usually pain relief for chronic back pain or labor pain).
Includes: monitors, tray, room, saline lock supplies, and nursing time
Charge separately for: anything extra that is used for the procedure

Epidural Tray – Arrow: 35131
An extra tray for an epidural steroid injection if needed/ used by the physician in the procedure

TRANSFUSION
Blood or Platelet Administration – outpatient
(Charge based on transfusion time regardless of number of units given)
OP Transfusion up to 2 hours: OPD59409
OP Transfusion 2-4 hours: OPD59408
OP Transfusion 4-6 hours: OPD59404
OP Transfusion 6-8 hours: OPD32001
Transfusion of blood or blood products for therapeutic effect and observation for possible sequelae.

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Includes: Tubing, background Normal Saline, nursing time and monitors.
Charge separately for: If used: oral premeds (such as Tylenol, Benadryl), Lasix, and blood warmer tubing,

BLADDER PROCEDURES

Bladder Scanner: OPD51798

Use of portable ultrasound to determine the approximate volume of urine in a bladder.
Includes: Aqueous gel
Note: Only one charge submitted when multiple scans are made to determine an accurate volume, often several scans are necessary to locate the bladder directly in the center of the ultrasound picture. Separately charge for catheterization if this is necessary

Insertion Bladder Catheter, Non-indwelling: OPD51701

Insertion Bladder Catheter, Indwelling Catheter: OPD51702

Insertion of a Foley catheter for urine sample or to empty a full bladder (non-indwelling)
Or insertion of Foley catheter with a bag for continuous drainage of the bladder (indwelling)
Includes: Catheter, catheter insertion kit, miscellaneous supplies (chux)
Note: Level I Evaluation and Management is also charged for nursing time / expertise, and room

Insertion Suprapubic Bladder Catheter: OPD51010

Insertion of a suprapubic bladder catheter by a physician to empty the bladder where ureteral catheterization is not an option.
Includes: supplies, nursing time, room.

SEDATION

Moderate Sedation IV / Oral: OPD99151: for patient less than 5 years of age initial 15 minutes

Administration of intravenous or oral medications on the order of a physician to obtund, dull or reduce the intensity of pain and awareness **without loss of protective reflexes.** Conscious sedation is generally achieved when there is drowsiness but the **patient is arousable and is able to respond.**
Includes: Monitors, oxygen delivery, nasal cannula or mask, and nursing time.
Charge separately for: IV fluids and medications.

Moderate Sedation IV / Oral: OPD99152: for patient 5 years of age or older initial 15 minutes

Administration of intravenous or oral medications on the order of a physician to obtund, dull or reduce the intensity of pain and awareness **without loss of protective reflexes.** Conscious sedation is generally achieved when there is drowsiness but the **patient is arousable and is able to respond.**
Includes: Monitors, oxygen delivery, nasal cannula or mask, and nursing time.
Charge separately for: IV fluids and medications.

Moderate Sedation IV/ Oral: OPD99153 each additional 15 minutes (after initial sedation charge)

WOUND CARE

Selective Wound Debridement (Waterjet/ Sharp): OPD97597
Debridement Wound (Waterjet /sharp) each additional 20cm: OPD97598
Nonselective Wound Debridement (Wet to Dry): OPD97602
Debridement by MD 10% BSA: OPD11000

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Debridement by MD additional BSA: OPD11011
Negative Pressure Dressing Change: OPD97605 (50sq. cm), OPD97606 (less than or equal to 50sq. cm), OPD97607 (greater than 50sq. cm)
Una Wrap (multilayer compression dressing): OPD8960 (lower leg), OPD8961 (separate), OPD8962 (bilateral), OPD8963 (upper leg)

Includes: nursing time and room
Charge separately for: dressing supplies that have a separate charge number

MISCELLANEOUS

Oxygen infusion, Outpatient, each hour: OPD32004

Oxygen use (by the hour or fraction of an hour) for patients that have oxygen ordered by their physician while in the outpatient unit for another procedure (for example chemotherapy or while having a phlebotomy).
Includes: oxygen, cannula or mask (unless patient already has one), SpO2 check
Note: Oxygen is applied by physician order and start/stop times must be documented in patient care record.

OUTPATIENT PROCEDURES THAT ARE NOT CHARGED SEPARATELY

Monitoring Outpatients Following biopsies, discograms, myelograms, radiofrequency ablations, vertebroplasties, and other interventional radiology procedures done in Radiology

Patients are frequently observed and monitored in the Outpatient Nursing Unit following Interventional Radiology procedures.
No charge submitted by nursing unit. The charge for the procedure includes the time, room, monitoring that these patients require and nursing hours are changed to the radiology cost center for RN time.
Charge separately for: Moderate sedation, oxygen or medication ordered/given to the patient for example: pain medication

Stress Testing with Nuclear Medicine

Injection of a radioisotope by a nuclear medicine technician while patient undergoes a stress test in EKG or while receiving IV Adenosine. OP Nursing responsible for starting a saline lock, administering Adenosine, and charting saline lock and Adenosine administration on Nuclear Stress Test form.
Includes: supplies that are used in the saline lock start (bifurcated clave tubing, IV catheter, veniguard, lidocaine 1%, normal saline), radioisotope, and scanning. Pharmacy charges for the Adenosine.
No charge submitted by nursing unit. Radiology charges for the procedure and nursing hours are changed to a radiology cost center as needed.
Charge separately for: Any other procedure done or medication ordered/ given.

Injection of Lasix or CCK in Nuclear Medicine

Injection of a medication by an RN to complete a nuclear radiology test, such as lasix for a renal scan or CCK for a HIDA scan will not be charged separately. The outpatient RN or Nuclear medicine technician will be responsible for starting a saline lock; the RN is responsible for administering and charting the medication.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Outpatient Infusion Charge Descriptions	
Scope: Outpatient Services	Manual: Infusion Center
Source: DON Perioperative Services	Effective Date:

Includes: Supplies that are used in the saline lock start (bifurcated clave tubing, IV catheter, veniguard, lidocaine 1%, normal saline) and the medication.
No charge submitted by nursing unit. Radiology charges for the procedure and nursing hours are changed to a radiology cost center as needed.
Charge separately for: Any other procedure done or medication ordered/ given.

DOCUMENTATION: Most charges will be submitted electronically through Order Management in Paragon by the Outpatient Clerk. The charge sheets (paper) are still available for use during down times.

Approval	**Date**
NEC	5/3/17
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised: 1/98, 2/2001, 3/06, 08/10 AW, 05/11AW, 9/12AW, 12/16AW
Supersedes:
Index Listings: Charge Sheet and Charge Description in the OPD, OPD; OPD Charge Sheet and Charge Descriptions

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Charge Sheet and Charge Description in the PACU	
Scope: PACU	Manual: PACU
Source: PACU Nurse Manager	Effective Date:

PURPOSE:
To clarify use of the PACU charge sheet so that appropriate charges are made.

POLICY:
All PACU patients will be charged for the PACU time and medications by computer or on the charge sheet unless they are charged a procedure charge. PACU time should not be charged for patients undergoing OP procedures performed in the PACU for staffing convenience.

PROCEDURE

- Obtain an OP/PACU Charge sheet from the PACU clerk desk.
- Apply patient label to the upper right hand corner of charge sheet, fill in date to the left.
- An arabic number "1" should be placed on the "QTY" column to the right of the rendered or supply used. If multiple items are used write a 2 or 3 on the "QTY" column. Do not use Roman numerals (II, or III, etc.).
- Unless the patient is being charged for a procedure, PACU time will be charged for
  First Hour
  Each additional 15 minutes (time over 6 minutes is counted as an additional 15min)

Example: 2 hours of PACU will be 1-First Hour and 4-additional 15-minute increments.

- IV's and medications used are charged for on the second sheet. Pharmacy will charge for all inpatient IV's and IV piggybacks, however, note IV's used, etc. on the yellow copy of the orders. The Pharmacy will supply the code number on any medication not printed on the sheet. In this case, the medication, quantity and code number should be written in under the miscellaneous section.
- These sheets are generated by the PACU clerk and charges are submitted electronically through Order Management in Paragon. The sheets are kept for a month before they are discarded; they are in a binder at the PACU clerk desk in the event there is a question about a charge.

CHARGE DESCRIPTIONS

PACU CHARGES

Time is rounded up to the nearest 15 minutes. Time over 6 minutes is counted as an additional 15min. (51 minutes would be a 1 hour charge)

The following procedures are not charged for PACU time (PACU time is part of the procedure charge):

- Blepharoplasties
- Bronchoscopies
- Cataract extraction / lens implant surgeries
- Colonoscopies (Diagnostic and Screening)
- EGD procedures (UGI Endoscopy procedures)
- Frenulectomies
- LEEP procedures, cold conizations, cervical biopsies
- Rectal Exam under anesthesia with fulguration / excision skin tags/ drain placement

Title: Charge Sheet and Charge Description in the PACU	
Scope: PACU	Manual: PACU
Source: PACU Nurse Manager	Effective Date:

PACU 1 Hour: 00029

An initial hour of PACU time is charged **ONE TIME** only for all patients excluding those patients using MAC anesthesia or procedural sedation.
Includes: Monitors, oxygen, oxygen mask or cannula, nursing expertise and time, and administration of medications.
Note: Does not include medications and IVs administered in PACU (these are charged separately by Pharmacy).

PACU ¼ Hour: 10016

Additional PACU time is charged in 15 minute increments; time is rounded up to the nearest 15 minute increment. Use for patients receiving MAC anesthesia or procedural sedation other than special screening colonoscopies and cataract extraction / lens implant surgeries which do not receive a PACU charge – these charges are part of the procedure itself.
Includes: Nursing expertise and time for those patients in PACU longer than an hour. For MAC or Procedural Sedation patients this includes the monitors, oxygen, oxygen mask or cannula, as well as the nursing expertise.
Note: The 10016 charge does not include medications administered in PACU (these are charged separately by Pharmacy).

PACU IV Injection, (IVP) / Infusion lasting 15 minutes or less: PACU90774

Administration of an IV medication by syringe as a "push" with or without a syringe pump or IV infusion of a medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, IV catheter or IV tubing.
Includes: IV start supplies, IV tubings, syringe pump, nursing expertise and time.
Charge separately for: Medication(s) administered.
Note: *Only charged if the medication administration is unrelated to the surgical procedure. Medication used to control pain or nausea in the PACU would be related to the surgical procedure.*
Note: Fluids used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately.

PACU SEQUENTIAL IV Injection, (IVP) / Infusion lasting 15 minutes or less: PACU90774

Administration of a different, sequential IV medication by syringe as a "push" with or without a syringe pump or IV infusion of a medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, IV catheter or IV tubing.
Includes: IV start supplies, IV tubings, syringe pump, nursing expertise and time.
Charge separately for: Medication(s) administered.
Note: *Only charged if the medication administration is unrelated to the surgical procedure. Only 1 injection charged for when a medication is given in divided doses (2 or more syringes) or multiple times (example might be two doses of Zometa given in PACU for cancer metastases to the bone).*
A sequential dose would be charged for each different medication administered by IVP or short IV infusion. (an example would be several IVP doses of Zometa would be an initial IVP charge; if the patient was given a dose of IVP Labetolol afterwards, this would constitute a sequential charge.
Note: Fluids used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately.

Title: Charge Sheet and Charge Description in the PACU	
Scope: PACU	Manual: PACU
Source: PACU Nurse Manager	Effective Date:

PACU Same Drug IV Injection, (IVP)/ Infusion lasting 15 minutes or less: PACU90776

Administration of the same drug IV medication by syringe as a "push" with or without a syringe pump or IV infusion of a medication infusing over 15 minutes or less by gravity or use of IV pump into a vein, IV catheter or IV tubing.

Includes: IV start supplies, IV tubings, syringe pump, nursing expertise and time.

Charge separately for: Medication(s) administered.

Note: Only charged if the medication administration is unrelated to the surgical procedure. Only 1 injection charged for when a medication is given in divided doses (2 or more syringes) or multiple times (example might be two doses of Zometa given in PACU for cancer metastases to the bone). A same drug dose would be charged for each 30 minute incremental medication administered by IVP or short IV infusion. (an example would be several IVP doses of Zometa would be an initial IVP charge; if the patient was given a dose of IVP Labetolol afterwards, this would constitute a sequential charge.

Note: Fluids used to flush before and/or after medication administration are considered a part of the medication administration and are not billed separately

PACU IV Infusion lasting 90 minutes or less: PACU 64404

Administration and monitoring of IV medications for diagnostic or therapeutic purposes, through a primary or secondary IV tubing into a vein or catheter. Includes an IVPB infusion lasting longer than 15 minutes. Additional time (after 90 minutes) will be charged (each hour) as an additional infusion hour. Infusion time is defined as the time an infusion is started until that particular infusion has finished.

Includes: IV start supplies, IV tubings and pumps, nursing expertise and time.

Charge separately for: Medication(s) administered.

***Note**: Fluids used to flush before and/or after medication administration are considered part of the medication administration and are not billed separately. Only charge if the infusion is unrelated to the surgical procedure.*

PACU Infusion, Additional Hour after Initial 90 minutes: PACU 90780

Each additional hour or fraction of an hour of infusion time for administration and monitoring of an intravenous diagnostic or therapeutic medication through a primary or secondary IV tubing into a vein or catheter. Includes IVPB infusion lasting longer than 15 minutes by gravity or infusion pump administration. Initial 90 minutes is charged as the 64404 (IV Infusion 90 minutes or less). Infusion time is defined as the time from start of the primary medication until the infusion of that particular medication is finished.

Includes: start supplies, IV tubings and pumps, nursing expertise and time.

***Note:** Only charge if the infusion is unrelated to the surgical procedure.*

LASER CHARGES

Argon Laser / Indirect Laser: OPD32002

Use of the Argon or Indirect laser (sometimes both lasers are used for the same procedure) for ophthalmic procedures such as: pan-retinal photocoagulation

Includes: Use of lenses, miscellaneous supplies such as sterile Q-tips, retrobulbar needles, eye patches and shields

Note: does not include eye drops, Goniosol, injectable anesthetics such as Lidocaine – which are charged separately by Pharmacy

Title: Charge Sheet and Charge Description in the PACU	
Scope: PACU	Manual: PACU
Source: PACU Nurse Manager	Effective Date:

SEDATION CHARGES

IV Conscious Sedation: OPD99141
Administration of intravenous medications on the order of a physician to obtund, dull or reduce the intensity of pain and awareness **without loss of protective reflexes.** Conscious sedation is generally achieved when there is drowsiness but the **patient is arousable and is able to respond.**
Includes: Monitors, oxygen delivery, nasal cannula or mask, and nursing time.
Charge separately for: IV fluids and medications.

Oral Conscious Sedation: OPD99142
Administration of oral medication on the order of a physician to obtund, dull, or reduce the intensity of pain and/or awareness without the loss of protective reflexes. Conscious sedation is generally achieved when there is drowsiness but the patient is arousable and is able to respond.
Includes: monitors, oxygen delivery, cannula or mask, and nursing time.
Charge Separately for: IV fluids and all medications.

TRANSFUSION CHARGES

Blood or Platelet Administration – outpatient
(Charge based on transfusion time regardless of number of units given)
OP Transfusion up to 2 hours: OPD59409
OP Transfusion 2-4 hours: OPD59408
OP Transfusion 4-6 hours: OPD59404
OP Transfusion 6-8 hours: OPD32001
Transfusion of blood or blood products for therapeutic effect and observation for possible sequelae.
Includes: Tubing, background Normal Saline, nursing time and monitors.
Charge separately for: If used: oral premeds (such as Tylenol, Benadryl), Lasix, and blood warmer tubing,

MISCELLANEOUS

BLADDER PROCEDURES

Bladder Scanner: OPD51798
Use of portable ultrasound to determine the approximate volume of urine in a bladder.
Includes: Aqueous gel
Note: Only one charge submitted when multiple scans are made to determine an accurate volume, often several scans are necessary to locate the bladder directly in the center of the ultrasound picture. Separately charge for catheterization if this is necessary

Title: Charge Sheet and Charge Description in the PACU	
Scope: PACU	Manual: PACU
Source: PACU Nurse Manager	Effective Date:

Insertion Bladder Catheter, Non-indwelling: OPD51701

Insertion Bladder Catheter, Indwelling Catheter: OPD51702

Insertion of a Foley catheter for urine sample or to empty a full bladder (non-indwelling)
Or insertion of Foley catheter with a bag for continuous drainage of the bladder (indwelling)
Includes: Catheter, catheter insertion kit, miscellaneous supplies (chux)
Note: Level I Evaluation and Management is also charged for nursing time / expertise, and room

Oxygen infusion, Outpatient, each hour: OPD32004

- Oxygen use (by the hour or fraction of an hour) for patients that have oxygen ordered by their physician while in the outpatient unit for another procedure (for example chemotherapy or while having a phlebotomy).
Includes: oxygen, cannula or mask (unless patient already has one), SpO2 check
Note: Oxygen is applied by physician order and start/stop times must be documented in patient care record.

OUTPATIENT PROCEDURES THAT ARE NOT CHARGED SEPARATELY

Monitoring Outpatients Following procedures done in Radiology
Patients are frequently observed and monitored in the Outpatient Nursing Unit following Radiology procedures such a liver, lung, or renal biopsies, paracentesis, thoracentesis, discogram or myelogram.
No charge submitted by nursing unit. The charge for the procedure includes the time, room, monitoring that these patients require.
Charge separately for: Any oxygen or medication ordered/given to the patient for example: pain medication

Approval	Date
NEC	5/3/17
Board of Directors	
Last Board of Director review	

Initiated: 3/98 AW
Revised: 2/01, 03/06, 07/10 AW
Reviewed: 05/11AW, 9/12AW, 12/16AW
Index Listing: Charge Sheet, PACU; PACU Charge Sheet

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Dress Code in the OP/PACU	
Scope: OP/PACU	Manual: PACU
Source: PACU Nurse Manager	Effective Date:

PURPOSE:
To maintain a neat, clean area. To prevent "track thru" into the OR corridor, Sterile Processing, and OR suites.

POLICY:
- The PACU is considered a "Clean" area.
- The OP/PACU personnel will wear a clean scrub uniform provided by the hospital. Shoes should be clean and worn only in the Surgery area, PACU and Sterile Processing area. Shoe covers should be worn over the shoes when going into Surgery or Sterile Processing if the shoes have been worn outside these areas.
- The PACU should appear neat and clean at all times. The appearance of the PACU personnel is a reflection of the area itself. Good judgment is requested in the choice of jewelry, make-up, etc.
- Patients going into the surgical area are dressed in hospital gowns (Bair Paws or cloth), feet are covered with shoe covers, and hair is covered with a hair cover. The exception is the cataract patient that may wear socks or shoes and pants that are covered with shoe covers, a gown, and all personal clothing covered with a bath blanket prior to the patient's transport (via gurney) to the OR.,
- If visitors are planning to go into the OR, surgical attire should be worn which includes surgical scrubs, hair cover and shoe covers. These items should be put on before entering the OR and can be removed after leaving the OR.

EQUIPMENT:
Cover gowns and shoe covers.

PRECAUTIONS:
If indicated, visitors need to wear shoe covers. Advise them that shoe covers can be slippery - use caution.

Approval	Date
NEC	5/3/17
Board of Directors	
Last Board of Director Review	

Index Listing: Dress code, PACU
Revised: 3/98, 7/99AW, 07/10AW, 05/11AW, 9/12AW

NORTHERN INYO HOSPITAL
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Approval	Date
NEC	5/3/17
Board of Directors	
Last Board of Director Review	

Index Listing: Dress code, PACU
Revised: 3/98, 7/99AW, 07/10AW, 05/11AW, 9/12AW

ATTACHMENT A TO THE AGENDA FOR THE

NORTHERN INYO HEALTHCARE DISTRICT REGULAR BOARD MEETING,

MARCH 15, 2017

COMPLIANCE DEPARTMENT

POLICY AND PROCEDURE ANNUAL APPROVAL

1. California Public Records Act – Information Requests

POLICIES TO THE BOD
ENVIRONMENTAL SERVICES

	POLICY & PROCEDURES TO THE BOARD	MAY, 2017		
	EVS			
	TITLE	TO BOD	APPROVED	COMMENTS
1	Cleaning Procedures: Non-Clinical Areas: Entrances	5/17/2017		
2	Cleaining Procedures: Non-Clinical Areas: Hallways	5/17/2017		
3	Cleaning Procedures: Non-Clinical Areas: Lobbies and Waiting Rooms	5/17/2017		
4	Cleaning Procedures: Non-Clinical Areas: Offices	5/17/2017		
5	Cleaning Procedures: Non-Clinical Areas, Public, Staff Restrooms	5/17/2017		
6	Cleaning Procedures: Non-Clinical Areas: Storage Areas, Unlocked	5/17/2017		
7	Cleaning Procedures: Non-Patient Care Equipment: Cubicle Curtains and Drapes	5/17/2017		
8	Cleaning Procedures: Non-Patient Care Equipment: Furniture	5/17/2017		

HUMAN RESOURCES
POLICY AND PROCEDURES APPROVAL LIST
MAY 2017

1. HOSPITAL ACCOUNTS
2. BENEFITS AS AFFECTED BY CHANGES IN EMPLOYMENT STATUS
3. EMPLOYEE RECOGNITION
4. LEAVING WORK AREA OR PREMISES
5. WORK RELATED ACCIDENTS
6. INJURY TO PATIENTS AND VISITORS
7. ACCEPTANCE OF TIPS, GRATUITIES, REWARDS, PROMOTIONAL GIFTS OR INCENTIVES
8. STANDARDS OF CONDUCT
9. ADDRESS CHANGE
10. CLEANLINESS AND NEATNESS
11. INFORMATION REGARDING PATIENTS
12. UNAUTHORIZED HOSPITAL VISITORS
13. LICENSES AND REGISTRATIONS
14. TELEPHONE USE
15. TELEPHONE COURTESY
16. SAFETY
17. PROMOTIONS
18. TRANSFERS
19. PERFORMANCE EVALUATIONS
20. REPORTING LATE AND LEAVING EARLY

Christensen, Robin (Quality Nurse/Infection Control Preventionist)
Area: Published

Ref #	Title	TO BOD	APPROVED	COMMENTS
3782	Admission of a Patient with a Communicable Disease*			
147	AIDS/HIV Testing and Orders			
1728	Airborne Infection Isolation Rooms (AIIR)*			
1434	Appendix A1, Type And Duration Of Precautions Recommended For Selected Infections And Conditions			
1090	Avian Influenza-H5N1 Flu Hospitalized Patients Infection			
1254	Bloodborne Pathogens			
136	Chickenpox and Shingles			
3816	Dishes in Staff Break Room Areas			
154	Disposal of Bottled Body Fluids			
150	Environmental Disinfectant - Cleaning Solution			
3800	Food and Drink in Patient Care Areas			
1503	GUIDELINES FOR MANAGEMENT OF HEALTH CARE PROVIDERS WHO ARE INFECTED WITH HEPATITIS B VIRUS, HEPATITIS C VIRUS and/or HIV			
139	Handling and Disposal of Contaminated Needles/Syringes			
149	Handling of Dishes/Utensils			
144	Handling of Infectious/Non-Infectious Waste			
148	Handling of Soiled Linen			
160	HIV Testing Without Consent			
168	Hospi-Gard Portable Filtration Unit (H.G.U.)			
158	Infection Control Exposure Hotline			
143	Infection Control Policy for Admitting/Administrative			
4048	Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Or New Construction Projects			
3754	Infection Prevention Plan			
1088	Infection Prevention Process Improvement Program & Management Plan			
1115	Infectious/Non-Infectious Waste Disposal Procedure			
1255	Inservice in Infection Control			
3783	Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Ebola Virus*			
171	Intravenous Therapy			
169	IV Therapy Facts			
1200	Multidrug Resistant Organism (MDRO) Control Plan			
1198	Nasal Swab Procedure, MRSA			
1287	Northern Inyo Hospital Surge Plan			
142	Nuclear Scan			
156	Patient Exposure			
138	Personal Protective Equipment (PPE's) and Supplies			
1286	Post Discharge Surveillance for Nosocomial Infections			
170	Prevention of Catheter Associated Urinary Tract Infections (UTI's), Guidelines			
1201	Protocol for Hospital Epidemic			
1248	Respiratory Syncytial Virus (RSV) Policy*			

643	Role of Microbiology in Infectious Disease Control			
3829	Scope of Service - Infection Control*			
163	Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients			
152	Toy Cleaning*			
3784	Triage of Patients Suspected of Ebola*			
167	Tuberculosis Exposure Control Plan			

POLICIES TO THE BOD
PHARMACY

	POLICY & PROCEDURES TO THE BOARD	MAY, 2017		
	PHARMACY DEPT.			
	TITLE	TO BOD	APPROVED	COMMENTS
1	Protecting Public from Impaired or Dishonest Pharmacy Employee	5/17/2017		
2	Pharmacy Operations During the Temporary Absence of a Pharmacist	5/17/2017		
3	Pharmacy Downtime Procedure	5/17/2017		
4	Pharmacy confidentiality: Storage and Destruction of PHI-containing documents	5/17/2017		
5	Pharmacist Clinical Interventions	5/17/2017		
6	OmniCell Automated Dispensing Unit (ADU)	5/17/2017		

POLICIES TO THE BOD
PROPERTY MGMT, SECURITY AND MAINTENANCE

	POLICY & PROCEDURES TO THE BOARD	MAY, 2017		
	ENVIRONMENT OF CARE			
	PROPERTY MGMT, SECURITY AND			
	TITLE	TO BOD	APPROVED	COMMENTS
1	Maintaining Temperature & Humidity in Anesthetizing Locations	5/17/2017		
2	Policy on Providing a Safe Environment	5/17/2017		
3	Policy on Roles and Responsibilities-Competency	5/17/2017		
4	Monitoring Conditions	5/17/2017		
5	Performance Improvement Activity	5/17/2017		
6	Safety Committee	5/17/2017		

CAP Notification

Date of Review 5/3/17

PCP ID# _____

Site ID# _____

Health Plan Performing Evaluation: California Health and Wellness	Health Net	L.A. Care	Blue Cross	Care First	Kaiser	Molina

Facility Name: Northern Inyo

PCP Name(s):

# of PCPs Reviewed: 3 PCP + 1 pod

# of Charts Reviewed: 20

Address: 153-B - Pioneer Lane, Bishop

Contact Person and Title: Dan David

Telephone: 760 873-2849

Fax: 760-873-2836

☒ Exempted Pass for the Site Review Survey – No CAP Due

☒ Exempted Pass for the Medical Record Review Survey – No CAP Due

Site Review Score: 98%

Date Critical Element CAP Due:

Date Site Review CAP Due: N/A

Medical Record Score: 94%

Date Medical Record CAP Due: n/a

CAP Follow-up: ☐ Mail/Fax ☒ Schedule Follow-up visit

☐ Critical Element ☐ Site Review ☐ Medical Records

☐ Follow-up visit scheduled date/time : _____ N/A

CAP Closed Date: N/A

Reviewer's Name/Title (Print): Pam Carpenter, RN

Reviewer's signature/Title:

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Corrective Action Plan (CAP) Completion and Submission Requirements

ne Health Plans have collaborated in establishing a process to facilitate compliance while limiting the intrusion into your facility. Participating Health Plans agree to accept evaluation findings the other Health Plans upon the physician's signature of Disclosure and Release. The collaborative process does not supersede any contractual requirements, and participation is oluntary.

Disclosure and Release

ave received and reviewed copies of the above listed site's evaluations and corrective action plans for the facility and medical record reviews. I agree to correct each identified deficiency by plementing any corrective action that may be required. **I understand that failure to correct any of the noted Critical Element deficiencies within the required 10 business days and ny other noted deficiencies within the 30 day time period from the review date,** may result in the exclusion of this facility and the associated provider(s) from the roster. **The completed AP must include evidence of correction** {e.g. invoices, education sign sheets, forms used} **and dates completed.**

For assistance in completing the CAP, please call Pam Carpenter,RN at 209-943-4803

ereby authorize the above mentioned health plans and any government agencies that have authority over the health plans, and authorized county entities in the State of California, to furnish each other these reviews and corrective action plans of this facility.

_____ STACEY BROWN, MD 5/3/17

Physician/Designee Signature **Printed Name and Title** **Date**

Please Return Completed CAP via U.S. Mail or FAX to:

California Health and Wellness Plan
1740 Creekside Oaks Drive, Suite 200
Sacramento, CA 95833

Attention: Pam Carpenter, RN, DHCS-MT
Quality Improvement Manager
FAX: 844-897- 5951

BOARD PRESENTATION

CCAHN Group Purchasing Program and New Consultant/Broker for 2018 Benefit Program

Purpose of Meeting

We are recommending that Northern Inyo Hospital move to a new Consultant and TPA, and join the Group Purchasing Program which is sponsored by the California Critical Access Hospital Network (CCAHN).

Background

- CCAHN has been working for the past 18 months to develop a benefits group purchasing program with their consultant, Keenan HealthCare.
- Keenan is building a JPA for District Hospitals and qualifying rural, nonprofit Hospitals.
- Keenan has discussed the JPA with several hospitals for membership: Fairchild, Healdsburg, Kern Valley, Mayers Memorial, Mee Memorial, Modoc, Plumas, Ridgecrest, So. Humboldt and Tahoe Forest.
- All benefits (Medical, Dental, Vision, Life and Disability) will be included.
- The effective date will be January 2018.

Why Should NIH Join the CCAHN Sponsored Program?

Joining other hospitals to purchase benefits will bring:

- Reduced medical plan expenses. We expect lower cost for Stop Loss, TPA fees and Network access fees.
- Expected savings for Rx is at least 10 – 12% of retail claims.
- Expected savings for Dental, Vision, Life and Disability is 5 – 10% or more.
- A TPA experienced in custom design administration
- Reporting to assist with decisions based on member utilization, in addition to more benchmarking data.
- Potential for risk sharing which will leave us less vulnerable to large claims.

JPA Commitment

- No cost to join the JPA
- No capital requirement
- Minimum time commitment – all meetings will be held by WebEx
- Two year commitment to the JPA – NIH can leave after two years
- Supports CCAHN and other critical access/rural hospitals

Why Change to Keenan HealthCare for Consulting and TPA Services?

- Industry Focused - KHC provides consulting/brokerage services exclusively to Hospitals and Medical Groups. KHC has over 100 California health care clients and the TPA has over 75 hospital clients.
- Experience - Keenan has developed many group purchasing programs and has created dozens of JPAs.
- Expertise - They were chosen as the managing Consultant for the Hospital Association of Southern California (HASC) and as the preferred Consultant for CCAHN members.

How Keenan will Help Us Achieve Our Benefit Program Objectives

- Cost Reduction – KHC has extensive experience in providing options and programs proven to lower cost
- Domestic Utilization Optimization – Will design programs to channel business back to NIH with a TPA that has vast experience in administering custom plan designs
- Competitive Plans – KHC has more California hospital benchmark data than any California consulting firm
- Compliance – In-house Benefit and ACA attorneys to assure NIH is in compliance with all State and Federal regulations

How Keenan will Help Us Achieve Our Benefit Program Objectives

- Population Health Management – KHC has PHM Division that has built and managed many successful programs to improve health outcomes for employees
- Human Resource Support and Ease of Administration – Dedicated Account Management team with corporate support for Underwriting, Communications, Legal counsel, and Voluntary Plans.

Keenan's Group Purchasing Programs

Below is an example of one of Keenan's group purchasing programs, the Keenan Pharmacy Purchasing Coalition, managed by Express Scripts.

- The Rx coalition has over 500,000 members including many hospital systems (Dignity, Prime) and independent facilities (Eisenhower, Kern Valley, Ridgecrest)
- Expected savings of 10 – 15% for retail claims. 2016 average claim savings for hospitals was 15.4%.
- All hospitals have same Rx pricing regardless of size
- Strong clinical management programs to stay ahead of market

Keenan's Partial List of Healthcare organizations

Adventist Health

Antelope Valley Hospital

Avanti Hospitals, LLC

Beverly Hospital

California Rehab Institute Medical Group

Casa Colina

Children's Hospital, Los Angeles

Citrus Valley Physicians Partners

Dameron Hospital Association

Dignity Health

Eisenhower Medical Center

Enloe Medical Center

EPIC Mgmt./Beaver Medical

Facey Medical Foundation

Fairchild Medical Center

Gateways Hospital

Gould Medical Group

Henry Mayo Newhall Memorial

Hospital Association of Southern California

Huntington Hospital

Huntington Health Physicians

John Muir Health

Marshall Medical Center

Martin Luther King

Motion Picture & Television Fund

NorthBay Healthcare

Orthopaedic Institute for Children

Oroville Hospital

Prime Healthcare Services, Inc.

Prospect Medical Holdings

Ridgecrest Regional Hospital

Saint Joseph Health System

Sky Lakes Medical Center

Sutter Medical Group

Tahoe Forest Hospital District

The Doctors of Providence Saint John's Medical Group

Torrance Memorial Medical Center

Timing and Compensation

- Recommend move to Keenan as Broker of Record as soon as possible. Keenan will accept the same compensation as our current broker for Consulting services.
- Move to Keenan's TPA 1/1/18. 120 day implementation is needed. Fees for current clients are competitive with other TPAs.
- No added cost for travel or expenses.

Appendix

KHC's Consulting Scope of Services

- Strategic Planning
- Cost and Benefit Benchmarking
- Program Design
- Evaluate, Negotiate and Market Renewals
- Union Negotiation Strategy and Modeling
- Employee Contribution Strategies
- Plan Documents / SPDs preparation
- Financial Analysis and Evaluation
- Health Management Consulting

Third Party Claims Administration

- Keenan's In-House TPA
  - Over 75 hospital clients
  - State-of-the-art claims administration system
  - Access to both Anthem and Blue Shield networks
  - Direct contracting with specific providers on an ad hoc basis, as needed
  - MedeAnalytics data warehouse and reports
  - High touch service
  - Ad hoc reporting is typically provided at no charge

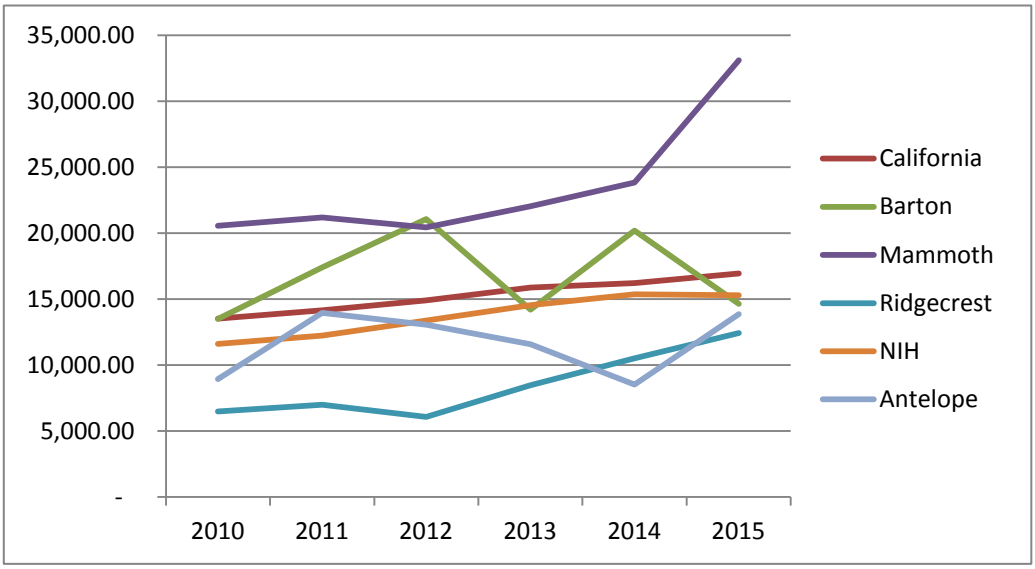
KPPC 2016 Audited Savings

Hospital	Members	2016 Drug Spend	2016 Savings	2016 Savings %
A	2,188	$2,682,732	$405,562	15.1%
B	1,363	$1,314,304	$328,637	25.0%
C	1,099	$673,500	$115,027	17.1%
D	1,436	$544,896	$69,175	12.7%
E	14,841	$18,415,085	$2,796,948	15.2%
F	5,843	$3,484,459	$250,310	7.2%
G	6,335	$5,605,416	$570,580	10.2%
H	2,865	$2,948,117	$670,980	22.8%
I	1,021	$977,697	$209,249	21.4%
J	2,623	$2,326,085	$614,426	26.4%
K	6,546	$5,997,870	$823,039	13.7%
L	13,405	$11,769,301	$1,839,687	15.6%
M	188	$153,019	$47,951	31.3%
N	1,592	$1,349,216	$332,063	24.6%
O	2,169	$1,734,743	$518,148	29.9%
P	1,694	$1,269,819	$187,849	14.8%
Q	36,532	$31,041,410	$4,616,417	14.9%
R	8,899	$9,258,313	$2,579,940	27.9%
S	745	$591,239	$106,688	18.0%
T	2,045	$1,927,788	$240,993	12.5%
U	44,230	$40,234,737	$5,060,927	12.6%
V	1,305	$1,181,497	$115,472	9.8%
W	2,255	$2,936,376	$378,844	12.9%
Total	**161,219**	**$148,417,619**	**$22,878,912**	**15.4%**

Comparison of Average Charge Per Inpatient Day

For California Hospitals for Commercial and Managed Care Inpatients

Year	California	Barton	Mammoth	Ridgecrest	NIH	Antelope
2010	13,523.36	13,486.61	20,561.96	6,484.74	11,599.03	8,939.35
2011	14,158.16	17,406.31	21,191.37	6,997.64	12,238.57	13,945.86
2012	14,908.75	21,056.72	20,435.71	6,082.79	13,371.97	13,050.26
2013	15,872.52	14,188.79	22,039.18	8,476.47	14,533.28	11,582.06
2014	16,219.67	20,198.71	23,825.27	10,521.85	15,360.55	8,529.30
2015	16,937.13	14,641.22	33,084.26	12,425.63	15,279.39	13,863.03



CALL TO ORDER

The meeting was called to order at 5:30 pm by Peter Watercott, President.

PRESENT

Peter Watercott, President
John Ungersma MD, Vice President
M.C. Hubbard, Secretary
Mary Mae Kilpatrick, Treasurer
Phil Hartz, Member at Large

ALSO PRESENT

Kelli Huntsinger, Chief Operating Officer
Joy Engblade MD, Chief of Staff
Carrie Petersen, Chief Accounting Officer
John Tremble, Interim Chief Financial Officer
Tracy Aspel, Chief Nursing Officer
Alison Murray, Interim Chief Human Relations Officer
Sandy Blumberg, Executive Assistant

ABSENT

Kevin S. Flanigan, MD, MBA, Chief Executive Officer

OPPORTUNITY FOR PUBLIC COMMENT

Mr. Watercott asked if any members of the public wished to comment on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. No comments were heard.

OLD BUSINESS

BUHS SCHOOL CLINIC

Mr. Watercott called to attention to approval of collaboration with Bishop Union High School District (BUHSD) to operate an on-campus student health clinic, noting that the clinic has already been approved by the BUHSD School Board. Comments in support of the proposed clinic were heard from the following:

- Lois Alexander, retired Northern Inyo Healthcare District (NIHD) Nurse Practitioner
- Robbin Cromer-Tyler, MD

Mr. Watercott stated his belief that NIHD has both the opportunity and responsibility to support the proposed student clinic, and collaboration with the School District on this project supports the District's mission statement and demonstrates NIHD's willingness to be the healthcare leader in this community. Following brief discussion it was moved by M.C. Hubbard, seconded by John Ungersma MD, and unanimously passed to approve the proposed collaboration with BUHSD to operate an on-campus student clinic at Bishop Union High School.

NEW BUSINESS

FISCAL POLICY AND PROCEDURE APPROVALS

Chief Accounting Officer Carrie Petersen called attention to approval of the following Fiscal Department policies and procedures:

- *Remote Deposit Service*
- *Sales and Use Tax*

It was moved by Mary Mae Kilpatrick, seconded by Phil Hartz, and unanimously passed to approve both policies and procedures as presented.

NURSING DEPARTMENT POLICY AND PROCEDURE

Chief Nursing Officer Tracy Aspel, RN called attention to approval of a Nursing Department policy and procedure titled *Pain Management and Documentation*. It was moved by Ms. Hubbard, seconded by Mr. Hartz, and unanimously passed to approve the *Pain Management and Documentation* policy and procedure as presented.

COMPLIANCE DEPARTMENT POLICY AND PROCEDURE

Compliance Officer Patty Dickson called attention to approval of a proposed policy and procedure titled *Minors with Legal Authority to Consent*. It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the Compliance policy and procedure titled *Minors with Legal Authority to Consent* as presented.

ANNUAL POLICY AND PROCEDURE APPROVALS

Mr. Watercott called attention to the list of policies and procedures being presented for annual approval as listed on Attachment A to the agenda for this meeting. It was moved by Doctor Ungersma, seconded by Mr. Hartz, and unanimously passed to approve all policies and procedures included on Attachment A as presented.

APPROVAL OF CAPITAL BUDGET FOR 2017/2018 FISCAL YEAR

Interim Chief Financial Officer John Tremble called attention to the proposed capital budget for the upcoming 2017/2018 fiscal year. He also reviewed the challenges to budgeting for the upcoming year, which included the following:

- The District has not experienced growth in many service areas including inpatient services, surgery, imaging, and clinics visits and procedures
- A significant increase has been seen in employee wages, largely due to minimum wage increases and adoption of new salary scales for District employees
- Full year commitments in anesthesia, compliance, and coding have increased costs
- Fewer governmental settlements are expected in the upcoming year

Mr. Tremble also reviewed volume trends in all revenue areas, and compared NIHD's charges for inpatient services to the State average, and to the charges for services billed by the nearest healthcare facility, Mammoth Hospital. That comparison reveals that NIHD’s charges are below the State average, and significantly lower than Mammoth Hospital’s charges. An increase to NIHD's charges for patient services could be justified if it becomes necessary in order to balance the budget for the upcoming fiscal year. Following review of the information provided it was moved by Doctor Ungersma, seconded by Mr. Hartz, and unanimously passed to approve the proposed capital budget for the 2017 / 2018 fiscal year as presented.

NIHD AUXILIARY BYLAWS REVIEW

Mr. Watercott called attention to the NIHD Auxiliary Bylaws which were submitted for the annual review and approval of the District Board (no new changes of significance have been made to the bylaws). It was

moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the NIHD Auxiliary Bylaws as presented.

APPOINTMENT OF ACHD DELEGATE AND ALTERNATE

Mr. Watercott announced that the Association of California Healthcare Districts (ACHD) has requested that the NIHD Board of Directors appoint a Board Member to act as a delegate, and one to act as an alternate to help the organization with a review and update of its bylaws. Following brief discussion it was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to appoint Doctor Ungersma to be the ACHD delegate, and to appoint Director Hartz to be the alternate to participate in the bylaws review.

CONSENT AGENDA

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

- Approval of minutes of the March 15 2017 regular meeting
- 2013 CMS Validation Survey Monitoring, April 2017
- Financial and Statistical Reports for the period ending February 28, 2017

It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve all three Consent Agenda items as presented.

DATA AND INFORMATION COMMITTEE REPORT

Ms. Petersen reported that the NIHD Data and Information Committee meets monthly, and the main focus of the Committee at this time is to aid and support the search for a new Electronic Health Record (EHR) for the District. She additionally stated that two employee and management surveys have launched in order to collect data that will be needed to make the EHR decision.

CHIEF OF STAFF REPORT

POLICY AND PROCEDURE APPROVALS

Chief of Staff Joy Engblade MD reported following careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following hospital wide policies and procedures:

- *Training and Competency in Point-of-Care Testing*
- *Point of Care Accu-Check Blood Glucose Testing*
- *Gastric Occult Blood*
- *Fecal Occult Blood by Beckman Coulter Card Method Hemoccult SENSA*
- *Urine Dipstick Chemistries*
- *Point of Care HemoCue Hbv201 + Hemoglobin Testing – (RHC)*
- *Hemosure-One Step Immunological Fecal Occult Blood Test – (RHC)*
- *Point of Care QuickVue hCG Urine Test – (RHC)*
- *Point of Care QuickVue Dipstick Step A Test – (RHC*)

It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve all 9 policies and procedures as presented.

RADIOLOGY SERVICES CRITICAL INDICATORS

Doctor Engblade also called attention to approval of proposed Radiology Services Critical Indicators for 2017. It was moved by Doctor Ungersma, seconded by Mr. Hartz, and unanimously passed to approve the proposed Radiology Services Critical Indicators for 2017 as presented.

MEDICAL STAFF APPOINTMENTS AND PRIVILEGING

Doctor Engblade stated following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee also requests approval of the following Medical Staff appointments and privileging:

- Active Staff: N. Michelle Inforzato, MD (*hospitalist*); and Jessica Paulson, MD (*emergency medicine*)
- Consulting Staff: Joseph Ludwick, MD (*pediatric cardiology*); and Katrinka Kip, MD (*pediatric cardiology*)
- Temporary Staff: Wilbur Peralta, MD (*hospitalist – temporary assignment until 8/31/17*); and Hung Nguyen, MD (*hospitalist – temporary assignment until 8/31/17*)

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

ADVANCE PRACTICE PROVIDER PRIVILEGING

Doctor Engblade also stated following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends advance practice provider privileging for David Nicholson, CRNA (nurse anesthesia). It was moved by Ms. Hubbard, seconded by Doctor Ungersma, and unanimously passed to approve the advance practice provider privileging of David Nicholson, CRNA as requested.

EXTENSION OF PRIVILEGES AND CHANGE IN STAFF CATEGORY

Doctor Engblade also stated the Medical Executive Committee recommends extension of privileges and a change in Staff category for Carolyn Saba MD, as follows:

- Change of Staff category from Temporary to Consulting Staff; and extension of privileges from 5/31/17 to 12/31/17 during the pendency of Dr. Saba's Consulting Staff reappointment application

It was moved by Ms. Hubbard, seconded by Mr. Hartz and unanimously passed to approve the extension of privileges and change in Staff category for Carolyn Saba, MD as requested.

MEDICAL STAFF ADVANCEMENT

Dr. Engblade also stated the Medical Executive Committee requests approval of the advancement of Manish Pandya, MD (hospitalist); request to advance from Provisional Active Staff to Active Staff (member in good standing). It was moved by Doctor Ungersma, seconded by Ms. Kilpatrick, and unanimously passed to approve the Medical Staff advancement of Doctor Manish Pandya as requested.

MEDICAL STAFF RESIGNATION

Doctor Engblade also requested Board approval of the Medical Staff resignation of Felix Karp, MD (effective 3/31/17, privileges in effect

through 12/31/17). It was moved by Ms. Kilpatrick, seconded by Mr. Hartz, and unanimously passed to approve the Medical Staff resignation of Felix Karp, MD as requested.

OTHER

Doctor Engblade also reported (as an informational item) that ACLS will become a required certification for new hospitalist applicants, and for current hospitalists at the time of Medical Staff reappointment.

CHIEF OPERATING OFFICER REPORT

Chief Operating Officer Kelli Huntsinger provided a bi-monthly report which included the following:

- Congratulations go out to NIHD Patient Navigator Rosie Graves, who has earned certification as a Breast Patient Navigator
- NIHD recently held its' annual years of service employee recognition event, at which 36 employees were recognized
- The District recently completed an upgrade to its Emergency Services radio amplifier, and the County of Inyo contributed approximately $35,000 toward the cost
- The State of California recently inspected Northern Inyo Hospital's (NIH's) Mammography services program, and the District passed the inspection with flying colors
- The NIHD Lab is expecting a Joint Commission survey at any time
- Dietary manager Susan Pernal has relocated out of this area, and the District is recruiting for an additional dietician to assist in the Dietary Department.
- Another round of 7 Habits training recently took place. Approximately 100 NIHD employees have now completed the 7 Habits training, with the goal being to eventually have all staff members trained.

CHIEF ACCOUNTING OFFICER REPORT

Carrie Petersen provided a Chief Accounting Officer report, which included the following:

- The cost report for 2015 has been finalized
- The MediCal cost report for 2013 has been finalized
- Ms. Petersen is in the process of training Fiscal Department staff to take over her current responsibilities, as part of her off-boarding process and in preparation for her October 2017 retirement.
- The Fiscal Department continues to work diligently on finalizing the 2017/2018 operating budget
- The NIHD PEPRA retirement plan has been funded

CHIEF NURSING OFFICER REPORT

Chief Nursing Officer Tracy Aspel, RN reported on the following:

- A recruitment update was given in regard to RN staffing
- Gina Riesche, RN has accepted the Emergency Department Nurse Manager and Disaster Planning position
- Justin Nott, RN has accepted the position of Medical Surgical and ICU Unit Nurse Manager (acute and subacute)
- As a result of a nursing management re-organization, the Nursing

Department will have more managers and fewer directors in the future
- Employee Health nurse Nel Hecht, RN will retire as of the end of this week

CHIEF HUMAN RELATIONS OFFICER REPORT

Interim Chief Human Relations Officer Alison Murray reported that NIHD's new salary scale went into effect as of April 2, 2017, and 38% of employee pay rates were adjusted to a higher scale. Ms. Murray also reported that the Human Relations Department is in the process of updating employee evaluation templates and improving the District's employee evaluation process. A recruitment update was also provided, and it was noted that we have a strong candidate for the permanent Chief Human Relations Officer position.

BOARD MEMBER REPORTS

Mr. Watercott asked if any members of the Board of Directors wished to report on any items of interest. Director Ungersma provided a report on the Association of Healthcare Districts (ACHD) Legislative Day, which was held on April 2, 3, and 4. No other reports were heard.

CLOSED SESSION

At 7:24pm Mr. Watercott reported the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 4 matters pending (*pursuant to Government Code Section 54956.9*).
C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:01 pm the meeting returned to open session. Mr. Watercott reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 8:02 pm.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

CALL TO ORDER	The meeting was called to order at 11:30 am by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma, MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer
ALSO PRESENT	Kevin S. Flanigan, MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Carrie Petersen, Chief Accounting Officer Tracy Aspel, Chief Nursing Officer Alison Murray, Interim Chief Human Relations Officer Sandy Blumberg, Executive Assistant
ABSENT	Phil Hartz, Member At Large
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott announced that at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers are limited to a maximum of three minutes each.
ADJOURNMENT TO CLOSED SESSION	At 11:31 am the meeting adjourned to closed session to allow the Board of Directors to confer with Legal Counsel regarding pending litigation (*pursuant to Government code Section 54956.9*).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 12:48 p.m. the meeting returned to open session. Mr. Watercott reported the Board took no reportable action.
ADJOURNMENT	The meeting adjourned at 12:48 p.m..

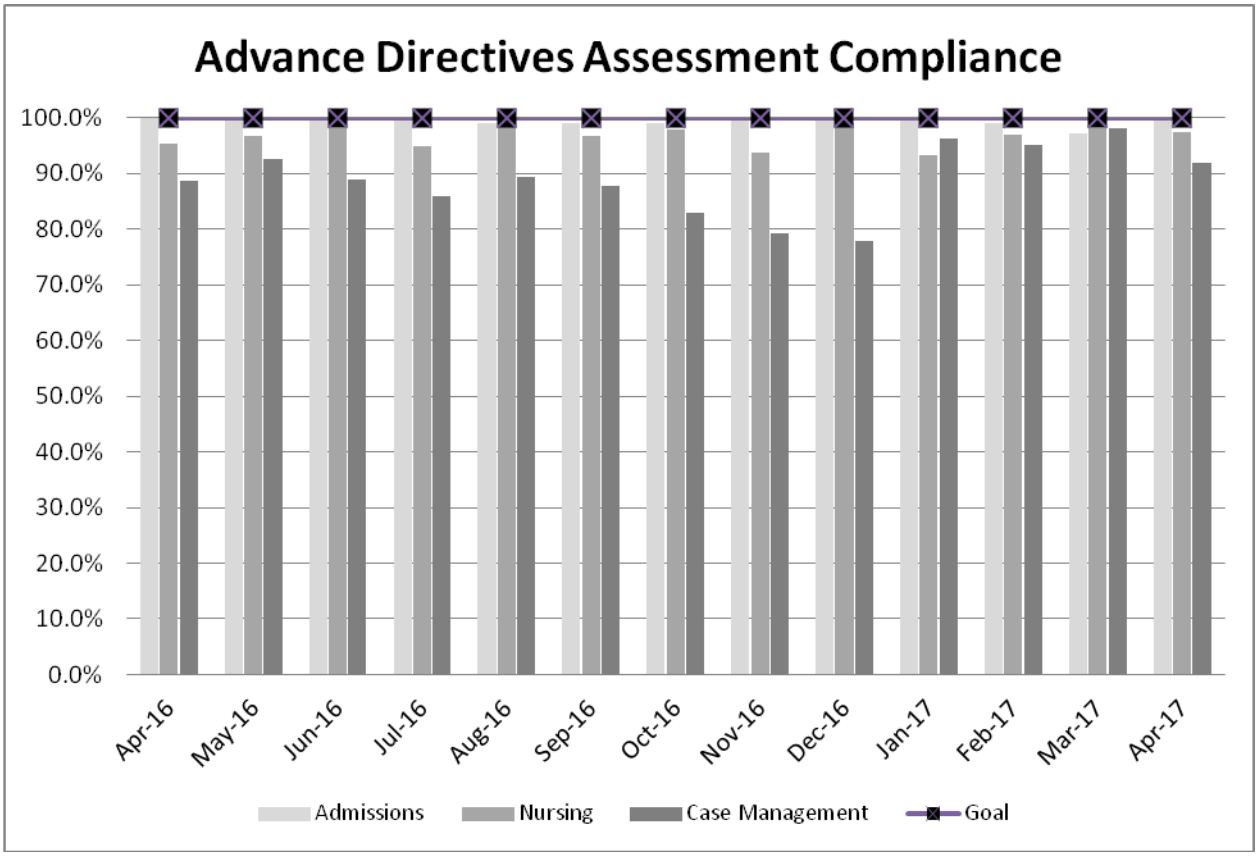
_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

2013 CMS Validation Survey Monitoring-May 2017

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

    a. Advance Directives Monitoring.

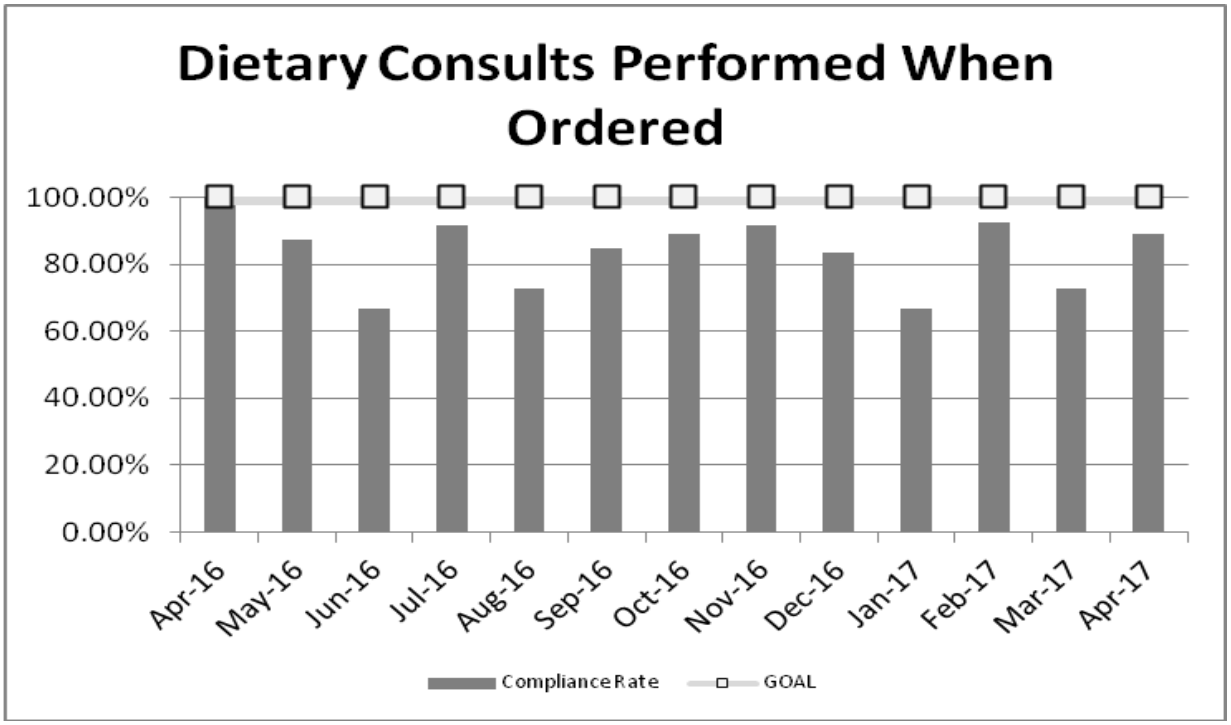


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

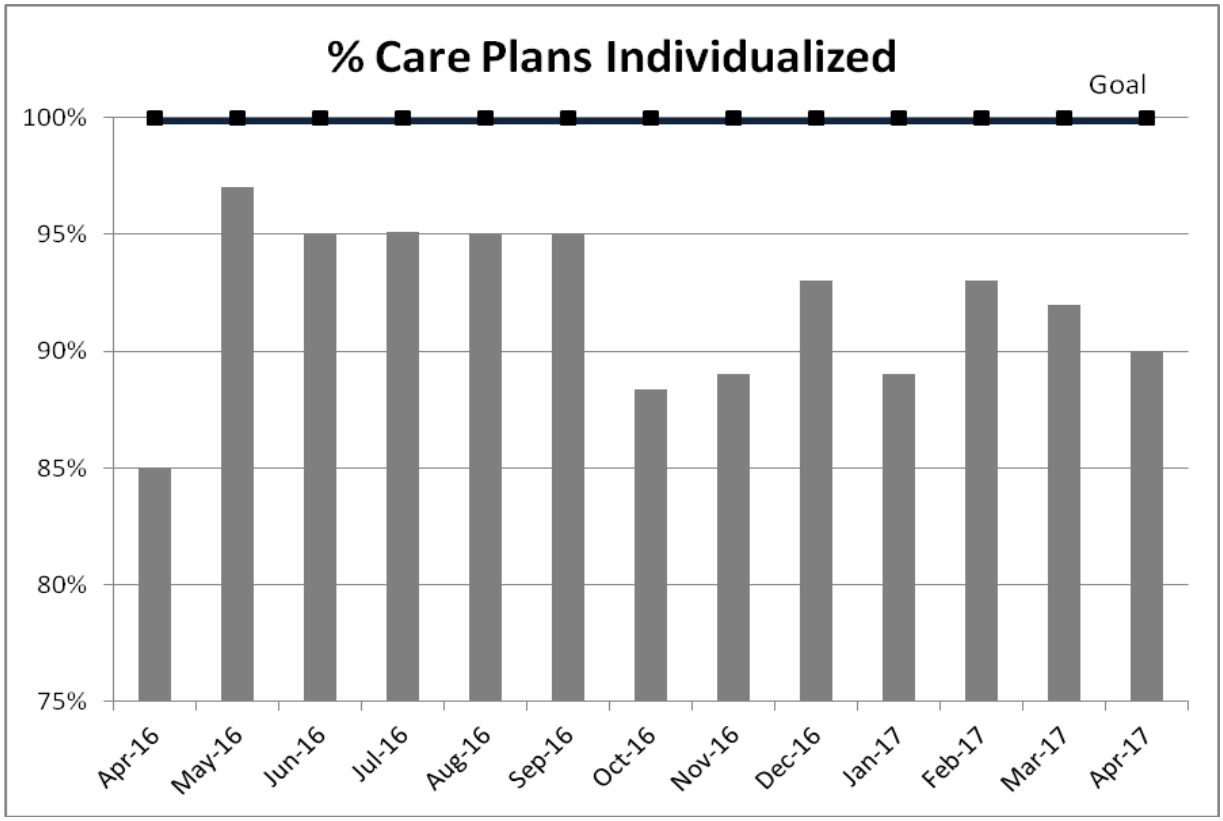
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.

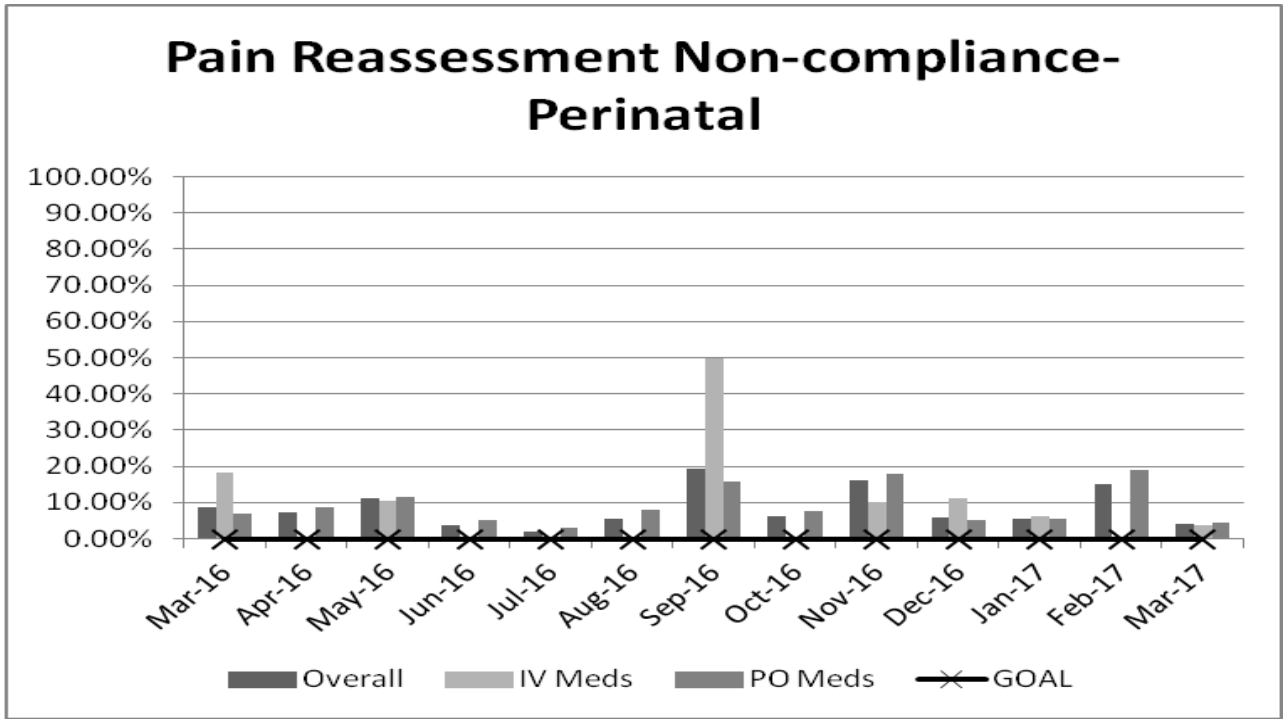


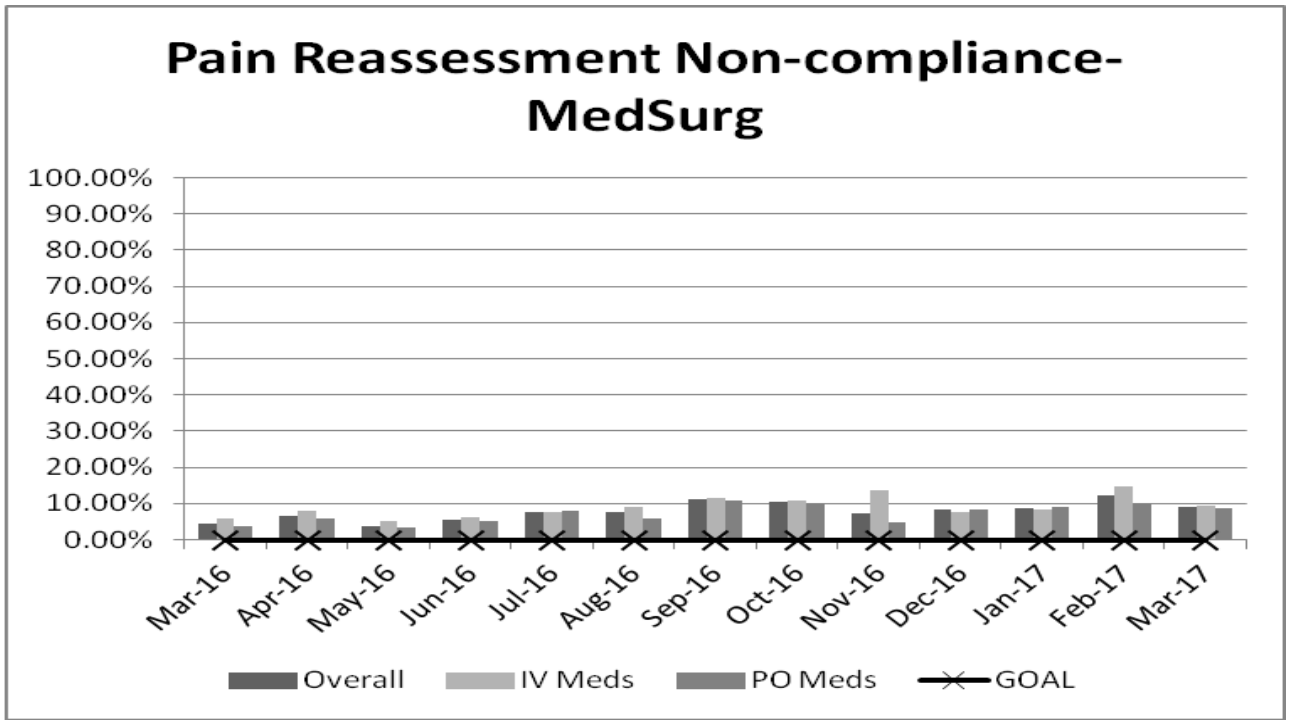
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

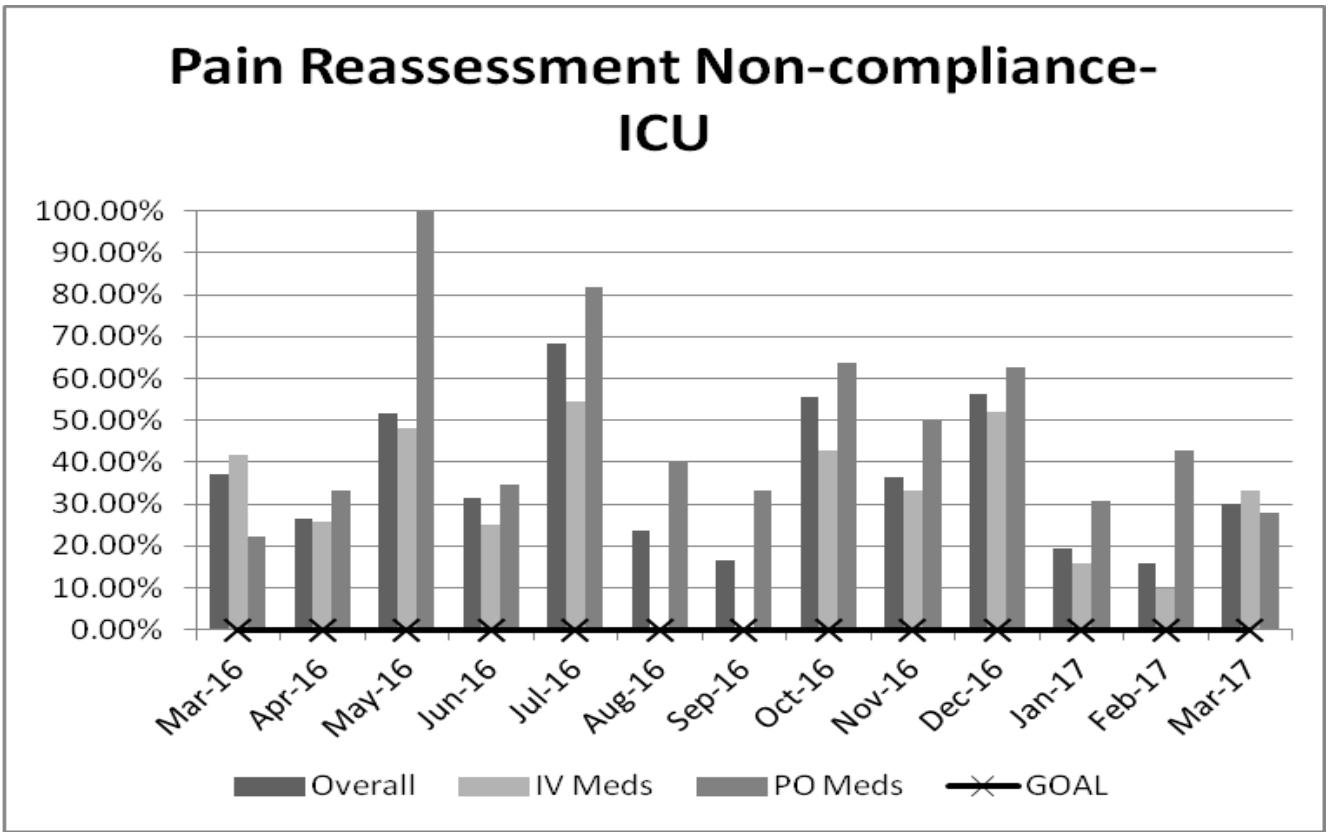


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.







Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.

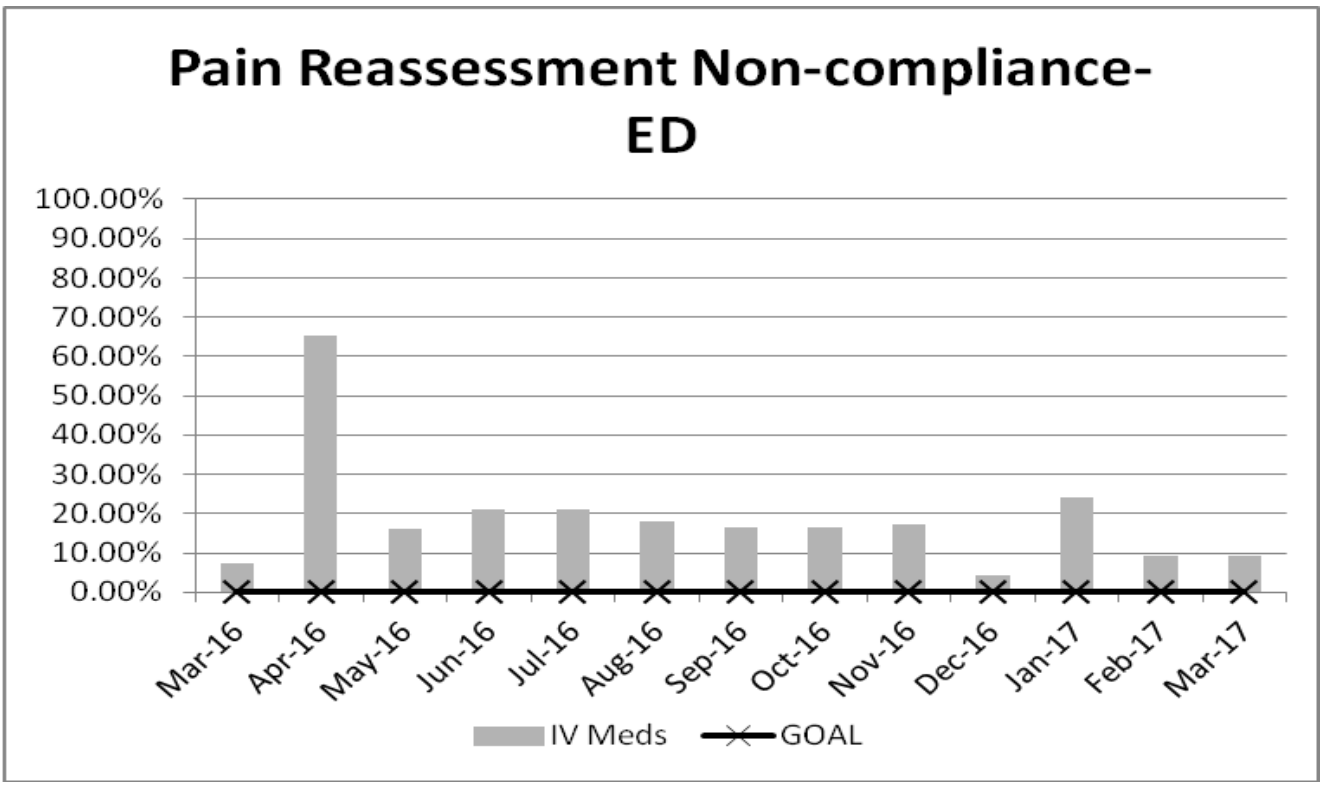


Table 6. Restraint chart monitoring for legal orders.

	Oct 2016	***Nov 2016***	***Dec 2016***	***Jan 2017***	***Feb 2017***	***March 2017***	***April 2017****	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	1/2 (50%)	1/1 (100%)	2/2 (100%)	2/2 (100%	1/1 (100%)	1/1 (100%)		100%
Physician signed order within 24 hours	1/2 (50%)	0/1 (0%)	2/2 (100%)	½ (50%)	1/1 (100%)	0/1 (0%)		100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	0/2 (0%)	0/1 (0%)	2/2 (100%)	0/2 (0%)	1/1 (100%)	0/1 (0%)		100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	2/4 (50%)	1/3 (33%)	2/2 (100%)	3/9 (33%)	0/1 (0%)	0/1 (0%)		100%
Orders are for 24 hours	5/6 (83%)	4/4 (100%)	4/4 (100%)	11/11 (100%)	2/2 (100%)	2/2 (100%)		100%
Is this a PRN (as needed) Order	0/6 (0%)	0/4 (0%)	0/4 (0%)	0/11 (0%)	0/2 (0%)	0/2 (0%)		0%

*No restraint orders for this time interval

NORTHERN INYO HEALTHCARE DISTRICT

Hospital-Wide Pillars of Excellence: FY July 1, 2016-June 30, 2017

Indicator	Baseline	Goal	J-S Q1	O-D Q2	J-M Q3	A-J Q4	YTD
Service							
1. Patient satisfaction							
a. Avatar RHC- Overall score % Top Box	**75.28 Below Average**	**85.0 Better Than Most**	**78.10 Below Average**	**75.5 Below Average[1]**			**Not Yet Available**
b. Avatar Emergency Department- Overall score % Top Box	**78.20 Above Average**	**85.0 Better Than Most**	**73.28 Below Average**	**69.8 Below Average [2]**			**Not Yet Available**
c. HCAHPS Perinatal- Overall score % Top Box	**72.64 Below Average**	**85.0 Better Than Most**	**68.65 Below Average**	**62.5 Below Average[3]**			**Not Yet Available**
d. HCAHPS MedSurg- Overall score % Top Box	**75.86 About Average**	**85.0 Better Than Most**	**74.52 About Average**	**67.5 Below Average[4]**			**Not Yet Available**
Note: Q1 data is bases on three months due to switch from Avatar to Press Ganey. Data for the Perinatal Unit for Q1 and Q2 should be interpreted with caution due to small sample size. 1. Peer Comparison = All PG Medical Practice Groups. 2. Peer Comparison= Hospitals with 10,000 or less visits/year. 3. Peer Comparison= Hospitals with 20-30 Beds. 4. Peer Comparison= Hospitals with 20-30 Beds.							
Quality							
1. Adverse Drug Events-Anticoagulants*	**2/44 (4.5%)**	**0**	**1/2 (50%)**	**0/4 0%)**	**0/10 (0%)**		**1/6 (16.7%)**
2. Surgical Site Infections*,[1]	**5/1104 (0.45%)**	**0**	**2/312 (0.64%)**	**3/348 (0.86%)**	**2/362 (.20%)**		**5/660 (0.76%)**
3. Central Line Associated Bloodstream Infections (CLABSI) CLABSI/Line Days (Per 1000 Line Days)*	**0/155 (0)**	**0**	**0/79 (0)**	**0/60 (0)**	**0/66 (0)**		**0/205 (0)**
4. Catheter Associated Urinary Tract Infections (CAUTI) CAUTI/Catheter Days (Per 1000 Catheter Days)*	**0/579 (0)**	**0**	**1/180 (5.55)**	**0/189 (0)**	**0/159 (0)**		**1/528 (1.89)**
5. Ventilator Associated Pneumonia*	**0/36 (0%)**	**0**	**0/3 (0%)**	**0/5 (0%)**	**0/9 (0%)**		**0/17 (0%)**
6. Falls With Injuries (Per 1000 Patient Days)*	**3/4394 (0.68)**	**0**	**0/943 (0)**	**1/707 (1.41)**	**1/804 (1.24)**		**2/2454 (0.81)**
7. 30 Day Readmission Rate (Inpatient)*	**64/1181 (5.4%)**	**<15%**	**10/324[2] (3.1%)**	**7/277 (2.5%)**	**2/281 (0.7%)**		**17/601[2] (2.8%)**
*Note: Baseline period for these metrics is FY 15-16. 1. SSI National average is about 2.0%. 2. Correction was made in denominator for this data.							
People							
1. Overall Turnover Rate, 3	**89/491 (18.13%)**	**<15%**	**21/432 (4.86%)**	**21/441 (4.76%)**	**14/446 (3.14%)**		**56/488 (11.48%)**
2. Total Recordable Incident Rate (OSHA) per 100 employees-Modified**, 3	**37/407 (9.09)**	**0**	**14/414 (3.38%)**	**3/416 (0.72%)**	**24/432 (5.56%)**		**41/421 (9.75%)**
3.Benchmark data for these metrics only available per annum and since the number of incidents accumulates, but number of employees is relatively constant, it is most appropriate to compare only per annum data to the goal. To compute YTD prior to year end, an average of the quarterly metric denominator will be used. **OSHA metric is per 100 FTE; NIH proxy measure is per 100 employees. National average for hospitals is 6.2. (Reference available in PEX office)							
Finance							
1. Current Ratio	**2.87**	**>2.0**	**2.27**	**3.16**	**3.46**		**2.96**
2. Days Cash on Hand-Short Term Sources	**82**	**>75**	**85**	**72**	**77**		**78**
3. Debt Service Coverage Ratio	**2.43**	**>1.5-2.0**	**2.67**	**2.30**	**2.16**		**2.38**
4. A/R Days (Inpatient & Outpatient)	**65**	**<60**	**76**	**76**	**81**		**78**

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

Important General Notes:

1. Goals in Blue are stretch goals and may follow a 'zero defects' approach outlined in the Hospital-Wide Quality Assurance and Performance Improvement (QAPI) plan. On some metrics, we have set the bold goal of zero defects (best-in-class). For the metrics with a goal of zero, either we are best-in-class and get a blue color code or not best-in-class and get a red code. It is important to note that a code of red in the 'Quality' category of indicators for metrics with goals of zero does not necessarily indicate poor performance, just that we have not met our goal of zero. For example, on Surgical Site infections for Quarter 1, FY 15-16, we did not meet our goal of zero defects, but are still outperforming most of the country with an infection rate of 4 times LOWER than the national average of 2.0%.
2. Patient Satisfaction/Patient Experience-For each department the Top Box Percentile Rank for the chosen Peer Comparison groups was used to classify the performance category based on the following cut points; 90-100 Best in Class (Blue), 75-89 Above Average (Green), 50-74 About Average (Yellow), ≤49 Below Average (Red). It is recommended that specific performance dimensions be further assessed by area leadership to identify specific opportunities for improvement.

Rev. 5/5/17 mag

NORTHERN INYO HEALTHCARE DISTRICT

CALL TO ORDER	The meeting was called to order at 1:00 pm by Peter Watercott, President.
PRESENT	Peter Watercott, President John Ungersma MD, Vice President M.C. Hubbard, Secretary Mary Mae Kilpatrick, Treasurer
ALSO PRESENT	Kevin S. Flanigan, MD, MBA, Chief Executive Officer Joy Engblade MD, Chief of Staff Colin Coffey, District Legal Counsel Kelli Huntsinger, Chief Operating Officer Carrie Petersen, Chief Accounting Officer Maria Sirois, Chief Performance Excellence Officer Alison Murray, Interim Chief Human Relations Officer Tracy Aspel, Chief Nursing Officer Sandy Blumberg, Executive Assistant
ABSENT	Phil Hartz, Member at Large
OPPORTUNITY FOR PUBLIC COMMENT	Mr. Watercott asked if any members of the public wished to comment on any items listed on the Notice for this meeting (*speakers are limited to a maximum of three minutes each*). No comments were heard.
BROWN ACT, COMPLIANCE, AND GOVERNANCE TRAINING	Attorney Colin Coffey was present to provide Board education on the topics of the Brown Act; Compliance; and Governance as it relates to Healthcare Districts. The following handouts were provided: - *Board Member Legal Orientation Manual*, containing information on transparency, ethics, and fiduciary compliance responsibilities - *Tips for Chief Executive / Staff Success* - *Orientation Materials for Newly Elected Officials* Information was also provided on the following: - Brown Act Guide reference materials - The People's Business Guidebook (including information on Public Records Act requests) - Fair Political Practices Commission Conflict of Interest Rules and Guidelines - Statement of Director Duties and Responsibilities - Fiduciary duties and public service - Healthcare Director's compliance duties It was noted that Northern Inyo Healthcare District (NIHD) Board members complete Brown Act and ethics training on a bi-annual basis. Discussion of the following matters also took place: - The pros and cons of possibly establishing a Board Commitment

Letter

- Discussion of the cautions involving Board members becoming actively engaged with District staff in group staff meetings, etc.
- Review and discussion of Closed Session guidelines, restrictions, and confidentiality issues
- Discussion of cautions regarding what constitutes a serial meeting of the Board
- Discussion of potential conflicts of interest
- Discussion of the role of Directors vs. the role of hospital management
- Handling opportunities for public comment during meetings

ADJOURNMENT The meeting adjourned at 3:35pm.

_____
Peter Watercott, President

Attest: _____
M.C. Hubbard, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

BUDGET VARIANCE ANALYSIS

Mar-17 *Fiscal Year Ending June 30, 2017*

Year to date for the month ending March 31, 2017

	-496 or	-16%	less IP days than in the prior fiscal year
$	(4,388,410) or	-12.94%	under budget in Total IP Revenue and
$	781,072 or	1.2%	over budget in OP Revenue resulting in
$	(3,607,337) or	-3.6%	under budget in gross patient revenue &
$	(1,427,943) or	-2.4%	under budget in net patient revenue

Year-to-date Net Revenue was		$	57,658,354
Total Operating Expenses were:		$	54,563,581
			for the fiscal year to date
$	(184,733) or	-0.3%	under budget. Salaries and Wages were
$	(2,166,648) or	-11.2%	under budget and Employee Benefits
$	219,762 or	1.7%	over budget due to Pension & Health Claims
		75%	Employee Benefits Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$	1,562,914 or	24.6%	Professional Fees continue to run over budget due to contracted or registry personnel also seen in Salaries & Wages being under budget.
$	304,439 or	6.1%	Supplies running slightly over budget
$	15,014 or	0.4%	Depreciation Expense continues to be just over budget
$	300,950 or	17.2%	Bad Debt Expense running over budget
$	119,038 or	4.1%	Other Expenses are contiuning to run over budget

Other Information:

$	3,520,012		Operating Income, less
$	(2,863,419)		loss in non-operating activities created a net income of;
$	656,593	$ (331,458)	Under budget.
		40.27%	Contractual Percentages for Year and
		41.00%	Budgeted Contractual Percentages including

$ 4,979,917 in prior year cost report settlement activity for Medicare & Medi-Cal including Intergovernment Transfer Funds (IGT) from Managed Care Medi-Cal & Contractuals are also reduced for the PRIME IGT of $1,490,000 and Final for Medicare 15

Non-Operating actives included:

$	(3,061,439) loss	$ (50,969)	under budget in Medical Office Activities
$	(45,111)	$ (153,958)	under budget in 340B Pharmacy Activity

NORTHERN INYO HEALTHCARE DISTRICT
STATEMENT OF OPERATIONS
for period ending March 31, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	886,333	891,349	(5,016)	6,846,676	7,878,390	(1,031,714)
Ancillary	2,467,475	2,944,453	(476,978)	22,668,484	26,025,180	(3,356,696)
Total Inpatient Service Revenue	3,353,808	3,835,802	(481,994)	29,515,160	33,903,570	(4,388,410)
Outpatient Service Revenue	8,496,520	7,494,616	1,001,904	67,023,779	66,242,707	781,072
Gross Patient Service Revenue	**11,850,329**	**11,330,418**	**519,911**	**96,538,940**	**100,146,277**	**(3,607,337)**
Less Deductions from Revenue						
Patient Service Revenue Deductions	171,778	174,933	(3,155)	1,812,907	1,546,183	266,724
Contractual Adjustments	5,421,531	4,470,539	950,992	42,047,596	39,513,797	2,533,799
Prior Period Adjustments	(233)	-	(233)	(4,979,917)	-	(4,979,917)
Total Deductions from Patient Service Revenue	**5,593,075**	**4,645,472**	**947,603**	**38,880,585**	**41,059,980**	**(2,179,395)**
Net Patient Service Revenue	**6,257,253**	**6,684,946**	**(427,693)**	**57,658,354**	**59,086,297**	**(1,427,943)**
Other revenue	41,734	53,820	(12,086)	425,239	475,697	(50,458)
Total Other Revenue	**41,734**	**53,820**	**(12,086)**	**425,239**	**475,697**	**(50,458)**
Expenses:						
Salaries and Wages	2,060,544	2,188,850	(128,306)	17,179,957	19,346,605	(2,166,648)
Employee Benefits	1,545,979	1,423,901	122,078	12,805,244	12,585,482	219,762
Professional Fees	841,217	718,979	122,238	7,917,757	6,354,843	1,562,914
Supplies	712,813	568,638	144,175	5,330,468	5,026,029	304,439
Purchased Services	218,300	342,193	(123,893)	2,484,352	3,024,553	(540,201)
Depreciation	388,907	428,152	(39,245)	3,799,323	3,784,309	15,014
Bad Debts	237,962	198,503	39,459	2,055,461	1,754,511	300,950
Other Expense	334,325	324,933	9,392	2,991,020	2,871,982	119,038
Total Expenses	**6,340,047**	**6,194,149**	**145,898**	**54,563,581**	**54,748,314**	**(184,733)**
Operating Income (Loss)	**(41,060)**	**544,617**	**(585,677)**	**3,520,012**	**4,813,680**	**(1,293,668)**
Other Income:						
District Tax Receipts	48,644	49,577	(933)	437,795	438,197	(402)
Tax Revenue for Debt	150,920	73,076	77,844	1,358,280	645,898	712,382
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted	2,638	8,493	(5,855)	600,323	75,067	525,256
Interest Income	31,842	18,563	13,279	162,402	164,075	(1,673)
Interest Expense	(263,636)	(244,925)	(18,711)	(2,384,559)	(2,164,821)	(219,738)
Other Non-Operating Income	52,103	2,208	49,895	68,890	19,516	49,374
Net Medical Office Activity	(357,764)	(352,134)	(5,630)	(3,061,439)	(3,112,408)	50,969
340B Net Activity	8,665	12,315	(3,650)	(45,111)	108,847	(153,958)
Non-Operating Income/Loss	**(326,588)**	**(432,827)**	**106,239**	**(2,863,419)**	**(3,825,629)**	**962,210**
Net Income/Loss	**(367,648)**	**111,790**	**(479,438)**	**656,593**	**988,051**	**(331,458)**

Northern Inyo Healthcare District
Balance Sheet
Period Ending March 31, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	2,936,898	4,083,484	(1,146,586)
Short-Term Investments	12,527,786	11,790,494	737,292
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	779,134	779,134	-
Patient Receivable	60,019,107	57,361,600	2,657,507
Less: Allowances	(45,692,045)	(44,288,428)	(1,403,617)
Other Receivables	646,596	483,554	163,041
Inventories	3,615,343	3,641,965	(26,622)
Prepaid Expenses	1,450,852	1,449,560	1,293
Total Current Assets	**36,283,672**	**35,301,366**	**982,307**
Internally Designated for Capital Acquisitions	1,124,853	1,124,805	48
Special Purpose Assets	1,191,620	1,191,583	38
Limited Use Asset; Defined Contribution Pension	1,118,722	1,053,149	65,573
Limited Use Assets Defined Benefit Plan	14,144,525	14,144,525	-
Limited Use Asset Defined Benefit Plan 003	41,839	36,561	5,278
Revenue Bonds Held by a Trustee	2,694,928	2,534,820	160,108
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**20,316,487**	**20,085,443**	**231,044**
Long Term Investments	1,750,000	2,552,143	(802,143)
			-
Property & equipment, net Accumulated Depreciation	81,150,672	81,435,815	(285,143)
Unamortized Bond Costs	-	-	-
Total Assets	**139,500,832**	**139,374,767**	**126,065**

Northern Inyo Healthcare District
Balance Sheet
Period Ending March 31, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	434,407	523,314	(88,907)
Accounts Payable	1,301,606	1,291,979	9,627
Accrued Salaries, Wages & Benefits	5,285,481	4,927,593	357,888
Accrued Interest and Sales Tax	441,401	287,031	154,369
Deferred Income	145,932	194,576	(48,644)
Due to 3rd Party Payors	1,593,023	1,593,023	-
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	1,427,520	1,427,520	-
Total Current Liabilities	**10,629,370**	**10,245,036**	**384,334**
Long Term Debt, Net of Current Maturities	46,012,756	46,012,756	-
Bond Premium	722,593	723,847	(1,254)
Accreted Interest	10,535,448	10,424,899	110,549
Other Non-Current Liabilities; Pension	33,492,468	33,492,468	-
Total Long Term Debt	**90,763,265**	**90,653,971**	**109,294**
Net Assets			
Unrestricted Net Assets less Income Clearing	36,259,984	36,259,936	48
Temporarily Restricted	1,191,620	1,191,583	38
Net Income (Income Clearing)	656,593	1,024,241	(367,648)
Total Net Assets	**38,108,197**	**38,475,759**	**(367,562)**
Total Liabilities and Net Assets	**139,500,832**	**139,374,766**	**126,065**

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending March 31, 2017

	Current Month	Prior Month	Change
Board Designated Funds:			
Tobacco Fund Savings Account	$ 1,098,129	$ 1,098,082	47
Equipment Fund Savings Account	$ 26,724	$ 26,723	1
Total Board Designated Funds:	**$ 1,124,853**	**$ 1,124,805**	**$ 48**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,058,492	$ 1,058,468	$ 24
Nursing Scholarship Savings Account	$ 33,036	$ 33,036	$ 1
Medical Education Savings Account	$ 75	$ 76	$ (1)
Joint NIHD/Physician Group Savings Account	$ 100,016	$ 100,003	$ 12
Total Specific Purpose Funds:	**$ 1,191,620**	**$ 1,191,583**	**$ 37**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,316,473**	**$ 2,316,388**	**$ 85**
	-	(0)	

***Bond and Interest Saving Account Activity is the result of receipt of debt service from Inyo County**

NORTHERN INYO HEALTHCARE DISTRICT

OPERATING STATISTICS

for period ending March 31, 2017

	Month to Date	FYE 2017 Year-to-Date	FYE 2016 Year-to-Date	Variance from PY	Variance %
Licensed Beds	25	25	25		
Total Patient Days with NB	317	2,657	3,153	(496)	-16%
Total Patient Days without NB	281	2,393	2,859	(466)	-16%
Swing Bed Days	15	322	569	(247)	-43%
Discharges without NB	91	805	852	(47)	-6%
Swing Discharges	4	50	85	(35)	-41%
Days in Month	31	274	275		
Occupancy without NB	9.06	8.73	10.40	(1.7)	-16%
Average Stay (days) without NB	3.09	2.97	3.36	(0.4)	-11%
Average LOS without NB/Swing	3.06	2.74	2.99	(0.2)	-8%
Hours of Observation (OSHPD)	965	6,822	5,058	1,764	35%
Observation Adj Days	40	284	211	74	35%
ER Visits All Visits	934	7,355	7,091	264	4%
RHC Visits (OSHPD)	3,476	20,472	20,582	(110)	-1%
Outpatient Visits (OSHPD)	3,639	29,217	28,904	313	1%
IP Surgeries (OSHPD)	21	208	234	(26)	-11%
OP Surgery (OSHPD)	125	901	907	(6)	-1%
Worked FTE's	344.00	329.00	325.00	4	1%
Paid FTE's	385.00	369.00	370.00	(1)	0%
Hours Worked to Hours Paid%	89.4%	89.2%	87.8%	1.3%	2%
Payor %					
Medicare		40%	40%	0%	
Medi-Cal		23%	24%	-1%	
Insurance, HMO & PPO		34%	35%	-1%	
Indigent (Charity Care)		1.0%	0.3%	0.7%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of March 31, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
3	24-Mar-17	01-Apr-17	Local Agency Investment Fund	Northern Inyo Hospital	0.82%		12,277,785.69
4	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				SHORT TERM INVESTMENTS		$	12,527,785.69
5	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
6	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
7	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
8	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
9	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
10	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
12	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				LONG TERM INVESTMENTS		$	1,750,000.00
				TOTAL INVESTMENTS		$	14,277,785.69
1	24-Mar-17	01-Apr-17	LAIF Defined Cont Plan	Northern Inyo Hospital	0.82%		1,118,722.46
2	24-Mar-17	01-Apr-17	LAIF PEPRA DB PLAN	Northern Inyo Hospital	0.82%		41,838.59
				LAIF PENSION INVESTMENTS		$	1,160,561.05
							15,438,346.74

Northern Inyo Healthcare District

Financial Indicators as of March 31, 2017

	Target	Mar-17	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16
Current Ratio	>1.5-2.0	3.41	3.45	3.53	3.69	2.85	2.95	2.60	2.15	2.05	1.98
Quick Ratio	>1.33-1.5	2.88	2.90	2.93	2.92	2.46	2.41	2.20	1.83	1.74	1.71
Days Cash on Hand prior method	>75	160.80	157.10	151.40	140.37	160.86	145.43	157.98	168.91	162.64	161.90
Days Cash on Hand Short Term Sources	>75	77.66	79.99	71.85	62.90	85.97	67.02	77.60	86.56	91.08	96.57
Debt Service Coverage	>1.5-2.0	2.07	2.23	2.17	2.13	2.46	2.30	2.80	3.18	2.03	1.95
Operating Margin		6.01	6.83	6.30	5.59	7.48	6.43	8.37			
Outpatient Revenue % of Total Revenue		69.43	69.11	69.10	69.28	68.11	67.48	67.03			
Cash flow (CF) margin (EBIDA to revenue)		3.41	4.27	3.94	3.71	5.43	4.53	7.01			
Days in Patient Accounts Receivable	<60 Days	85.10	76.70	80.80	77.70	75.60	75.00	77.80	78.50	73.10	63.20

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income / (Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

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

Northern Inyo Healthcare District

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

Compliance Report
May 2017

1. In October 2016, NIHD Board of Directors approved a comprehensive Compliance Program for the District.
    a. As of May 1, 2017, 62% of the 479 individuals to whom it was assigned have reviewed the Compliance Program. The goal is 100%.
2. Breaches
    a. See attached breach outcome analysis, exhibit A
3. Issues, Inquiries and requests
    a. See attached , exhibit B
4. Audits
    a. Employee Access Audits – See attached, exhibit C
        i. The Compliance Office manually completes access audits of patient information systems to ensure that employees access records only on a work-related, "need to know," and "minimum necessary" basis.
        ii. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
        iii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
5. Annual review of employee Conflicts of Interest questionnaires.
    a. See attached analysis, exhibit D
6. CPRA Requests
    a. The Compliance Office has prepared documents for 5 CPRA requests
    b. NIHD has invested 42.8 hours preparing these requests.
7. Policies for review
    a. No changes
        i. California Public Records Act – Information requests, exhibit E

Northern Inyo Healthcare District

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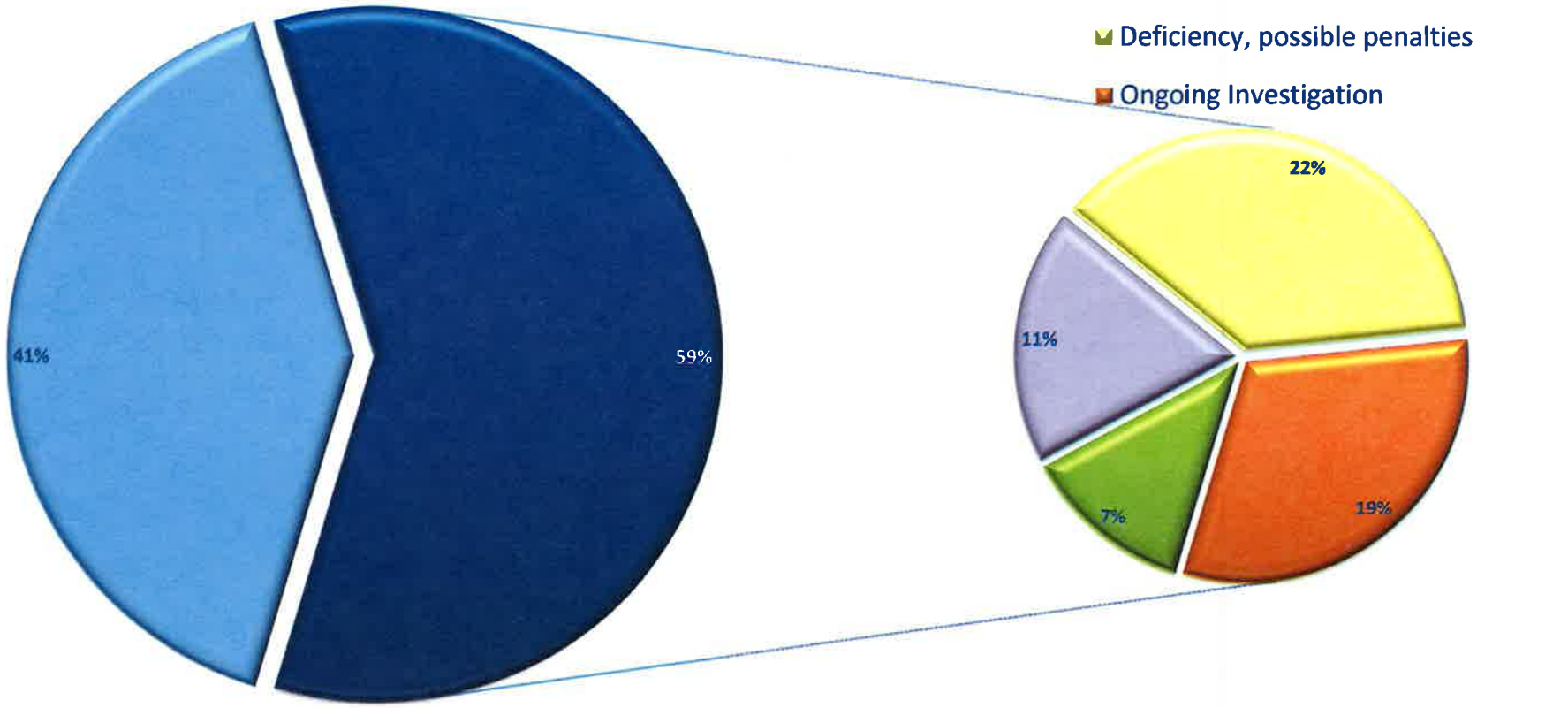
b. Minor changes
    i. False Claims Act Employee Training and Prevention Policy, exhibit F
        1. Updated penalty fees.

8. In progress
    a. Business Ethics and Compliance Committee implementation
    b. Compliance Department Work Plan
    c. Employee Access Auditing Software Project (FY 2018)
    d. HIPAA Privacy and Security Audit

2017 Breach Outcomes

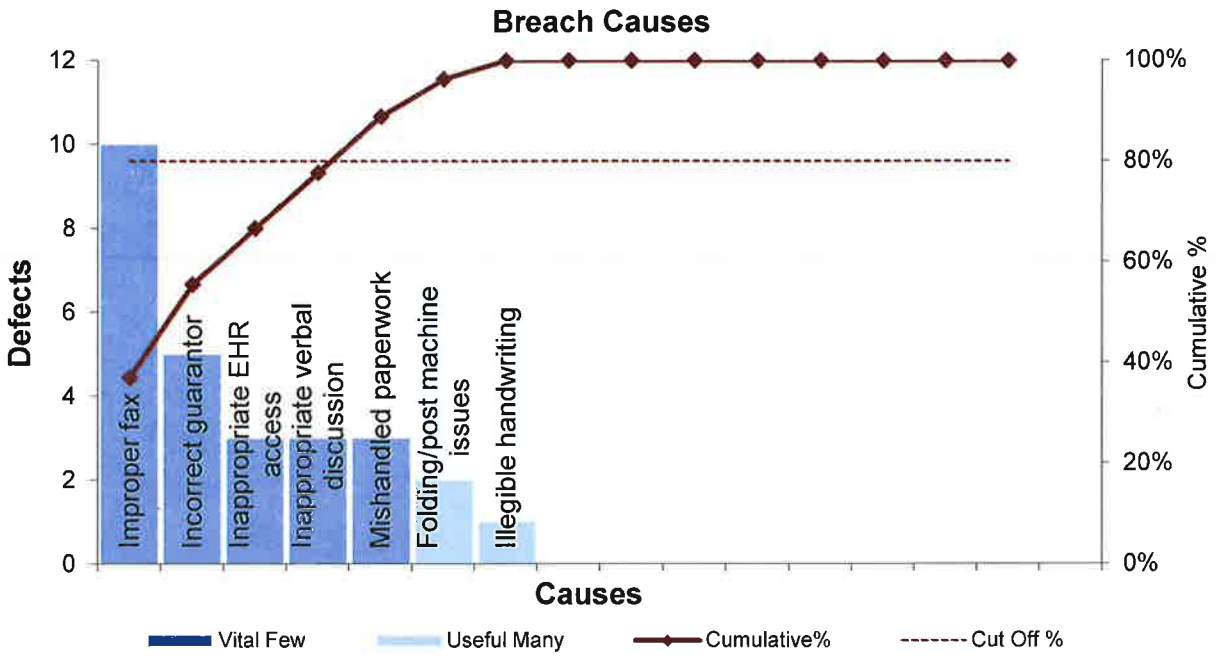
27 Breach investigations potentially affecting 37 patients



May 1, 2017

Exhibit A-1

Pareto Analysis - Breach of Protected Health Information

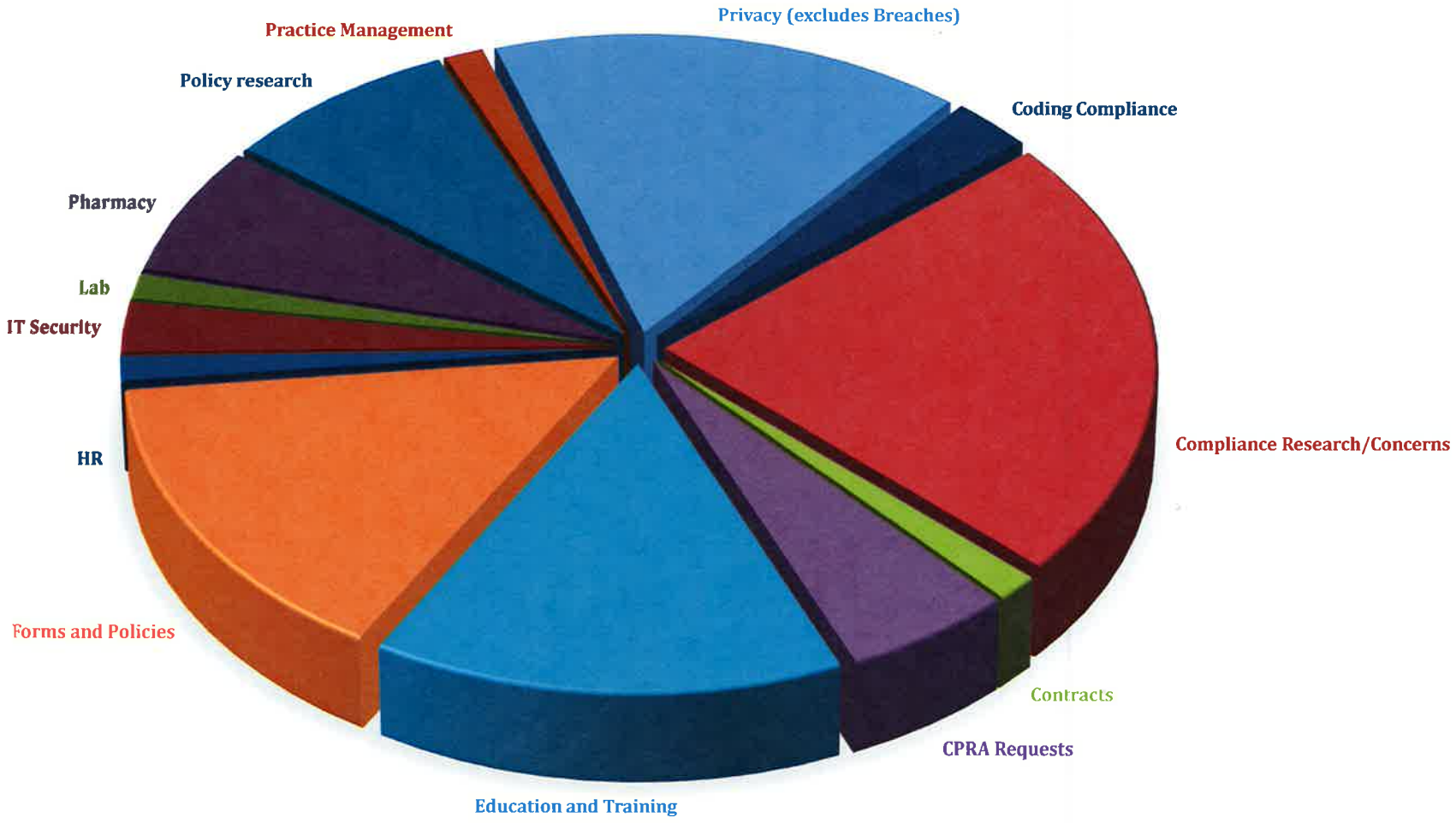


The first 5 Causes cover 88.89% of the Total Defects

Cumulative Percentage Cutoff: 80%

#	Causes	Defects	Cumulative%
1	Improper fax	10	37.0%
2	Incorrect guarantor	5	55.6%
3	Inappropriate EHR access	3	66.7%
4	Inappropriate verbal discussion	3	77.8%
5	Mishandled paperwork	3	88.9%
6	Folding/post machine issues	2	96.3%
7	Illegible handwriting	1	100.0%
8			100.0%
9			100.0%
10			100.0%
11			100.0%
12			100.0%
13			100.0%
14			100.0%
15			100.0%

REQUESTS FOR RESEARCH AND ASSISTANCE FROM THE COMPLIANCE DEPARTMENT



The Compliance Department has provided assistance and support to other departments for more than 70 requests in calendar year 2017. This chart demonstrates the general areas of requests, inquiries, and concerns.

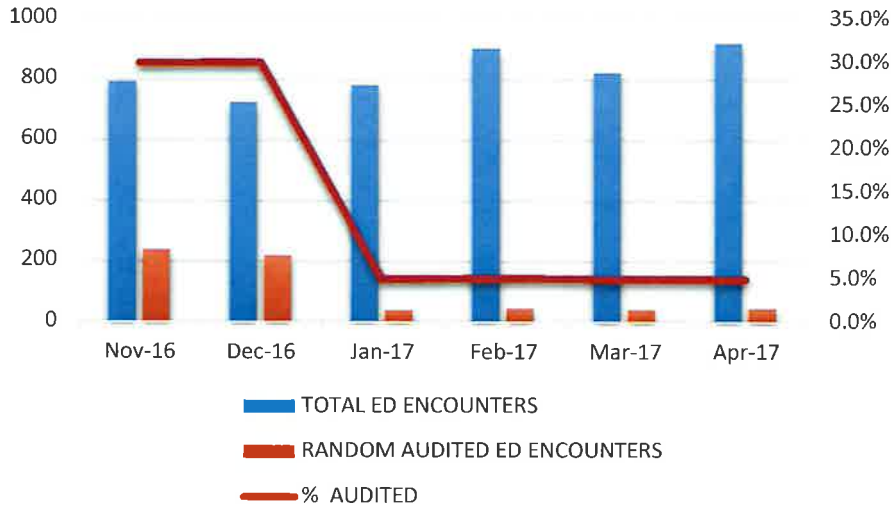
Exhibit B

5/1/2017

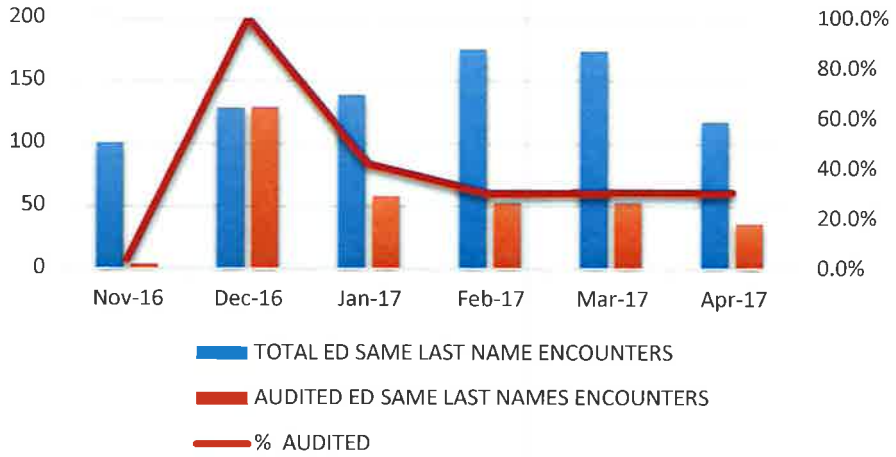
Employee EHR Access Audits

Emergency Room Encounters

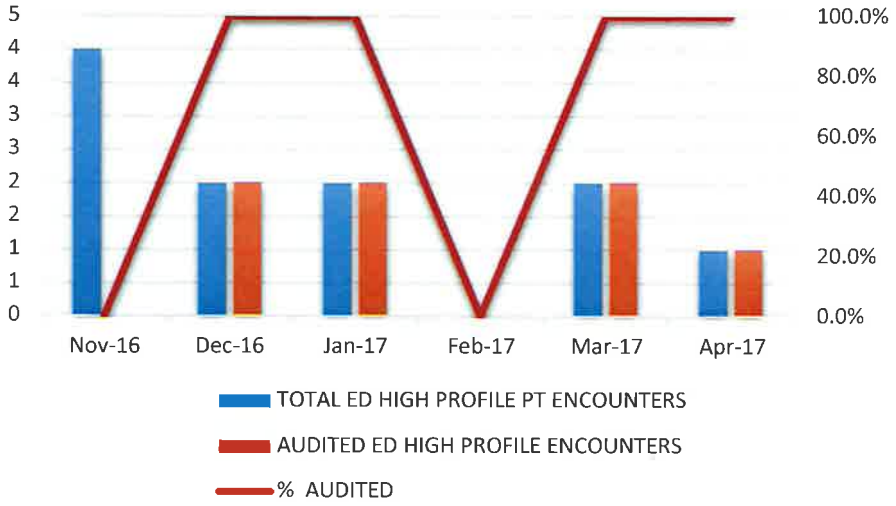
Random ED Encounter Audits



ED Patient with the same last name as an employee



ED High profile individuals



Employee as ED patient

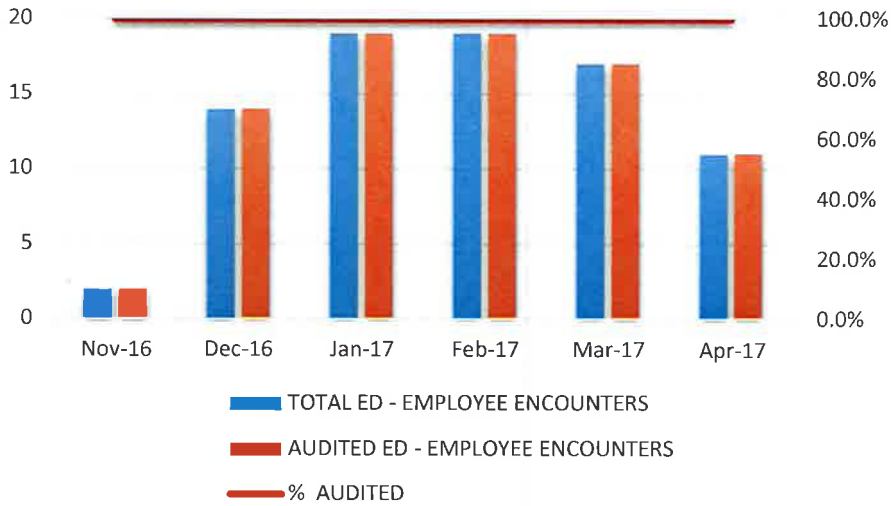
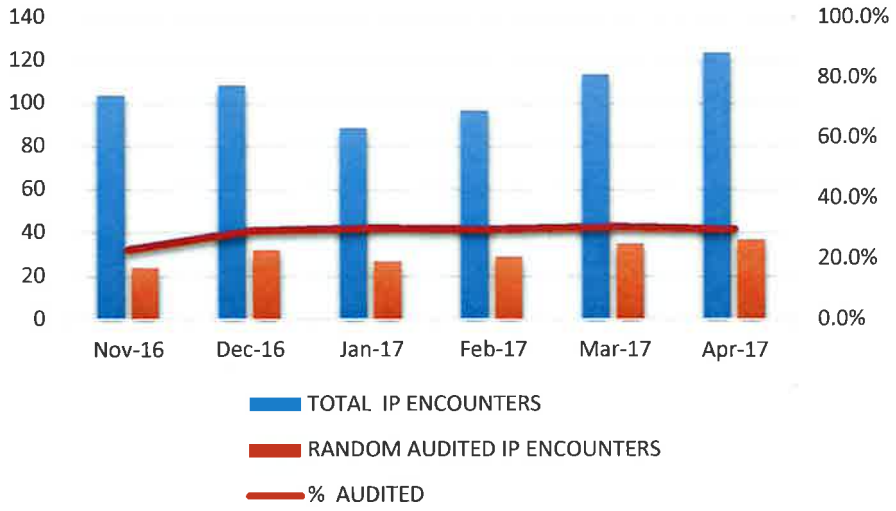


Exhibit C-1

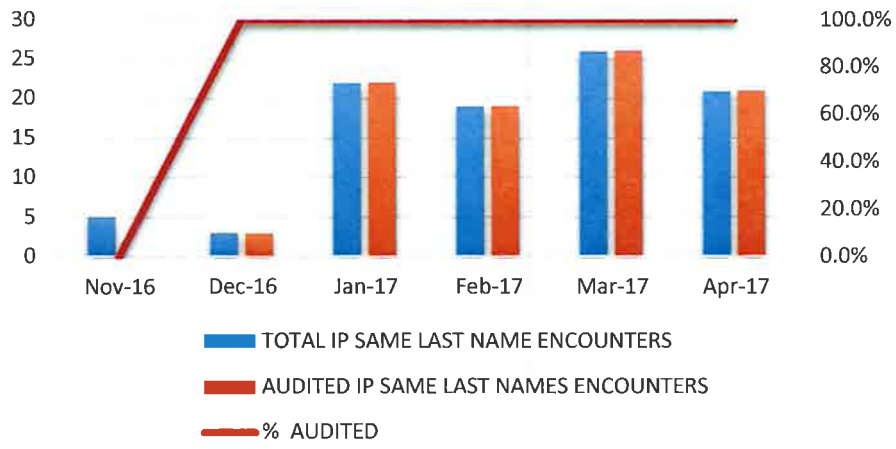
Employee EHR Access Audits

Inpatient Encounters

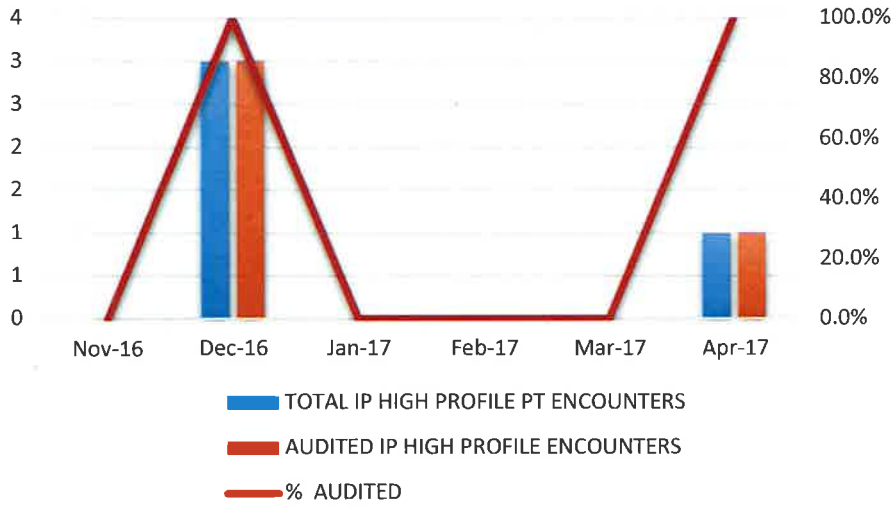
Random IP encounter Audits



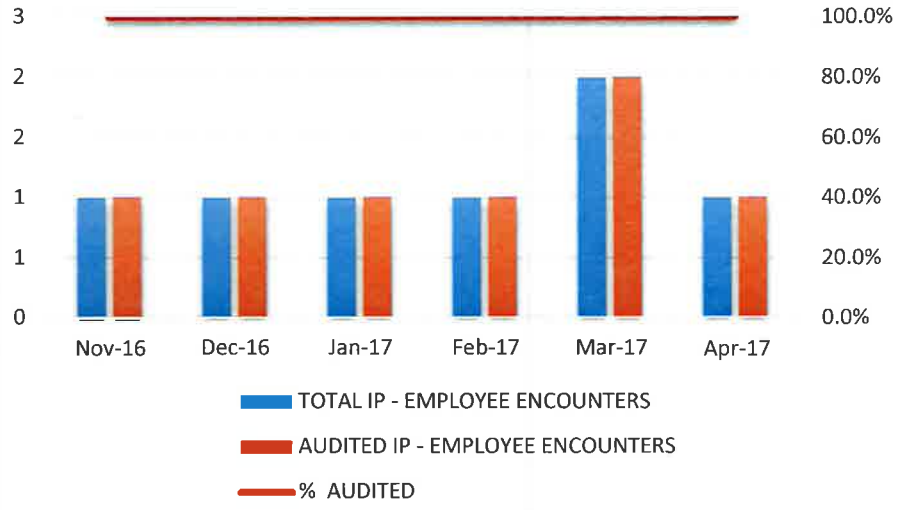
Inpatient with the same last name as an employee



Encounters



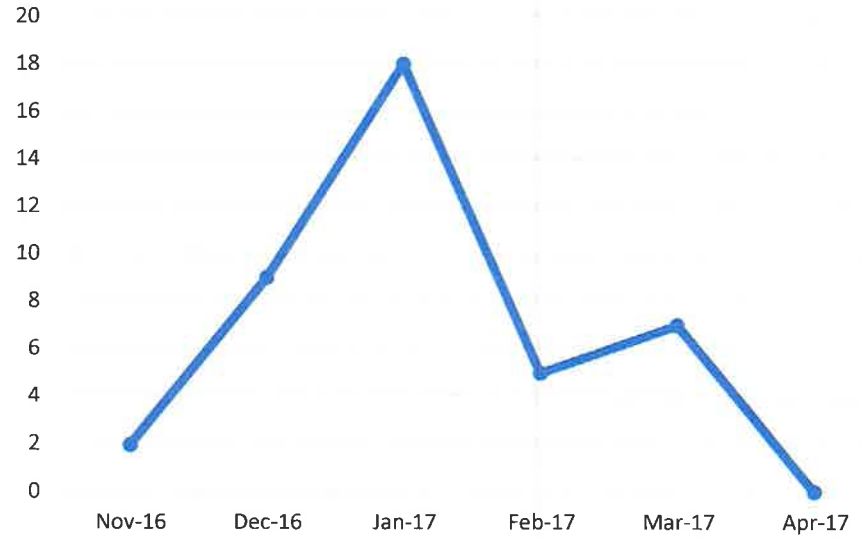
Encounters



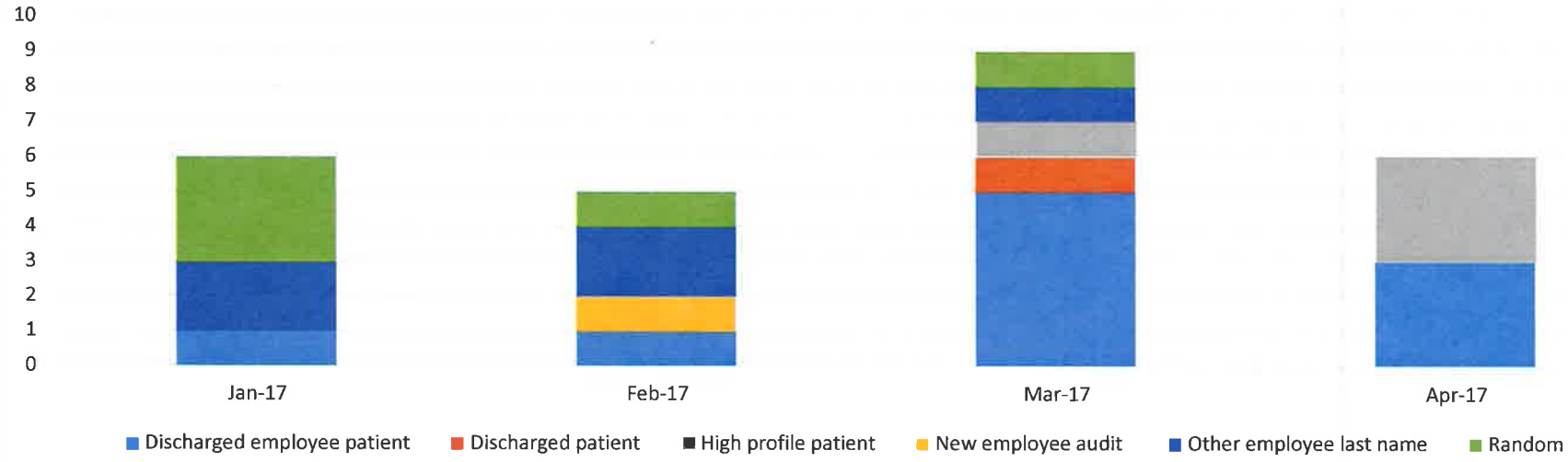
Employee EHR Access Audits

New Employee

FOR-CAUSE AUDITS



"FLAGS" - Audits requiring further investigation



Employee EHR Access Audits

"FLAGS" Outcomes

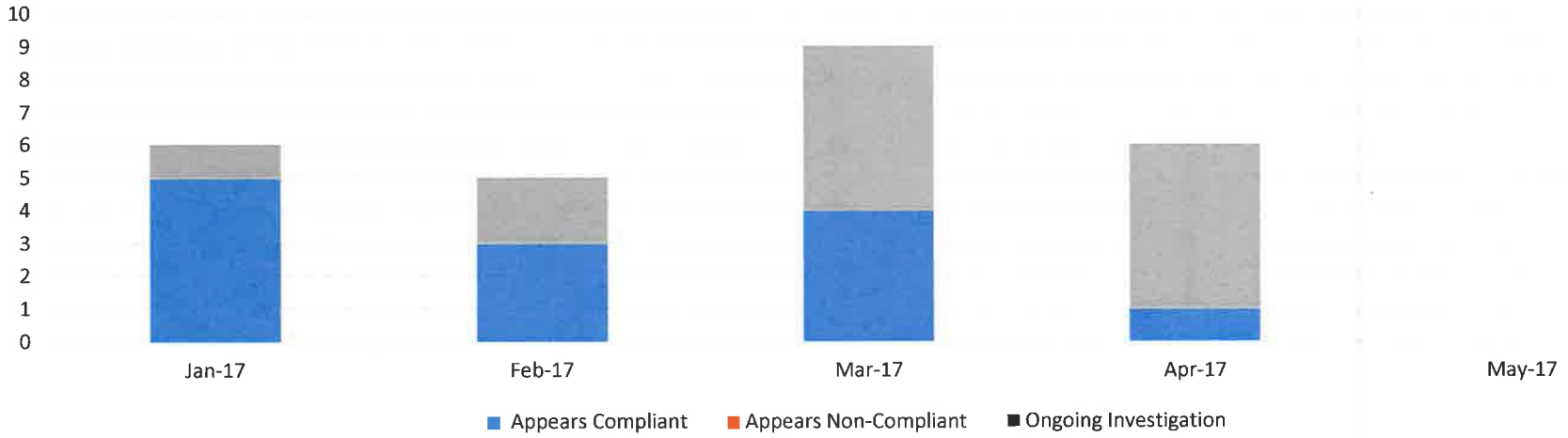


Exhibit D

Conflicts of Interest Questionnaires

Required annually		Goal
COI Questionnaires Requested	465	
COI Questionnaires Received	444	
	95.5%	100%
COI Questionnaires Reviewed	440	
	99.1%	>99%
Category A Conflicts	76	Not significant and generally permissible activities.
Category B Conflicts	54	Potential or perceived conflict which may require Non-Disclosure Agreement or management plan.
Category C Conflicts	0	Real conflict, must be resolved
Total	130	

- Conflicts of interest questionnaires are required to be completed by all employees at hire, annually, and with significant changes that may create or resolve real or perceived conflicts of interest.
- Completion of this document as described is mandatory, per the Compliance Program.
- Forms for Medical Staff and members of the Board of Directors are in development, although Inyo County requires financial conflicts disclosure from Board members.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests	
Scope: Administrative	Manual: Compliance
Source: Compliance Officer	Effective Date: 1/19/16

PURPOSE

This policy establishes guidelines for the employees of Northern Inyo Hospital ("Hospital") to follow when there has been a request for information under the California Public Records Act.

POLICY

All California Public Records Act requests for Northern Inyo Hospital related information are to be referred to the Compliance Officer.

DEFINITIONS

California Public Records Act – The fundamental precept of the California Records Act is that governmental records shall be disclosed to the public, upon request, unless there is a specific reason not to do so.

Public Record – Any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by the entity regardless of physical form or characteristics.

EXEMPTIONS FROM DISCLOSURE

Key exemptions include:

- Preliminary drafts, notes, or memoranda not retained in the ordinary course of business.
- Records relating to "pending litigation". Documents that may be withheld under this section must be specifically prepared for litigation in which the Hospital is party.
- Personnel, medical, or similar files where disclosure would constitute an "unwarranted invasion of privacy".
- Police files, including investigatory or security files compiled by any state or local police agency.
- Real estate appraisals or prospective public supply and construction contracts may be withheld until the property is acquired or all of the contract agreements are obtained.
- Exemptions based on prohibitions of disclosure under federal or state law, including provisions relating to privilege. This includes:
  - Attorney-client/attorney work product and doctor-patient privileges
  - "Official Information" privilege governing "information acquired in confidence by a public employee in the course of his/her duty and not open, or officially disclosed, to the public prior to the time the claim of privilege is made".
  - "Trade Secret" privilege. "Trade Secret" is defined as "information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (1) Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and (2) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
  - Any other state or federal law protecting records, including HIPAA, FERPA, etc.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests	
Scope: Administrative	Manual: Compliance
Source: Compliance Officer	Effective Date: 1/19/16

- The "Catch-all" or "Balancing Test"
  - Is applied to protect records, even when there is no other exemption that would apply, where "on the facts of the particular case the public interest served by not making the record public clearly outweighs the public interest served by disclosure of the record".
  - Includes the "Deliberative Process" privilege, to protect candid internal pre-decisional deliberations.
  - Includes "burdensomeness". A request might be so burdensome, and the public interest in the material so small, that the balancing test might allow us to deny the request.
  - Balances the public interest in disclosure against the public interest (not strictly the Hospital's interest) in withholding.

PROCEDURE:

1. Requests to inspect and copy public records should be made directly to the Compliance Office.
2. The Hospital is entitled to review and redact records before producing them to the requester.
3. Public records are open to inspection during the normal business hours of the Compliance Office. The "open to inspection" provision does not require that an individual be given immediate access to the records upon request. In all cases, the records would first need to be located and collected, possibly from multiple locations.
4. An appointment to inspect records may be necessary under these circumstances. If the requester requests access to a large number of documents, the requester may need to make additional appointments to complete the document inspection process.
5. Upon either the completion of the inspection or the oral request of Hospital personnel, the person conducting the inspection shall relinquish physical possession of the records.
6. Persons inspecting Hospital records shall not destroy, mutilate, deface, alter, or remove any such records from the Hospital.
7. The Hospital reserves the right to have Hospital personnel present during the inspection of records in order to prevent the loss or destruction of records.
8. The operational functions of the Hospital will not be suspended to permit inspection of records.
9. The Hospital is required to determine within 10 days (can be extended to 24 days for voluminous/complex requests) after receipt of a records request whether or not the requested records exist and/or are subject to disclosure, and to notify the person making the request of the reasons for that determination. The records themselves are not required to be released in 10 days. At the time of making a determination, the Hospital will provide a good faith estimate of when the records will be available.
10. The Hospital is required to "assist the member of the public in making a focused and effective request that reasonably describes an identifiable record".
11. The Hospital may not consider the identity of the requester or the purpose for the request, in making its determination.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests	
Scope: Administrative	Manual: Compliance
Source: Compliance Officer	Effective Date: 1/19/16

12. The Hospital does not have to create new records or answer questions. The California Public Records Act simply requires access and disclosure of existing records. However, we are required to extract data from a database upon request.
13. Copies will be provided upon request, at a cost of $0.25 per page for scanned or paper copy or $15.00 for USB electronic format. The requester may inspect records at no cost. Staff time for searching, collecting, reviewing, and redacting documents, is not considered to fall within the "direct cost of duplication". Pre-payment for all copying/scanning, electronic format costs are required before release of public records.

REFERENCES:

1. California Government Code §6250, 6252(f), 6253.9
2. "The ABC's of Privacy and Public Record", by Maria Shanle
3. www.thefirstamendment.org/capra.html

Approval	**Date**
Board of Directors	1-19-2016

Developed: 1/19/2016
Reviewed: 5/1/2017
Revised:
Supercedes:

Responsibility for review and maintenance: Compliance Officer

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **False Claims Act Employee Training and Prevention Policy**	
Scope: District Wide	Department: All
Source: Compliance	Effective Date: May 22, 2017

PURPOSE:
To comply with the provider bulletin, "Federal Deficit Reduction Act 2005: Employee Education on False Claims Recovery" issued in December 2006 and Welfare & Institutions (W & I) Code Section 14115.75 and Section 1902(a) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(68)).

POLICY:

1. The hospital will provide annual education to all hospital employees, contracted employees, medical staff, and directors on provisions of the State and Federal False Claims Acts (FCA) to comply with the requirements to understand the laws.
2. The hospital will teach all hospital employees (including Management), contracted employees, medical staff and directors detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (Medi-Cal or Medicare).
3. Up-coding, coding maximization and coding not in compliance with the hospital's Coding Compliance Policy is strictly prohibited and will be prevented by training of coding personnel, requirement for reporting the "illegal, incompetent, or unethical acts of others", and oversight by the hospital's Billing, Coding, and Compliance Committee.
4. Department managers, the Billing, Coding, and Compliance Committee, and the Controller of the hospital will oversee charging and billing practices. Any fraud, waste, or abuse will be prevented or immediately corrected by this oversight.
5. Employees will be given a compliance hotline number to report any suspected fraud, waste, or abuse. The hotline will be monitored by the Compliance Officer and any allegations of fraud, waste, and abuse will be investigated by the Compliance Officer.
6. Any hospital employees (including Management), contracted employees, medical staff or directors who become "qui tam" plaintiffs or report fraud, waste, or abuse (become whistleblowers) shall be protected from any and all retaliation or retribution by any hospital employee (including Management), contracted employee, medical staff or director. Such protection shall include immediate disciplinary action or sanction of the perpetrator of retaliation or retribution in addition to any remedies available under law.
7. Employee education and information available on the hospital intranet site pursuant to this policy shall include, but not be limited to the following facts.
    a. The FCA establishes liability for any person who knowingly submits a false claim to the government or causes another to submit a false claim to the government or knowingly makes a false record or statement to get a false claim paid by the government. Section 3729(a)(1)(G) of the FCA is known as the reverse false claims section; it provides liability where one acts improperly – not to get money from the government, but to avoid having to pay money to the government. Section 3729(a)(1)(C) creates liability for those who conspire to violate the FCA.
    b. The statute provides that one who is liable must pay a civil penalty of between $11,000 and $21,916 for each false claim (those amounts are adjusted from time to time; the current amounts are $11,000 to $21,916) and treble the amount of the government's

damages. Where a person who has violated the FCA reports the violation to the government under certain conditions, the FCA provides that the person shall be liable for not less than double damages.

c. A person does not violate the False Claims Act by submitting a false claim to the government; to violate the FCA a person must have submitted, or caused the submission of, the false claim (or made a false statement or record) with knowledge of the falsity. In § 3729(b)(1), knowledge of false information is defined as being (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.

d. The FCA also defines what a claim is and says that it is a demand for money or property made directly to the Federal Government or to a contractor, grantee, or other recipient if the money is to be spent on the government's behalf, and if the Federal Government provides any of the money demanded or if the Federal Government will reimburse the contractor or grantee.

e. The FCA states that the statute does not apply to tax claims under the Internal Revenue Code.

f. The FCA allows private persons to file suit for violations of the FCA on behalf of the government (a "*qui tam*" action), and the person bringing the action is referred to as a "relator."

g. The *qui tam* provisions beginning at § 3730(b) of the FCA; § 3730(b)(1) state that a person may file a *qui tam* action. Section 3730(b)(2) provides that a *qui tam* complaint must be filed with the court under seal. The complaint and a written disclosure of all the relevant information known to the relator must be served on the U.S. Attorney for the judicial district where the *qui tam* was filed and on the Attorney General of the United States. The *qui tam* complaint is initially sealed for 60 days. The government is required to investigate the allegations in the complaint; if the government cannot complete its investigation in 60 days, it can seek extensions of the seal period while it continues its investigation. The government must then notify the court that it is proceeding with the action (generally referred to as "intervening" in the action) or declining to take over the action, in which case the relator can proceed with the action. If the government intervenes in the *qui tam* action it has the primary responsibility for prosecuting the action. § 3730(c)(1). It can dismiss the action, even over the objection of the relator, so long as the court gives the relator an opportunity for a hearing (§ 3730(c)(2)(A)) and it can settle the action even if the relator objects so long as the relator is given a hearing and the court determines that the settlement is fair. § 3730(c)(2)(B). If a relator seeks to settle or dismiss a *qui tam* action, it must obtain the consent of the government. § 3730(b)(1). When the case is proceeding, the government (§ 3730(c)(2)(C)) and the defendant (§ 3730(c)(2)(D)) can ask the court to limit the relator's participation in the litigation. d. Award to the relator If the government intervenes in the *qui tam* action, the relator is entitled to receive between 15 and 25 percent of the amount recovered by the government through the *qui tam* action. If the government declines to intervene in the action, the relator's share is increased to 25 to 30 percent. Under certain circumstances, the relator's share may be reduced to no more than ten percent. If the relator planned and initiated the fraud, the court may reduce the award without limitation. The relator's

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **False Claims Act Employee Training and Prevention Policy**	
Scope: District Wide	Department: All
Source: Compliance	Effective Date: May 22, 2017

share is paid to the relator by the government out of the payment received by the government from the defendant. If a *qui tam* action is successful, the relator also is entitled to legal fees and other expenses of the action by the defendant. All of these provisions are in § 3730(d) of the FCA. In §3730(c)(5), the FCA also provides that if the government chooses to obtain a recovery from the defendant in certain types of proceedings other than the relator's FCA suit, this is known as an alternate remedy and the relator is entitled to the same share of the recovery as if the recovery was obtained through the relator's FCA suit. The FCA provides several circumstances in which a relator cannot file or pursue a *qui tam* action:

i. The relator was convicted of criminal conduct arising from his or her role in the FCA violation. § 3730(d)(3).
ii. Another *qui tam* concerning the same conduct already has been filed (this is known as the "first to file bar"). §3730(b)(5).
iii. The government already is a party to a civil or administrative money proceeding concerning the same conduct. §3730(e)(3).
iv. The *qui tam* action is based upon information that has been disclosed to the public through any of several means: criminal, civil, or administrative hearings in which the government is a party, government hearings, audits, reports, or investigations, or through the news media (this is known as the "public disclosure bar.") §3730(e)(4)(A). There is an exception to the public disclosure bar where the relator was the original source of the information.

h. The California False Claims Act (CFCA) requires that the claim (controversy) must exceed $500.00 in value.
i. Criminal penalties include up to 5 years in prison and a $25,000 fine.
j. Whistleblowers and filers of Qui Tam actions may recover 15-50% of the liability depending on whether the recovery is under the California False Claims Act (CFCA) or the federal False Claims Act (FCA) and whether the government pursues action or not.

Approval	**Date**
Administrator	
Board of Directors	

Index Listings:
Developed: 1-14-14
Revised: 5/1/2017
Reviewed: 12/16/15

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

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: Joy Engblade, MD, Chief of Medical Staff
DATE: May 2, 2017
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:

1. **Policy/Procedure/Protocols/Order Sets (Action item)**
   - *Venous Blood Collection*
   - *Insulin Continuous Subcutaneous Infusion Self Management of the Patient in the Acute Setting*
   - Consent Form: Videotaping, Voice Recording, and Photography in the Perinatal Unit

2. **Perinatal Critical Indicators 2017 (Action item)**

3. **Medical Staff Appointment/Privileges (Action item)**
   - **Temporary Staff:**
     - John Franklin, MD (internal medicine – temporary assignment until 12/31/17)

4. **Additional Privileges (Action item)**
   - Richard Meredick, MD (orthopedic surgery) – additional surgical privileges granted:
     - Biopsy
     - Excision Biopsy Tumors (incl ganglion etc)
     - Pathological Fracture Fixation

_____
Joy Engblade, MD, Chief of Staff

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Venous Blood Collection	
Scope: NIH	Manual: Laboratory, CPM – F&B
Source: Coordinator of Chemistry CLS	Effective Date:

PURPOSE:
Quality patient care and accurate specimen results are dependent upon proper venipuncture technique, timely specimen collection, and proper processing of patient specimens. This procedure establishes criteria for the proper collection of specimens for Venous Blood Gas analysis, (VBG).

MATERIALS:
A. Arterial Blood Sampling Kit with Luer
B. Safety Lok Butterfly Blood collection Set with Luer

SPECIMEN COLLECTION / STORAGE / LABELING
Venous Blood Gas Only
RN or Phlebotomist will draw sample, have Respiratory Therapist present

- Using Butterfly collection set
  1. Connect 3 cc syringe to the butterfly collection set prior to veinipuncture
  2. Perform venipuncture.
  3. Draw back on the syringe slowly to remove air from the butterfly tubing.
  4. Connect Arterial syringe to the butterfly collection set.
  5. Draw back on the syringe slowly to obtain greater than 1 mL in the syringe. A minimum of 1 mL is required for testing.
  6. Remove the air bubbles if present.
  7. Fasten transport cap included in package to syringe.
  8. Discard sharp appropriately.
  9. Appropriately label the syringe.
  10. Give specimen to Respiratory Therapy for testing.
  11. Mix thoroughly by rotating the syringe several times ensuring adequate anticoagulation.

LIMITATIONS OF THE PROCEDURE
Specimens not meeting the minimum 1 mL requirement will be rejected.

REFERENCES:

CROSS REFERENCES:
1. Arterial Blood Gas – Lippincott Procedures

Committee	Date
CCOC	12/12/16
Emergency Room Committee	3/16/17
Med Services/ICU	4/27/17
MEC	
Board of Directors	

Developed: 12/16
Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Venous Blood Collection	
Scope: NIH	Manual: Laboratory, CPM – F&B
Source: Coordinator of Chemistry CLS	Effective Date:

Reviewed:
Index Listing:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Insulin Continuous Subcutaneous Infusion Self Management Of The Patient In The Acute Setting	
Scope: Nursing Services	Manual: CPM - Endocrine (END)
Source: DON ACUTE & SUBACUTE	Effective Date:

PURPOSE:

1. Guidelines to meet the needs of patients with diabetes who are administering Insulin through their own insulin pump while in the hospital.
2. For the Patient to be able to continue self-management of their Diabetes while in the hospital in collaboration with the health team.

POLICY:

An order by a physician must be obtained for the diabetic patient (parent or care-giver) to manage insulin requirements via the patient's insulin pump.

1. Pursuant to this policy, the patient will use her/his own insulin pump, tubing, skin preparation items and Insulin. Blood glucose will be checked regularly per Physician order using hospital monitoring items (monitor & strips) and lancets while in the Hospital.
2. Nursing should assess the patient's (parent or caregiver's) ability to use the equipment effectively. The patient must be alert/oriented and knowledgeable in insulin pump therapy to make changes and maintain control of glucose levels.
3. If the insulin pump is not to be used for a specific time, the pump should be locked up in a secure place and a notation made in the EHR.
4. If the patient becomes NPO, specific insulin orders should be obtained from the patient's physician.
5. In the event that the nurse takes over the management of the pump and requires assistance with the pump settings or operation, the 800 number on the back of the patient's pump is to be called.
6. The patient with diabetes may use his or her own Blood Glucose monitor and supplies.

Contraindications include but are not limited to:

1. **Altered level of consciousness.**
2. **Critically ill.**
3. **Suicide risk.**
4. **Patient refuses or is unable to provide selfcare/pump management.**
5. **Patient's family member is unwilling or unable to manage the pump.**

Insulin pump therapy should be suspended and disconnected if the Patient is undergoing the following tests:
MRI
CT Scan
Radiology procedures.

EQUIPMENT:

1. Patient's own insulin pump with batteries.
    a. Medtronic Mini Med
    b. Animas
    c. Others
2. Patient's own insulin pump tubing
3. Patient's own insulin pump syringe and catheters (needles).
4. Patient's own Insulin:
    a. Lispro (Humalog)
    b. Aspart (Novolog)
    c. Regular (R)

d. Regular Buffered (Velosulin BR)

5. Skin preps
6. Dressings
7. Insulin set insertion device (self-starter or quick starter) optional
8. Glucose tabs or gel
9. Glucagon

Documentation:

- Every shift, on each unit specific patient care flow sheet.
  - The patient is using his or her own glucose monitor, supplies and insulin pump.
  - The patient is **mentally** and **physically** able to monitor his or her own insulin pump and glucose monitoring system.
  - Any signs or symptoms of Hyper or Hypoglycemia are documented and the physician notified.
  - The pumps basal rate if any.
  - Bolus doses including correctional doses.
  - Frequency of infusion set change and date.
  - Date of site change.
  - Assess condition and location of site.

Approval	Date
CCOC	2/27/17
Medical Services/ICU	4/27/17
Pharmacy and Therapeutics	4/20/17
Medical Executive Committee	
Board of Directors	

Initiated: 10/03
Revised: 2/08bss 2/17la
Reviewed: BS 9/12; BS 3/15
Supersedes:
Index Listing: Insulin Pump

VIDEOTAPING, VOICE RECORDING, AND PHOTOGRAPHY IN THE PERINATAL UNIT

The birth of a new baby is a special time for all involved – family, friends, and loved ones. Because of this, many love to capture these moments through videotape or photography – to share with others and to save, look back at, and remember as your child grows.

While we want you to be able to capture your and your baby's time here, we also want to keep the focus and attention of everyone – family, friends, and caregivers alike – on you throughout the birth process and, soon after, on both you and your new baby.

With this goal in mind, we have a few guidelines that we would like you to follow (please initial each one after reading):

_____ **Videotaping or photography of the actual birth is not allowed. However, photography is allowed before delivery and after delivery and stabilization of the newborn with mom's consent. Videotaping of those same time periods is allowed with mom's consent and the consent of the healthcare providers.**

_____ **Photography of procedures, such as administration of medications, suturing, epidural placement, etc., is not allowed.**

_____ **If requested by medical staff at any time, stop photographing or videotaping until given permission to resume.**

_____ **Capturing images or voices of medical staff through any means will only be allowed if verbal permission is given.**

_____ **Capturing images through any means of the fetal monitor strip or the computer is not allowed.**

If you have any questions about videotaping, voice recording, or photography in the Perinatal Unit, please don't hesitate to ask your doctor, nurse-midwife, or our nursing staff.

I have reviewed these guidelines with the NIHD representative listed below. I hereby release the attending physician/healthcare practitioner and Northern Inyo Healthcare District, their officers, directors, agents, and employees from any liability that is captured on videotape or in photographs. By initialing above and signing below, I agree to follow these guidelines.

Mother's Name (Printed)	*Date*	*Mother's Name (Signature)*
NIHD Representative (Printed)	*Date*	*NIHD Representative (Signature)*
Professional Photographer – if applicable (Printed)	*Date*	*Professional Photographer – if applicable (Signature)*

We look forward to sharing a healthy birth experience with you and your chosen support team!

Perinatal Critical Indicators

1. Fetal demise beyond 20 weeks
2. Maternal death
3. Transfers to higher level of care
4. Low APGAR scores (<6 at 1 minute)
5. Neonatal trauma
6. 3rd and 4th degree lacerations
7. Postpartum hemorrhage
8. Postpartum readmission
9. Disruption or infection of obstetrical wound
10. Vaginal deliveries coded with shoulder dystocia

Approved: Peri-Peds Committee on 4/13/2017

Approved: MEC on 5/2/2017

Approved: Board of Directors on 5/17/2017