Northern Inyo Hospital

April 18 2018 Regular Meeting

April 18 2018 Regular Meeting - April 18 2018 Regular Meeti

Chief of Staff Report for April 2018

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
April 18, 2018 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. New Business

A. Recommended Capital Budget for 2018/2019 (*action item*).

B. Financial and Statistical Reports as of February 2018 (*action item*).

C. Policy and Procedure approval, *Chart Check Guidelines* (*action item*).

D. Policy and Procedure approval, *Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information* (*action item*).

E. Policy and Procedure approval, *Auditing of Workforce Access to Patient Information* (*action item*).

F. Workforce Experience Committee report (*information item*).

G. Patient Experience Committee report (*information item*).

H. Quarterly Medical Staff Services Pillars of Excellence (*action item*).

I. Policy and Procedure approval, Board of Directors: *Attendance at Meetings* (*action item*).

J. Policy and Procedure approval, Board of Directors: *Northern Inyo Healthcare District Board of Directors Meetings* (*action item*).

K. Policy and Procedure approval, Board of Directors: *Basis of Authority*: *Role of Director*s (*action item*).

L. Policy and Procedure approval, Board of Directors: *Reimbursement of Expenses* (*action item*).

M. Policy and Procedure approval, Board of Directors: *Election Procedures and Related Conduct* (*action item*).

N. Formation of Ad Hoc Committee to fill District Zone 3 Board vacancy (*action item*).

Consent Agenda (action items)

4. Approval of minutes of the March 21 2018 regular meeting
5. 2013 CMS Survey Validation Monitoring
6. Policy and Procedure annual approvals

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7. Chief of Staff Report; Richard Meredick, MD:
   A. Policies/Procedures/Protocols/Order Sets (*action items*):
      1. *Bite Guidelines, Animals*
      2. *DI – Timely Performance Standards*
      3. *Discharge Instructions Emergency Department*
      4. *Pediatric Order Verification Overnight*
      5. *Radiology Critical Indicators for Chart Review Policy*
      6. *Safely Surrendered Baby Policy and Procedure*
      7. *Scope of Service for the Emergency Department*
      8. *Standards of Care for the Emergency Department*
   B. Annual Review (*action item*):
      1. Emergency Room Service Critical Indicators
   C. Medical Staff Appointments/Privileges (*action items*):
      1. Gabriel Overholtzer, DDS (*dentistry*) – Provisional Active Staff (*limited license practitioner*)
      2. Kinsey R. Pillsbury, MD (*radiology*) – Consulting Staff
8. Reports from Board members (*information items*).
9. Adjournment to closed session to/for:
   A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
   B. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).
   C. Discussion of labor negotiations, Agency Designated Representative Kevin Dale; Employee Organization AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
10. Return to open session and report of any action taken in closed session.
11. Adjournment

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

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

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District

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Bishop, California
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April 5, 2018

Memo To: The Board of Directors

From: John Tremble, CFO

Subject: 2018/2019 Capital Budget Request

Management received over 90 items for consideration for the 2018/2019 capital budget. Those requests were reduced to 79 requests after non-capital equipment and repairs were excluded (they will be addressed in the operating budget). Those total requests equalled $4,574,057 after duplicates were excluded.

These requests were forwarded to the Medical Staff Executive Committee to consider and to rank their importance. The Medical Staff also made their review and recommendation based upon the goal for NIHD to have 90 days of cash on hand as of June 30, 2019.

The Medical Staff gave each item a High, Medium or Low priority. After careful consideration, all the items ranked as High have been forwarded to you for funding consideration during the remainder of Fiscal 2018 and all of Fiscal 2019. The largest item on the budget is the not yet approved construction project related to OSHPD and the inpatient pharmacy. The sum of $1,745,323 is included in the budget to address this issue. The remaining requests total $1,402,622 for a total just below $3,150,000.

Total capital expenditures of $3,150,000 should result in NIHD having 90 days cash on hand at fiscal year end. The 90 day calculation included an assumption of a modest net income of $750,000 for Fiscal 2019.

Senior Management and the Medical Executive Staff is asking that you authorize a total capital budget of $3,150,000 based upon the High priority and OSHPD required capital requests. Both Management and Medical Staff would like to potentially submit a mid-year addition to this capital budget assuming success in our Athena implementation.

Summary of Capital Requests for Fiscal 2018/2019

Row Labels	Sum of Est Cost of Capital > $2,500
1	378,584.22
2	105,398.00
3	571,238.00
4	1,727,431.98
5	48,722.00
7	40,000.00
8	1,745,323.00
Grand Total	**4,616,697.20**

1-Patient Safety, Regulatory Compliance
2-Patient Satisfaction
3 - Strategic Purchase & New Services
4 - End of Life Assets
5- Dependent on EHR Selection/Installation
7- Staff Safety
8 - OSHPD Required

Expected Capital Budget per Governing Board Cash on Hand Requirements

Carryforward	$	1,745,323.00	**8 - OSHPD Required**
New Capital		1,404,677.00	With 90 Days Cash on Hand at Fiscal Year End
Total Estimate:	$	3,150,000.00	

2018/2019 Recommended Capital Request

Row Labels	Sum of Est Cost of Capital > $2,500	Sum of Annual Est. Depr
2018	**$ 1,745,323.00**	**$ 58,177.43**
H	**$ 1,402,622.80**	**$ 201,450.21**
(4) Cisco 3850-48U-L access layer switches	$ 28,000.00	$ 4,000.00
Adjustable height exam table	$ 4,000.00	$ 571.43
Badge Access for EKG	$ 4,000.00	$ 800.00
Breastmilk Refridgerator	$ 5,400.00	$ 771.43
Cardiac Monitors	$ 34,136.50	$ 4,876.64
Cardiac Monitors with hardware, software and install	$ 93,500.00	$ 13,357.14
Cardiac Montiors - Primary Server	$ 34,136.50	$ 4,876.64
Dietary Refridgerator	$ 8,000.00	$ 1,142.86
Fiberoptic endoscopic evaluation for swallowing	$ 35,000.00	$ 5,000.00
Gamma Camera	$ 340,000.00	$ 48,571.43
GE TIMS Unit - video recording of swallow studies	$ 25,000.00	$ 3,571.43
Hospital PIICiX ADT & Vital Sign Results via IBE	$ 19,100.00	$ 3,820.00
HoverJack Air Patient Lift	$ 6,200.00	$ 1,240.00
Integrated Video System (replacement & upgrade)	$ 243,240.00	$ 24,324.00
IntelliVue X3 infant monitor	$ 12,370.00	$ 2,474.00
Laboratory Room Refrigerator	$ 12,000.00	$ 1,714.29
Medication Freezer	$ 6,000.00	$ 857.14
Medication Refrigerator	$ 9,000.00	$ 1,285.71
Microsoft Exchange Archive Storage	$ 6,600.00	$ 1,320.00
Neonatal Bilirubin Blanket (need one more)	$ 4,000.00	$ 800.00
Offsite storage of data unit	$ 6,600.00	$ 1,320.00
PACU gurneys (2)	$ 15,874.00	$ 2,267.71
PCR Testing Equipment	$ 75,000.00	$ 10,714.29
Penthouse Area Above Infusion Roof Replacement	$ 15,000.00	$ 1,500.00
Point of Care Lead Testing Machine	$ 13,000.00	$ 2,600.00
Pulmonary Function System (replace 2008)	$ 47,000.00	$ 5,875.00
Radiant Infant Warmer	$ 18,500.00	$ 2,642.86
Refrigerator & Freezer Combo	$ 6,500.00	$ 928.57
Replace all 9 current Operating Room Monitors	$ 47,872.00	$ 9,574.40
Replace Carpet with sheet vinyl	$ 7,342.32	$ 734.23
Replace Carpet with sheet vinyl in exam rooms	$ 13,813.90	$ 1,381.39
Replace steam humidifier	$ 19,000.00	$ 1,900.00
Replace to Workstations on Wheels	$ 5,587.58	$ 1,117.52
Replace to Workstations on Wheels (2)	$ 11,175.00	$ 2,235.00
Replace to Workstations on Wheels (3)	$ 16,765.00	$ 3,353.00
Re-tube Ajax Boilers	$ 13,058.00	$ 652.90
Stryker eye gurney	$ 8,236.00	$ 1,176.57
Uninterrupted Power Source	$ 5,000.00	$ 1,000.00
V-Pro-Max Steris hydrogen peroxide sterilizer	$ 120,256.00	$ 24,051.20
Vulcan double deck oven	$ 7,360.00	$ 1,051.43
L	**$ 484,075.00**	**$ 68,871.39**
M	**$ 942,036.40**	**$ 128,974.16**
Grand Total	**$ 4,574,057.20**	**$ 457,473.19**

Total Primary Request for 2018/2019 $ 3,147,945.80

Northern Inyo Hospital - 2018-19 Capital Expenditure Requests									
1-Patient Safety, Regulatory Compliance	3 - Strategic Purchase & New Services	5- Dependent on EHR Selection/Installation	7- Staff Safety						
2-Patient Satisfaction	4 - End of Life Assets	6- Future year purchase per Exec	8 - OSHPD Required						
Dept ID	Department	Description	Purpose	Est Cost of Capital > $2,500	Yrs of Life	Primary Reason	Secondary Benefit	Med Staff Priority	note	Annual Est. Depr
	NIA Ortho Clinic	Replace Carpet with sheet vinyl	Update flooring for medical office space	$ 7,342.32	10	1	7	H		$ 734.23
	Rural Health Clinic	Replace Carpet with sheet vinyl in exam rooms	Update flooring for medical office space	$ 13,813.90	10	1	7	H		$ 1,381.39
7010	Emergency Department	HoverJack Air Patient Lift	System to lift patients who have fallen	$ 6,200.00	5	1	7	H	We have different type today	$ 1,240.00
7010	Emergency Department	Permanent Ceiling Mounted Patient Lift	Lifts patients up to 625 lbs. (for one bed area)	$ 20,000.00	7	1	7	L	One bed instead of a hoyer lift	$ 2,857.14
	EKG	Badge Access for EKG	Replace keys with electronic access	$ 4,000.00	5	1	7	H		$ 800.00
	Security	Additional Security cameras around campus		$ 15,000.00	7	1		L		$ 2,142.86
	Infection Control	Xenex Disinfection System (used in rooms after EVS)	UV light kills MDRO & C diff spores; portable	$ 85,000.00	5	1	7	M		$ 17,000.00
6400	Perinatal	IntelliVue X3 infant monitor	Add C02 monitoring capability per recommendation	$ 12,370.00	5	1		H		$ 2,474.00
	Diagnostic Imaging	Add Omnicell in MRI		$ 25,000.00	5	1		L	Should they use CT Scanner Unit?	$ 5,000.00
	Environmental Services	Carpet Extractor	to allow self cleaning of all areas of hospital	$ 5,500.00	5	1	7	M		$ 1,100.00
8460	Maintenance	Re-tube Ajax Boilers	Used for Medical Waste	$ 13,058.00	10	1		H	2018 approved	$ 652.90
8460	Maintenance	MRI HVAC Back up Unit	recommended by GE Repairman	$ 20,000.00	10	1		L	2018 approved	$ 1,000.00
8460	Maintenance	New Roof for MRI Building	End of Life Replacement	$ 40,000.00	4	1		L	2018 approved	$ 5,000.00
8460	Maintenance	Replace Frozen Chilled Water Coild with Factor Replacement Coil on AHU-1	Emergency Replacement of Surgery Coil if Needed; RHP recommended	$ 21,300.00	20	1		L	2018 approved	$ 532.50
8460	Maintenance	Used Pick-up Truck	Hospital usage	$ 40,000.00	4	1		L	2018 approved	$ 5,000.00
8410	Grounds	Repair of 4 different parking lots around campus	Main, PMA, RHC & RHC Annex parking lot repairs	$ 50,000.00	15	1		L	2018 approved	$ 1,666.67
	Rural Health Clinic	Adjustable height exam table	Address concerns for certain patients	$ 4,000.00	7	2	7	H		$ 571.43
7420	Surgery	2 additional flexible cystoscopes for office	To address processing time issues for Urology	$ 19,094.00	5	2	3	L		$ 3,818.80
6170	Med/Surg Inpatient	Vein Viewer Imaging System (B/Braun)	Allows staff to see blood vessels and improve IV	$ 16,010.00	7	2		M		$ 2,287.14
7420	Surgery	Olympus shock pulse lithotripsy	Replaces use of a mobile service	$ 50,284.00	5	2	3	L		$ 10,056.80
	Diagnostic Imaging	Vein Viewer Imaging System (B/Braun)	Allows staff to see blood vessels and improve IV	$ 16,010.00	7	2		L	Only Need one	$ 2,287.14
	Speech Language	Fiberoptic endoscopic evaluation for swallowing	Mobile unit to replace use of fluoroscopy suite	$ 35,000.00	7	3	2	H		$ 5,000.00
	Speech Language	Synchrony Rehabilitation Sys for swallowing rehab	provide virtual reality augmented EMG biofeedback	$ 20,000.00	7	3	2	M		$ 2,857.14
	Rural Health Clinic	Point of Care Lead Testing Machine	Testing available at RHC	$ 13,000.00	5	3		H	Will save a venipuncture if neg	$ 2,600.00
7420	Surgery	Supra Patellar upgrade for proximal approach	for tibial nailing (Stryker)	$ 10,233.00	5	3		M		$ 2,046.60
6170	Surgery	Integrated Video System (replacement & upgrade)	for all three OR Rooms icludes all wiring & install	$ 243,240.00	10	3	4	H	Does this include interface	$ 24,324.00
6170	Surgery	Clarity system captures OR images onto a flashdrive	Improves information to patients post surgery	$ 56,565.00	7	3		L	Is this necessary?	$ 8,080.71
8480	Information Technology	(4) Cisco 3850-48U-L access layer switches	allows enhanced bandwith serves up to 192 units	$ 28,000.00	7	3	4	H		$ 4,000.00
8480	Information Technology	Offsite storage of data unit	disaster recovery component	$ 6,600.00	5	3	1	H		$ 1,320.00
8480	Information Technology	Uninterrupted Power Source	disaster recovery component	$ 5,000.00	5	3	1	H		$ 1,000.00
848	Information Technology	Microsoft Exchange Archive Storage	disaster recovery component	$ 6,600.00	5	3	1	H		$ 1,320.00
6400	Perinatal	Neonatal Bilirubin Blanket (need one more)	Used to treat typerbilirubinemia in the newborn	$ 4,000.00	5	3		H		$ 800.00
	Diagnostic Imaging	Add Hand wrist MRI coil	improve hand and wrist studies	$ 33,000.00	5	3	1	M	Replaces standard coil	$ 6,600.00
	Pathology	Laboratory Microscope for presentations	Requested to supplement Tumor Board meetings	$ 35,000.00	7	3	1	M		$ 5,000.00
	Microbiology	PCR Testing Equipment	reduce turn around time for cultures	$ 75,000.00	7	3		H	Need to consult with Med staff before	$ 10,714.29
6010	ICU	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
7010	Emergency	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
7010	Emergency	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
7010	Education	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
6170	Acute	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48

Northern Inyo Hospital - 2018-19 Capital Expenditure Requests

1-Patient Safety, Regulatory Compliance
2-Patient Satisfaction
3 - Strategic Purchase & New Services
4 - End of Life Assets
5- Dependent on EHR Selection/Installation
6- Future year purchase per Exec
7- Staff Safety
8 - OSHPD Required

Dept ID	Department	Description	Purpose	Est Cost of Capital > $2,500	Yrs of Life	Primary Reason	Secondary Benefit	Med Staff Priority	note	Annual Est. Depr
7427	PACU	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
7420	Operating Rooms	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
	CT - Radiology	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
	EKG	Zoll R Series ALS Defibrillator	Replace Phillips units that are at end of life	$ 17,965.35	7	4	1	M		$ 2,566.48
	Education	Zoll R Series ALS SurePower Station & 4 extra batteries	Replace Phillips units that are at end of life	$ 3,465.25	7	4	1	M		$ 495.04
7010	Emergency Department	Replace to Workstations on Wheels (2)	Computer system on wheels for care coordination	$ 9,300.00	7	4	7	M		$ 1,328.57
7730	Pulmonary Function	Pulmonary Function System (replace 2008)	Provide pulmonary function studies	$ 47,000.00	8	4		H		$ 5,875.00
	Rural Health Clinic	Laboratory Room Refrigerator	End of Life Replacement	$ 4,000.00	7	4		H		$ 571.43
	Rural Health Clinic	Medication Freezer	End of Life Replacement	$ 6,000.00	7	4		H		$ 857.14
	Rural Health Clinic	Medication Refrigerator	End of Life Replacement	$ 4,000.00	7	4		H		$ 571.43
	Dietary	Vulcan double deck oven	End of Life Replacement	$ 7,360.00	7	4		H		$ 1,051.43
	Property Management	Archtectuaral fee's for various OSHPD projects		$ 250,000.00	10	4		M		$ 25,000.00
	Property Management	Replacement Plotter for drawings	Current unit is 9 years old	$ 30,000.00	7	4		L	wait for failure	$ 4,285.71
	Property Management	New Signs around campus	Replace sun damaged and out of date signage	$ 25,000.00	10	4		M		$ 2,500.00
	Security	Security camera software/hardware upgrade		$ 49,520.00	7	4		M		$ 7,074.29
6170	Med/Surg Inpatient	Refrigerator & Freezer Combo	True T023DT model	$ 6,500.00	7	4		H		$ 928.57
6170	Med/Surg Inpatient	Medication Refrigerator	End of Life Replacement	$ 5,000.00	7	4		H		$ 714.29
6170	Med/Surg Inpatient	Replace to Workstations on Wheels (2)	Computer system on wheels for care coordination	$ 11,175.00	5	4		H		$ 2,235.00
6010	ICU	Dietary Refridgerator	End of Life Replacement	$ 4,000.00	7	4		H		$ 571.43
6010	ICU	Hillrom pro 825 P7500 Progressa bed package	End of Life Replacement	$ 33,600.00	10	4		M	could delay nine months	$ 3,360.00
6010	ICU	Replace to Workstations on Wheels	Computer system on wheels for care coordination	$ 5,587.58	5	4		H		$ 1,117.52
7450	Anesthesia	Anesthesia Patient Monitors(3 plus transport unit)	GE units at end of life and no interface with Athena	$ 172,050.00	7	4	5	M	Review Athena interface/vendor	$ 24,578.57
7010	Emergency Department	Cardiac Monitors	End of Life Replacement	$ 34,136.50	7	4		H		$ 4,876.64
7010	Emergency Department	Cardiac Montiors - Primary Server	End of Life Replacement	$ 34,136.50	7	4		H		$ 4,876.64
6170	Med/Surg Inpatient	Cardiac Monitors with hardware, software and install	End of Life Replacement	$ 93,500.00	7	4		H		$ 13,357.14
7427	Surgery & PACU	Stryker eye gurney	End of Life Replacement	$ 8,236.00	7	4		H		$ 1,176.57
7427	PACU	PACU gurneys (2)	End of Life Replacement	$ 15,874.00	7	4		H		$ 2,267.71
7427	PACU	Bladder scanner	allow postoperative bladder assessment	$ 9,615.00	5	4		M	can they share with med/surg?	$ 1,923.00
6400	Perinatal	Ultrasound unit for the bedside	End of Life Replacement	$ 16,000.00	7	4		L		$ 2,285.71
6400	Perinatal	Radiant Infant Warmer	End of Life Replacement	$ 18,500.00	7	4		H		$ 2,642.86
6400	Perinatal	Dietary Refridgerator	End of Life Replacement	$ 4,000.00	7	4		H		$ 571.43
6400	Perinatal	Breastmilk Refridgerator	End of Life Replacement	$ 5,400.00	7	4		H		$ 771.43
6400	Perinatal	Laboratory Room Refrigerator	End of Life Replacement	$ 4,000.00	7	4		H		$ 571.43
7420	Surgery	Replace all 9 current Operating Room Monitors	End of Life Replacement with upgrade in system	$ 47,872.00	5	4		H		$ 9,574.40
6400	Perinatal	Replace to Workstations on Wheels (3)	Computer system on wheels for care coordination	$ 16,765.00	5	4		H		$ 3,353.00
8380	Sterile Processing	V-Pro-Max Steris hydrogen peroxide sterilizer	Improved results over current V-Pro	$ 120,256.00	5	4		H		$ 24,051.20
	Nuclear Medicine	Gamma Camera	End of Life Replacement as software is outdated	$ 340,000.00	7	4		H		$ 48,571.43
	Diagnostic Imaging	GE TIMS Unit - video recording of swallow studies	End of Life Replacement	$ 25,000.00	7	4	3	H	Need to coordinate with other	$ 3,571.43
	Pathology	Laboratory Room Refrigerator	End of Life Replacement	$ 4,000.00	7	4		H		$ 571.43

Northern Inyo Hospital - 2018-19 Capital Expenditure Requests									
1-Patient Safety, Regulatory Compliance	3 - Strategic Purchase & New Services	5- Dependent on EHR Selection/Installation	7- Staff Safety						
2-Patient Satisfaction	4 - End of Life Assets	6- Future year purchase per Exec	8 - OSHPD Required						
Dept ID	**Department**	**Description**	**Purpose**	**Est Cost of Capital > $2,500**	**Yrs of Life**	**Primary Reason**	**Secondary Benefit**	**Med Staff Priority**	**note**	**Annual Est. Depr**
8460	Maintenance	Penthouse Area Above Infusion Roof Replacement	End of Life Replacement	$ 15,000.00	10	4		H		$ 1,500.00
8460	Maintenance	Replace steam humidifier	End of Life Replacement	$ 19,000.00	10	4		H	2018 approved	$ 1,900.00
8460	Maintenance	A.C. Units for Back up cooling of the lab	End of Life Replacement	$ 13,255.00	10	4		M		$ 1,325.50
8460	Maintenance	Storage racks for workshop	allow for new product to lay flat	$ 5,000.00	10	4		L		$ 250.00
6170	Med/Surg Inpatient	Nursing Station Printer	Fax, Copy with Color	$ 9,800.00	7	5		M		$ 1,400.00
7010	Emergency Department	Hospital PIICiX ADT & Vital Sign Results via IBE	Moves Philips monitor results into Athena	$ 19,100.00	5	5		H		$ 3,820.00
	Pharmacy	Hardware & software to process electronic presciptions	from surescripts for employee pharmacy plan	$ 19,822.00	3	5		L		$ 6,607.33
	Maintenance	Replace manual locks with Badge Swipe	9 locations including MRI, Med Rec & Dietary	$ 40,000.00	5	7		L		$ 8,000.00
8390	Pharmacy	Modular Clean Room	Upgrade clearn room to be CDPH and OSHPD compliant	$ 210,859.00	15	8		2018	OSHPD Required	$ 7,028.63
8390	Pharmacy	Relocated Pharmacy to 1981 building	Upgrade to be CDPH and OSHPD compliant	$ 1,534,464.00	15	8		2018	OSHPD Required	$ 51,148.80

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending February 28, 2018

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	910,803	726,573	184,230	7,598,787	6,305,630	1,293,157
Ancillary	2,450,485	2,520,362	(69,877)	22,004,175	21,873,074	131,101
Total Inpatient Service Revenue	3,361,288	3,246,935	114,353	29,602,962	28,178,704	1,424,258
Outpatient Service	8,349,751	7,333,608	1,016,143	68,223,532	63,645,294	4,578,238
Gross Patient Service Revenue	**11,711,039**	**10,580,543**	**1,130,496**	**97,826,493**	**91,823,998**	**6,002,495**
Less Deductions from Revenue						
Patient Service Revenue Deductions	257,737	212,005	45,732	1,824,551	1,839,926	(15,375)
Contractual Adjustments	5,435,110	4,058,195	1,376,915	40,801,648	35,219,351	5,582,297
Prior Period Adjustments	(722,407)	(12,103)	(710,304)	(1,652,863)	(105,037)	(1,547,826)
Total Deductions from Patient Service Revenue	**4,970,440**	**4,258,097**	**712,343**	**40,973,335**	**36,954,240**	**4,019,095**
Net Patient Service Revenue	**6,740,598**	**6,322,446**	**418,152**	**56,853,158**	**54,869,758**	**1,983,400**
Other revenue	30,520	69,385	(38,865)	370,248	602,164	(231,916)
Total Other Revenue	**30,520**	**69,385**	**(38,865)**	**370,248**	**602,164**	**(231,916)**
Expenses:						
Salaries and Wages	2,085,646	2,103,377	(17,731)	16,918,577	18,254,308	(1,335,731)
Employee Benefits	1,327,477	1,436,056	(108,579)	12,560,829	12,462,834	97,995
Professional Fees	788,438	654,396	134,042	8,182,763	5,679,225	2,503,538
Supplies	707,392	585,726	121,666	5,730,723	5,083,300	647,423
Purchased Services	369,087	325,242	43,845	2,436,182	2,822,612	(386,430)
Depreciation	410,329	400,149	10,180	3,270,484	3,472,726	(202,242)
Bad Debts	207,199	219,289	(12,090)	1,923,931	1,903,113	20,818
Other Expense	421,495	318,568	102,927	3,272,046	2,764,722	507,324
Total Expenses	**6,317,063**	**6,042,803**	**274,260**	**54,295,536**	**52,442,840**	**1,852,696**
Operating Income (Loss)	**454,056**	**349,028**	**105,028**	**2,927,870**	**3,029,082**	**(101,212)**
Other Income:						
District Tax Receipts	43,955	44,345	(390)	351,640	384,851	(33,211)
Tax Revenue for Debt	128,647	149,472	(20,825)	1,029,174	1,297,203	(268,029)
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	8,604	38,356	(29,752)	1,529,932	332,878	1,197,054
Interest Income	24,582	15,215	9,367	238,372	132,044	106,328
Interest Expense	(238,189)	(235,333)	(2,856)	(1,990,892)	(2,042,352)	51,460
Other Non-Operating Income	4,651	2,188	2,463	36,961	18,986	17,975
Net Medical Office	(378,800)	(358,310)	(20,490)	(2,878,421)	(3,109,592)	231,171
340B Net Activity	-	15,343	(15,343)	(3,251)	133,156	(136,407)
Non-Operating Income/Loss	**(406,550)**	**(328,724)**	**(77,826)**	**(1,686,484)**	**(2,852,826)**	**1,166,342**
Net Income/Loss	**47,506**	**20,304**	**27,202**	**1,241,386**	**176,256**	**1,065,130**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending February 28, 2018

		FYE 2018	FYE 2017		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	284	2,498	2,340	158	7%
Total Patient Days without NB	268	2,275	2,112	163	8%
Swing Bed Days	51	280	307	(27)	-9%
Discharges without NB	81	726	714	12	2%
Swing Discharges	4	39	46	(7)	-15%
Days in Month	31	31	31		
Occupancy without NB	8.65	73.39	68.13	5.3	8%
Average Stay (days) without NB	3.31	3.13	2.96	0.2	6%
Average LOS without NB/Swing	2.82	2.90	2.70	0.2	7%
Hours of Observation	578	7,113	6,056	1,057	17%
Observation Adj Days	24	296	252	44	17%
ER Visits All Visits	744	6,450	6,509	(59)	-1%
RHC Visits	2,161	20,677	16,996	3,681	22%
Outpatient Visits	3,515	31,228	28,645	2,583	9%
IP Surgeries	15	161	187	(26)	-14%
OP Surgery	100	861	776	85	11%
Worked FTE's	368.48	341.93	327.57	14	4%
Paid FTE's	401.83	388.67	367.49	21	6%
Hours Worked to Hours Paid%	91.7%	88.0%	89.1%	-1.2%	-1%
Payor %					
Medicare		43%	41%	2%	
Medi-Cal		20%	23%	-3%	
Insurance, HMO & PPO		35%	33%	2%	
Indigent (Charity Care)		0.9%	1.2%	-0.2%	
All Other		2%	2%	0%	
Total		100%	100%		

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending February 28, 2018

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	9,665,123	9,067,440	597,683
Short-Term Investments	8,990,039	9,074,767	(84,728)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	63,663,215	63,189,156	474,059
Less: Allowances	(47,471,997)	(47,016,868)	(455,128)
Other Receivables	1,375,941	1,231,898	144,043
Inventories	4,012,133	3,993,471	18,662
Prepaid Expenses	1,694,749	1,714,912	(20,162)
Total Current Assets	**43,023,233**	**42,348,805**	**674,429**
Internally Designated for Capital Acquisitions	1,125,364	1,125,321	43
Special Purpose Assets	1,269,481	1,269,436	44
Limited Use Asset; Defined Contribution Pension	1,150,730	1,066,002	84,728
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	10,445	9,317	1,128
Revenue Bonds Held by a Trustee	2,527,091	2,366,034	161,057
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,448,495**	**19,201,496**	**247,000**
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated Depreciation	77,328,068	77,636,929	(308,861)
Unamortized Bond Costs	-	-	-
Total Assets	**141,549,796**	**140,937,230**	**612,567**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending February 28, 2018

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,115,347	2,120,589	(5,242)
Accounts Payable	2,355,196	1,751,688	603,508
Accrued Salaries, Wages & Benefits	5,493,319	5,351,652	141,667
Accrued Interest and Sales Tax	442,930	312,947	129,983
Deferred Income	1,394,916	1,874,288	(479,372)
Due to 3rd Party Payors	1,099,914	1,029,914	70,000
Due to Specific Purpose Funds	-	-	-
Other Deferred Credits; Pension	4,517,261	4,516,133	1,128
Total Current Liabilities	**17,418,882**	**16,957,211**	**461,671**
Long Term Debt, Net of Current Maturities	41,839,947	41,839,947	-
Bond Premium	563,480	570,727	(7,247)
Accreted Interest	11,751,484	11,640,935	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**84,642,444**	**84,539,141**	**103,302**
Net Assets			
Unrestricted Net Assets less Income	38,218,990	38,171,441	47,549
Temporarily Restricted	1,269,481	1,269,436	44
Net Income (Income Clearing)	(1,241,628)	(1,194,122)	(47,506)
Total Net Assets	**39,488,471**	**39,440,878**	**47,593**
Total Liabilities and Net Assets	**141,549,796**	**140,937,230**	**612,567**

Northern Inyo Healthcare District

Preliminary Financial Indicators as of February 28, 2018

	Target	Feb-18	Jan-18	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17
Current Ratio	>1.5-2.0	2.47	2.50	2.41	2.18	2.26	2.45	2.42	2.49	3.39	3.83	3.51	3.41	3.45
Quick Ratio	>1.33-1.5	2.06	2.09	1.99	1.83	1.84	1.82	1.81	2.05	2.84	3.23	2.96	2.88	2.90
Days Cash on Hand prior method	>75	168.44	166.36	165.72	169.35	165.31	140.47	142.06	160.31	154.70	160.60	159.55	160.80	157.10
Days Cash on Hand Short Term	>75	83.49	81.30	83.05	87.18	81.28	53.95	59.26	79.93	79.37	75.71	76.12	77.66	79.99
Debt Service Coverage	>1.5-2.0	2.68	2.73	2.67	2.74	2.78	2.79	2.87	2.34	1.81	1.96	1.91	2.07	2.23
Operating Margin		5.09	4.87	5.79	5.87	7.64	7.49	8.45	6.67	4.71	6.18	6.06	6.01	6.83
Outpatient Revenue % of Total		69.74	69.53	69.25	69.52	69.46	69.13	69.83	66.58	69.86	69.96	69.76	69.43	69.11
Cash flow (CF) margin (EBIDA to revenue)		4.17	4.31	4.05	4.30	4.69	4.82	5.62	3.68	2.48	2.84	2.59	3.41	4.27
Days in Patient Accounts Receivable	<60 Days	85.60	85.90	82.80	81.80	81.40	82.10	81.40	74.10	78.90	89.00	86.00	85.10	76.70

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 Receivlable 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

Preliminary BUDGET VARIANCE ANALYSIS

Feb-18 *Fiscal Year Ending June 30, 2018*

Year to date for the month ending February 28, 2018

158	or	6.8%	more IP days than in the prior fiscal year
$ 1,424,258	or	5.1%	over budget in Total IP Revenue and
$ 4,578,238	or	7.2%	over budget in OP Revenue resulting in
$ 6,002,495	or	6.5%	over budget in gross patient revenue &
$ 1,983,400	or	3.6%	over budget in net patient revenue

Year-to-date Net Revenue was			$	56,853,158
Total Operating Expenses were:			$	54,295,536
				for the fiscal Year To Date
$ 1,852,696	or	3.5%		over budget. Salaries and Wages were
$ (1,335,731)	or	-7.3%		under budget and Employee Benefits
$ 97,995	or	0.8%		over budget
		74%		Employee Benefits as Percentage of Wages

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

$ 2,503,538	or	44.1%	Professional Fees are over budget due to contract labor budgeted as employees
$ 507,324	or	18.3%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending

Other Information:

$ 2,927,870			Operating Income, less
$ (1,686,484)			loss in non-operating activities resulted in a Net
$ 1,241,386	or	$ 1,065,130	over budget.
		41.88%	Actual Contractual Percentages for Year versus
		40.24%	Budgeted Contractual Percentages including

$ 1,652,863 in prior year cost report favorable settlement activity for Medicare & Medi-Cal

Non-Operating activities included:

$ (2,878,421) loss		$ 231,171	favorable to budget in Medical Office Activities
$ 1,529,932		$ 1,197,054	favorable to budget in Grants and Other Contributions

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending February 28, 2018

	Current Month	Prior Month	Change
Board Designated Funds:	February		
Tobacco Fund Savings Account	$ 1,098,638	$ 1,098,595	43
Equipment Fund Savings Account	$ 26,726	$ 26,726	-
Total Board Designated Funds:	**$ 1,125,364**	**$ 1,125,321**	**$ 43**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 1,158,904	$ 1,158,859	$ 44
Nursing Scholarship Savings Account	$ 10,448	$ 10,448	$ -
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,053	$ 100,053	$ -
Total Specific Purpose Funds:	**$ 1,269,481**	**$ 1,269,436**	**$ 44**
Grand Total Restricted and Specific Purposes Funds:	**$ 2,394,845**	**$ 2,394,758**	**$ 87**

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of February 28, 2018

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	28-Feb-18	01-Mar-18	Local Agency Investment Fund	Northern Inyo Hospital	1.41%		8,740,038.53
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				Short Term Investments			8,990,038.53
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	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		$	10,740,038.53
1	28-Feb-18	01-Mar-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.41%	$	1,150,729.80
				LAIF PENSION INVESTMENTS		$	1,150,729.80

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Chart Check Guidelines**	
Scope: ICU, Med/Surg & Perinatal	Department: **ICU/CCU, Medical/Surgical, Perinatal**
Source: Manager ICU/Medical-Surgical	Effective Date:

PURPOSE:
Verification of the completion and processing of physician or Advanced Practice Provider (APP) orders and other documentation in the medical record and electronic medical record (EMR)

POLICY:
Inpatient units will check the medical record, including physician & APP orders, once daily on the PM shift to assure orders are being carried out as written and required documentation has occurred. If work load doesn't allow time for completion of daily chart check, the task will be passed on to the oncoming shift.

PROCEDURE:

A. It will be the responsibility of the PM licensed nurse to ensure that:
   1. Within the first 24 hours of admission (the time of admission is located on the patient's face sheet):
      a. Home Medication Verification has been completed by an NIHD RN. This may be done in the ED, Pre-operative area or on the inpatient unit; however it only needs to be done once upon entrance into the system to determine home medications prescribed and being taken by the patient.
      b. Medication Reconciliation has been completed by the physician or APP.
      c. VTE Assessment has been completed in the EHR.
      d. Any noted wound has an initial photograph documentation completed.
      e. Any patient with an indwelling urinary catheter has documentation of rationale for device.
      f. Any patient with a central line has physician documentation of the rationale for device.
      g. Any patient in restraints has a restraint order that has been authenticated by the physician or APP within policy. Nursing documentation per policy is in compliance.
      h. Nursing care plan has been initiated based upon diagnosis and individualized to the patient needs.
      i. Case Management intake assessment has been completed.

   2. Throughout patient stay - all orders have been correctly processed.
      a. Check orders to see if they have been completed.
      b. Review to determine that consultants have been contacted and/or have seen the patient within 24 hours of the order.
      c. All paper documents in the non-electronic portion of the patient record have correct patient labels.
      d. All outstanding orders have been brought to the attention of the charge nurse/department clerk.
      e. Verify that a progress note has been written by a physician or APP on all observation or admitted patients. (Swing patients must be seen at least weekly by physician/APP with a progress note.)
      f. Nursing care plan has been updated as goals are met or change.

   3. Communication of chart check results:
      a. Concerns related to missing items will be communicated to the physician/APP directly if they are present on the unit during the hours of 2200 to 0700 or via telephone if they impact patient care causing an immediate concern.
      b. Concerns related to missing items that do not cause immediate concern will be discussed at shift change by the off going/on coming RNs.
      c. RN performing the chart check will document "24 hour chart check completed" in the progress note within the electronic health record of the patient.

References:
1.

Comment [AK1]: Pharmacy technicians are also doing this.

Comment [AK2]: Current practice is that any wounds besides surgical wounds require a photo upon admission, as needed, and on discharge. Photos of surgical wounds are only taken when warranted due to the nature of the wound and as needed (ex: we don't take pictures of a routine knee arthroplasty).

Comment [RC3]: Daily necessity

Comment [RC4]: Daily

Comment [RC5]: This includes the time and date of each entry (orders, reports, notes, medications etc.) .

Comment [RC6]: Care plan must be evaluated each shift and closed when patient is discharged to transferred to another facility

Comment [RC7]: This has not been built. Current practice the nurse would review CPOE and initial and date. I am hoping with Athena the orders will not be printed out.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Chart Check Guidelines**	
Scope: ICU, Med/Surg & Perinatal	Department: **ICU/CCU, Medical/Surgical, Perinatal**
Source: Manager ICU/Medical-Surgical	Effective Date:

Cross Reference P&P:

1.

Committee Approval	**Date**
NEC	**4/4/18**
Board of Directors	
Board of Directors' Last Review	

Developed: 3/18ta
Reviewed:
Revised:
Supercedes:

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: **Privacy Officer**	Effective Date: 4-26-2018

PURPOSE:

To define the policy and procedures for investigations of suspected breaches of the privacy or security of protected health information and the reporting of such breaches to legally required entities.

Definitions

Breach/Unauthorized Activity - The unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.

Compromise the Security or Privacy of PHI – An act or omission that poses a significant risk of financial, reputational or other harm to the subject of PHI.

Disclosure - The release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

Electronic Protected Health Information or ePHI*:* Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all PHI that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive (USB), or other media.

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Unsecured PHI – PHI that is not secured through use of technology or methods approved by the Secretary of Health and Human Services.

Use – The sharing, employment, application, utilization, examination, or analysis of individually identifiable information within an entity that maintains such information.

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care, treatment, or services of NIHD's patients.

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: **Privacy Officer**	Effective Date: 4-26-2018

POLICY:

Northern Inyo Healthcare District (NIHD) shall comply with breach notification requirements under federal and state law, including the HIPAA privacy and security regulations, the HITECH regulations, the California Medical Information Act, and other relevant regulations. The Compliance Department shall investigate potential breaches of PHI and ePHI, determine whether notification is required, and manage the investigation, notification, and post-investigation process, as applicable.

A. Reporting Potential Breaches

1. NIHD workforce are required to immediately report unauthorized acquisition, access, use, or disclosure of PHI ("Breaches") to the Compliance Department utilizing the reporting form provided by NIHD on the NIHD Intranet in person, via interoffice email, or via email. Breaches are determined to be discovered when made known to NIHD workforce other than the workforce member(s) who engaged in the unauthorized activity.

2. Examples of potential Breaches that the workforce should report include but are not limited to:

    a. PHI mailed, faxed or electronically transmitted to the wrong recipient ;
    b. Accessing the medical record of a co-worker, colleague, friend, family member or celebrity without authorization;
    c. Lost or stolen computers, laptops, PDAs, or other electronic computing devices;
    d. Lost or stolen medical records, computer disks or other paper or electronic files;
    e. Unlawful verbal disclosures of PHI;
    f. Posting PHI on public websites;
    g. Malicious software virus detected in electronic information systems used in connection with PHI; and
    h. Intentional access to PHI for non-treatment, non-payment or non-healthcare operation purposes.

B. Preliminary Investigation

The Privacy Officer or designee shall conduct a preliminary investigation of all reports of unauthorized activity, and shall:

1. Determine if the unauthorized activity involved Unsecured PHI or other individually identifiable information subject to protections under state or federal laws.
2. Confirm additional facts underlying each report of unauthorized activity by reviewing the submitted PHI Breach Report form.

C. Assessment of Potential Breaches

In assessing a potential breach, the Privacy Officer shall:

1. Determine whether the potential breach fits within one of the following exceptions to the definition of Breach:

    a. The unauthorized activity involved the unintentional acquisition, access, or use of PHI by an NIHD workforce member;
    b. The unauthorized activity involved the inadvertent disclosure of PHI from an authorized workforce member or authorized individual within NIHD to another authorized member or authorized individual within NIHD; or
    c. The unauthorized activity involved unauthorized disclosures in which an unauthorized person to whom PHI was disclosed would not have been able to retain the information.

2. Conduct an assessment to determine whether the unauthorized activity poses a significant risk of financial, reputational or other harm to the subject of the PHI. The assessment may be conducted using the HIPAA Breach Decision Tool and Risk Assessment Documentation which may be found in the California Hospital Association Privacy Manual;
3. Determine whether steps were or should be taken to mitigate any known harm arising from the unauthorized activity;
4. Determine whether individual, governmental or other notice is required under federal or state law and oversee the provision of such notice; and
5. Create and maintain documentation regarding the investigation, risk assessment and related decision-making regarding the Privacy Officers review and response to the unauthorized activity.

D. Notification

1. Breach of PHI

Title: **Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: **Privacy Officer**	Effective Date: 4-26-2018

When the Privacy Officer determines a Breach has occurred, notification shall be made in accordance with the following:

a. Patient notice timing: Patient notification must be made without unreasonable delay and in no event later than 15 business days of discovery of the Breach.
b. Patient notice method: Notice to the patient(s) shall be provided in writing by USPS First Class or certified mail or by email if the individual has indicated a preference to receive email communications. For individuals for whom NIHD has insufficient contact information, refer to the U.S. Code of Federal Regulations, 45 C.F.R. 164.404, or the Privacy Officer should consult NIHD Legal Counsel.
c. Notice to the patient(s) shall contain a form titled "Notice of Data Breach,":
    a. The security breach notification shall be written in plain language, shall be titled "Notice of Data Breach," and
    b. Shall present the information under the following headings:
        i. "What Happened,"
        ii. "What Information Was Involved,"
        iii. "What We Are Doing,"
        iv. "What You Can Do," and
        v. "For More Information."
    c. Additional information may be provided as a supplement to the notice.
d. NIHD shall offer paid credit monitoring to patient(s) whose social security number, credit card information, or other significant financial information has been breached. The offer shall be for no less than 12 consecutive months of credit monitoring service.
e. California Department of Public Health (CDPH) notification must be made without unreasonable delay and in no event later than 15 business days of discovery of the Breach. Notice to the CDPH shall be provided online through the California Healthcare Event and Reporting Tool (CalHEART). CDPH notification shall include all fields on the CalHEART notification tool.
f. Media Notification: If a Breach of Unsecured PHI involves the PHI of more than 500 residents of a state, notification must be made to a prominent media outlet without unreasonable delay and in no event later than 15 business days of the discovery of the Breach. The Privacy Officer

shall consult with NIHD Legal Counsel for consultation prior to publication of any Media Notification.

g. Notification to the U.S. Department of Health and Human Services' Secretary ("Secretary"): If a Breach of Unsecured PHI involves the PHI of 500 or more individuals, notification must be made to the Secretary. Such notification shall be made at the same time individual notification is provided. In addition, notification of Breaches of individual PHI or Breaches of less than 500 individuals shall be made to the Secretary no later than 60 calendar days after the end of each calendar year. Nothing herein prevents the Privacy Officer of notifying the Secretary at the same time notification is made to CDPH.

Comment [e1]: Business or calendar?

E. HIPAA Accountings of Disclosures

The Privacy Officer or designee shall determine whether unauthorized activity is subject to inclusion in disclosures which must be tracked in order to comply with HIPAA accountings and disclosures requirements.

F. Breaches Involving Business Associates

In the event NIHD is notified of unauthorized activity by an NIHD HIPAA Business Associate, the Privacy Officer will investigate and assess the potential Breach in accordance with the Business Associate Agreement. The NIHD Privacy Officer or designee will coordinate with appropriate representatives of the Business Associate in order to ensure that NIHD receives all relevant and necessary information and documentation, and in accordance with the terms of the applicable Business Associate Agreement.

G. Post-Investigation Follow-up

1. The Compliance Department will work with Legal Counsel, Information Technology Services, Human Resources, Risk Management and any other department as necessary to mitigate any harmful effects of any breach that are known to NIHD.
2. The Compliance Department shall document and track a plan of action, if any, including Sanctions, as appropriate.

REFERENCES:

1. 42 U.S.C. Section 17932
2. 45 CFR 164.400

NORTHERN INYO HOSPITAL
MEDICAL RECORDS
POLICY AND PROCEDURE

Title: **Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information**	
Scope: **Hospital Wide**	Manual: **Compliance**
Source: **Privacy Officer**	Effective Date: 4-26-2018

3. California Civil Code Section 1798.82
4. California Health and Safety Code Section 1280.15
5. California Civil Code Section 56.05

Approval	**Date**
Compliance and Business Ethics Committee	
Board of Directors	
Last Board review	

Responsibility for review and maintenance: Privacy Officer
Index Listings: Privacy, Breach, PHI
Developed: 3-5-14
Revised: 3/30/2018
Reviewed: 12/16/15

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: April 1, 2018

PURPOSE: Establishes requirements for auditing access to confidential information including protected health information in accordance with Northern Inyo Healthcare District (NIHD) policy and state and federal regulations.

Definitions:

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

Confidential Information - protected health information (confidential medical information), workforce and employee health information, and proprietary information related to providers, financial data, trade secrets, business information, information protected by law and any other information pertaining to NIHD unless specifically designated as not confidential. Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information may include, but is not limited to, the business, financial, marketing, and contract arrangements associated with District services and products. It also may include computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information may include management know-how and processes; District business and product plans with outside vendors; a variety of internal databases, and copyrighted material, such as software. (Information published by governmental agencies or the NIHD Board of Directors on public sites is not considered confidential information in the form in which it is supplied and published. NIHD is governed by and complies with all freedom of information laws, such as the California Public Records Act and the Freedom of Information Act.)

Covered Entity – (for the purpose of this policy) a healthcare provider, a health plan, or a healthcare clearinghouse who transmits any health information in electronic form.

Minimum Necessary - covered entity must make reasonable efforts to limit the use, disclosure, and/or request for protected health information, and other confidential information to the minimum necessary (lowest amount) to accomplish the intended purpose of the use, disclosure, or request.

Need-to-Know - access to only the data he or she needs to perform a particular function (role based access).

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: April 1, 2018

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Electronic Protected Health Information or ePHI*:* Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive (USB) or other media.

Breach - the unauthorized acquisition, access, use or disclosure of PHI and/or confidential information which compromises the security or privacy of the PHI or other confidential information.

POLICY:
Access to information systems is granted on a need-to-know basis and is based on one's role with NIHD.

Audits will be performed which evaluate whether information accessed was based on "minimum necessary" and "need-to-know" principles and standards and appropriate corrective action is taken as applicable.

AUDIT TYPES:

1. **Routine Audits –** Routine audits can include but are not limited to:

Audit	Description
Same Last Name	Workforce who access the record of a patient with the same last name
Same Department	Workforce who access the record of a co-worker who works in the same department
Workforce Hospital Admission	When a Northern Inyo Healthcare District employee is admitted to the hospital as a patient
Confidential Document	Workforce who access "confidential" documents
New Workforce Member	All access made by new workforce members are audited prior to the end of their 90 day introductory period
High Profile Individual	The patient is a newsworthy individual

2. **Audits for Specific Cause –** A request to audit for cause may come from various sources including but not limited to:
    a. Administration

b. Human Resources
c. Department Director/Manager
d. Board of Directors
e. Quality Assurance/Performance Improvement (QAPI) professionals
f. Security Officer
g. Patient or representative
h. Community member

Audits for specific cause are conducted in all systems applicable to services provided at NIHD.

Causes or reasons for specific audits include but are not limited to:

Audit	Description
Internal Concern	Concern is expressed by a co-worker, Administration, Department Manager, Security Officer or other user
Patient Complaint	Patients request an audit of access to their medical record
Employee Family Member Admission	When an workforce member's family member is admitted as a patient
Restricted Information Patients	Users who access a patient's record who requests restricted access
Follow-Up	Workforce who have been subject to corrective action(s) for accessing records inappropriately
Disciplined Workforce	Workforce who have been disciplined for accessing records inappropriately

3. **Random Audits –** Random audits may be performed on clinical systems and may be done to determine clean-up of inactive users.

Audits Investigated and Evaluated

1. The Compliance Department will review the audit results for potential breaches of patient privacy based and confidential information on "minimum necessary" and "need-to-know" principles. When questionable access is discovered on the audit report:

    a. A member of the Compliance Department will meet with the workforce member requesting information and an explanation for accessing the

patient or other information. For workforce members covered by a Memorandum of Understanding (MOU), any meeting will conform to the MOU's process. If further information is required based on the information received, meetings with additional workforce may occur. Follow up with any findings will be done with relevant workforce member(s).

b. If the audit findings reveal, as determined by the Compliance/Privacy Officer, activity that appears to constitute a breach of confidentiality, audit and investigation results for disciplinary determination will be reported to, at a minimum, the following:

   i. Human Resources and/or the workforce members' department manager/supervisor.
   ii. State and/or Federal agencies, in accordance with current law.
   iii. For each breach, the department manager/supervisor shall follow up with appropriate corrective action(s) as applicable to each finding and report such actions taken to the Compliance Department.
   iv. Department manager/supervisor shall submit copies of all documents for workforce corrective action(s) to the Compliance Department and the Human Resources department.

Audit Record Disposition and Retention

1. Audit reports are confidential documents. Copies of audit reports will be shared internally with Administration and management as necessary, and disclosed as required by law or for other business operations.

2. Audit for specific cause outcomes may be communicated to the requestor via mail or telephone, as determined by the Compliance/Privacy Officer.

3. Audit results will be retained according to state and federal regulations.

Availability and Retention of Documents

1. Audit documents will be made available to appropriate workforce members, as needed for review, discussion, and appropriate corrective action per NIHD policy and any applicable MOU.

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: April 1, 2018

2. Audit documents will be made available to state and federal investigators upon request.
3. Audit documentation shall be maintained for no less than three (3) years.
4. Policy documents will be retained for no less than six (6) years from either the creation date or the last effective date, whichever is longer.

REFERENCES:

1. 45 CFR Part 164.308(a)(8) – Administrative Safeguards
2. 45 CFR Part 164.312 (a)(1) – Technical Safeguards
3. 45 CFR Part 164.308(a)(1)(ii)(D) – Administrative Safeguards
4. 45 CFR Part 164.312(b)– Administrative Safeguards
5. 45 CFR Part 164.316 – Policies and procedures and documentation requirements
6. TJC Standard IM.01.01.01
7. TJC Standard IM.02.01.01
8. TJC Standard IM.02.01.03
9. TJC Standard PI.03.01.01

Committee Approval	**Date**
Compliance Committee	1/31/2018
Administration	
Board of Directors	

Developed: 12/10/2013 KH
Revised: 9/1/2017, 3/29/2018PD
Reviewed: 12/16/15
Supersedes:

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

Medical Staff Services

Department: Medical Staff Administration

Pillars of Excellence: FY July 1, 2017-June 30, 2018 (**rolling quarter**)

Indicator	Baseline	Goal	Apr-Jun 2017 Q4	Jul-Sep 2017 Q1	Oct-Dec 2017 Q2	Jan-Mar 2018 Q3	YTD
Service							
1. Customer satisfaction							
a. Average Credentialing TAT (from receipt of complete application)	1 day	<21 days	14 d	9 d	8 d	16 d	12 d
b. Average Privileging TAT (from receipt of complete application)	17 days	<60 days	30 d	18 d	22 d	27 d	27 d
c. Percent on-time start	50%	100%	100%	92%	92%	100%	96%
2. Application times							
a. Average time for any application materials to be returned	23 days	<14 days	29 d	11 d	18 d	19 d	19 d
b. Average time for complete application to be returned	64 days	<45 days	48 d	36 d	38 d	32 d	37 d
Quality							
1. Credentialing/Privileging							
a. Percent processed within time frame specified in bylaws	100%	100%	100%	100%	100%	100%	100%
b. Percent of applicants granted temporary/expedited privileges	50%	<50%	13%	58%	33%	33%	36%
People							
1. Active Staff	38	N/A	39	39	41	41	
2. All Medical Staff Members and Allied Health Professionals	83	N/A	92	82	88	96	
3. Locums/Temporary Staff	1	N/A	3	9	5	5	
Finance							
1. Total applications processed	3	N/A	8	12	12	24	56
2. Number of locum tenens applications	1	N/A	3	6	5	4	18
3. Number of applications abandoned/discontinued	1	N/A	5	1	3	1	10

LEGEND	
	Exceeds/far exceeds goal
	Meets goal
	Does not meet goal
	Far from meeting goal

Dev. 2/17

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

Medical Staff Services

FY 2017-2018
Q3: January – March 2018

Narrative Notes:

The Medical Staff Office has seen a marked increase in the number of applications processed this quarter (doubled over the last quarter and approximately eight times the average numbers seen in 2015-2016), primarily due to NIHD's expansion of specialist services and the transition to a new radiology services contract. It is anticipated the number of applications will decrease next quarter, although the partnership with Adventist Health will likely keep an elevated number of applications until the program is fully established.

The increased workload caused the Medical Staff Office credentialing and verification process to double in time from 8 days to 16 days. However, the time to privilege an applicant did not exceed 30 days, which we consider to be a high customer satisfier.

Dianne Picken, M.S.
Medical Staff Support Manager
3/16/2018

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Attendance At Meetings	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Establish policy for Board of Directors (BOD) meeting attendance.

POLICY:

1. Directors are expected to the extent reasonable, to make good faith efforts to schedule vacation, business and personal commitments at time that with not conflict with the schedule of regular Board meetings.
2. It is recognized the timing of business and family commitments, since they involve addition people and outside factors, cannot always be controlled.

PROCEDURE:

1. Notwithstanding any other provision of law the term of any member of the BOD shall expire if they are absent from three consecutive regular Board meetings, or from three of any five consecutive meetings of the Board and the Board by resolution declares a vacancy exists.
2. As set forth in the Ralph M. Brown Act in CA Government Code Section 54953, a Director may attend a meeting by teleconference.

REFERENCES:

1. CA Health and Safety Code Section 32100.2
2. Ralph M. Brown Act in CA Government Code Section 54953

CROSS REFERENCE P&P:

1.

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

Developed: March 31, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Northern Inyo Healthcare District Board of Directors Meetings	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Establish procedures for Northern Inyo Healthcare District (NIHD) Board of Directors' (BOD) meetings.

POLICY:

1. All meetings of the NIHD BOD shall be conducted in accordance with the Ralph Brown Act, Government Code 54950 et seq. and such additional requirements as set forth in any other BOD Policy and Procedures.

PROCEDURE:

1. Meetings of the BOD shall be held at the NIHD Board Room located at 2957 Birch St. Bishop CA 93514 except as otherwise set forth in agenda notices.
2. Regular meetings shall be held the third Wednesday of each calendar month unless it is deemed necessary to cancel or hold the regular monthly meeting on a different date.
3. As the BOD encourages public participation at its meetings (whether regular, special, study sessions, or emergency) and to facilitate communications, the BOD will ensure agendas are posted in the required timeframe on the NIHD website in addition to other legal requirements. The place, date and time of the meeting shall be indicated on the agenda.
4. Each agenda shall include a time for public comment on non-agenda items as well as comment opportunity on each action agenda item when called.
5. If any Director is attending the meeting by teleconference, the location shall be posted and accessible to the public.
6. The President of the NIHD BOD shall preside at all board meetings at which they are present. In absence of the President, the Vice President shall perform the President's duties and have the President's rights. If both the President and Vice President are absent then the Secretary shall perform the President's duties and have the President's rights.
7. The President shall call the meeting to order at the time set on the agenda or as soon as a quorum is present.
8. A majority (3 of 5 members) shall constitute a quorum for transaction of business. An abstention does not count as a vote for or against.
9. If no directors are present the clerk of the board shall adjourn the meeting to a future date and time. A notice of the adjournment including the future date and time of the adjourned meeting shall be conspicuously posted on or near the door of the place where the meeting was held.
10. If the date of the adjourned meeting is within five (5) days of the original meeting, no new agenda need be posted if no additional agenda items are added. If the date of the adjourned meeting is more than five (5) days a new agenda must be posted.
11. The President of the BOD, as necessary to conduct business of the District, can call special meetings or study sessions.
12. Ordinarily, items on the agenda will be considered in the order set forth in the agenda. However, the President may alter the order of items on the agenda, as the President deems necessary for the good of the meeting.
13. The President may declare a short recess during any meeting.

Title: Northern Inyo Healthcare District Board of Directors Meetings	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

14. The President shall have the same rights as the other Board members in voting, introducing or seconding motions and resolutions as well as participating in discussions.
15. No action may be taken by secret ballot. (Government Code Section 54953(c).)
16. All votes taken during a teleconferenced meeting shall be by roll call. (Government Code Section 54953(b)(2).)
17. Directors shall observe all applicable conflict of interest rules. If a financial interest is determined by any board member they must abstain from any vote that may be in violation of Government Code 1090. The director shall leave the meeting room during any discussion and the vote and shall state the reason for abstention.
18. The annual organizational meeting shall be the regular BOD meeting held in December or at an earlier meeting if called. At that meeting officers shall be elected.5

REFERENCES:

1. Ralph Brown Act, Government Code 54950 et seq.
2. Government Code Section 54953(c)
3. Government Code Section 54953(b)(2)
4. Government Code 1090

CROSS REFERENCE P&P:

1.

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

Developed: March 31, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Basis of Authority: Role of Directors	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Establish governing Board of Directors (BOD) best practices and Director's roles.

POLICY:

1. A Director of Northern Inyo Healthcare District (NIHD) is to be conscientious and concerned with all aspects of the district including its financial health, community needs, quality of care, employee relations, and compliance with the law.
2. A Director must act in good faith, with the highest ethical standards, in the best interest of the organization.
3. A Director must act in a manner consistent with the Board's stated mission and bylaws and conduct their activities within the powers conferred upon them by federal, state, and local regulations.
4. A Director must work to ensure the District Missions, Vision, and Values are the center of decision-making.

PROCEDURE:

1. Apart from their normal function as part of the NIHD BOD a Director has no individual authority to commit the District to any policy, act, or expenditure, unless the BOD takes specific action to grant such authority as to a given matter.
2. The NIHD BOD primary responsibility is the formulation and evaluation of policy. Directors are responsible for monitoring the District's progress in attaining goals and objectives, while pursuing its mission.
3. Routine matters concerning the operations aspects of the District are to be delegated to the Chief Executive Officer of NIHD.
4. While the BOD is responsible for monitoring hospital management activities, a Board member shall not use inappropriate involvement in day-to-day management or interfere with senior management duties.
5. A Director shall not compete with the district or act on behalf of its competitors; not derive profits from inside information; not disclose confidential information; not accept improper payments or gratuities, and beware of potential conflicts of interest.
6. A Director has protection from organization and personal liability when their duties are exercised in good faith and legally using sound and informed judgment. Having all the information available to make a decision will not only increase the likelihood of making the right decision, but will go a long way to legally protect the BOD if they make a wrong one.
7. A Director is expected to become and stay current on District affairs and projects and become familiar with District financial reports and carefully review all materials in advance of Board Meetings.
8. A Director is expected to become familiar with the Ralph M. Brown Act and at all times conform to its policies and regulations.

REFERENCES:

1.

CROSS REFERENCE P&P:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Basis of Authority: Role of Directors	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

1.

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

Developed: March 31, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Reimbursement Of Expenses	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Procedure for reimbursement of qualified expenses to NIHD Board of Directors.

POLICY:

1. If requested, the District shall reimburse NIHD Directors for necessary travel and incidental expenses incurred in the performance of official duties as Directors, subject to requirements of the NIHD Policy and Procedures and the law.

PROCEDURE:

1. The following types of occurrences qualify for reimbursement if attended in the performance of official duties as NIHD Director.
    a. Training, workshops, seminars and conferences.
    b. Educational workshops, seminars, and conference.
    c. Meetings of local governmental entities and bodies.
    d. Meetings of community or civic groups or other state or national organizations.
    e. Any other activity approved by the BOD in advance of attendance.
2. Reimbursement for travel, meals, lodging, and other expenses shall be in accordance with the NIHD Travel and Reimbursement Policy.
3. Request for reimbursement shall include receipts for all expenses for which reimbursement is requested.

REFERENCES:

1.

CROSS REFERENCE P&P:

1. NIHD Travel and Reimbursement Policy and Procedure

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

Developed: March 26, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Election Procedures and Related Conduct	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

PURPOSE: Establish procedures for adherence to election process and conduct relating to elections as defined by state and county law for the five elected members of the Board of Directors.

POLICY:

1. Northern Inyo Healthcare District (NIHD) Board of Directors (BOD) shall consist of five elected members.
2. The District is divided into five (5) separate zones with each member living in and representing one of the zones.
3. An elected term shall be of four years duration.
4. There is no limit to the number of terms a member may serve.

PROCEDURE:

1. The District shall hold its general election consolidated with the statewide general election held on the first Tuesday after the first Monday in November in even numbered years.
2. The candidate receiving the most votes in each zone, even if not a majority shall be elected.
3. Unless as a result of a vacancy, all BOD terms shall be four (4) years.
4. Those Board members whose term in office has concluded shall continue on the board until the successor has qualified or the first Thursday in December following the election which ever is later.
5. All registered voters within each zone are qualified to run for office in their zone of residence.
6. Prospective Board members must be at least eighteen (18) years of age and District residents.
7. Interested candidates for the BOD are directed to the Inyo County Clerk/Recorder's office for information regarding the rules and regulations related to candidacy for a Board seat.
8. Law sets the candidate filing period for Statewide General Elections.
9. All candidates must file a Form 700 Statement of Economic Interest.
10. The candidate pays for the cost of the candidate's policy statement.
11. Directors shall not use any District resources, for example, photocopiers or paper supplies, or make requests of staff to produce or disseminate any partisan campaign material to be used in support of or in opposition to any candidate for public office or any ballot measure.
12. By law, NIHD may not use public funds or resources to advocate for or against any ballot measure or candidate.
13. It is permissible to use public funds for the dissemination of impartial educational information, to make a fair presentation of the facts to aid voters in making an informed decision.
14. It is permissible for the BOD to go on record at a public meeting in favor of or opposed to a particular ballot measure.

Title: Election Procedures and Related Conduct	
Scope: Board of Directors	Manual: BOD Policy Manual - Administration
Source: Board of Directors	Effective Date:

15. Directors shall not hand out any partisan campaign material supporting or opposing any candidate for public office or any ballot measure while the public Board meeting is in progress.

REFERENCES:

1. Inyo County Clerk/Recorder

CROSS REFERENCE P&P:

1.

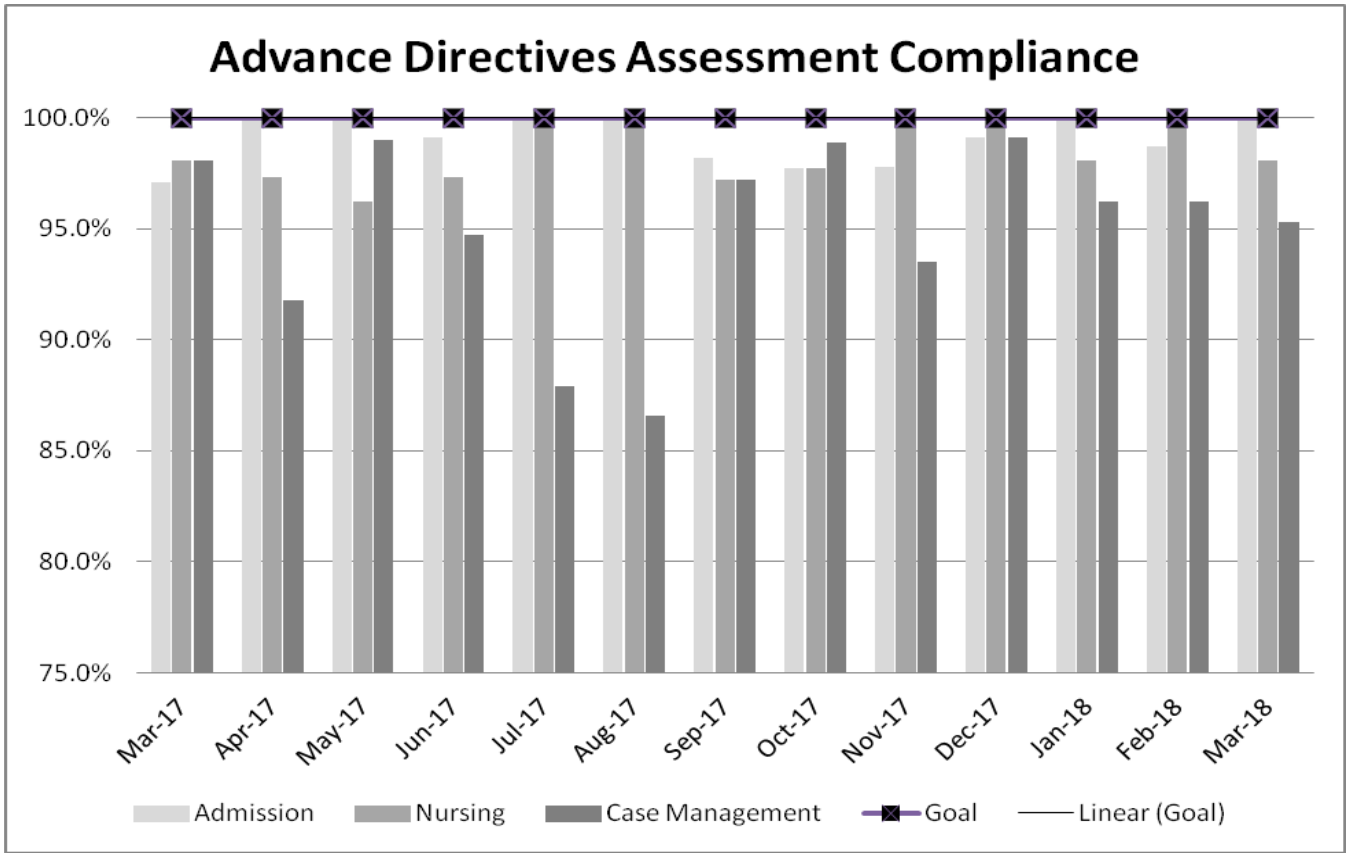
Approval	**Date**
Board of Directors	
Last Board of Directors Review	

Developed: March 31, 2018
Reviewed:
Revised:
Supersedes:
Index Listings:

2013 CMS Validation Survey Monitoring-April 2018

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.

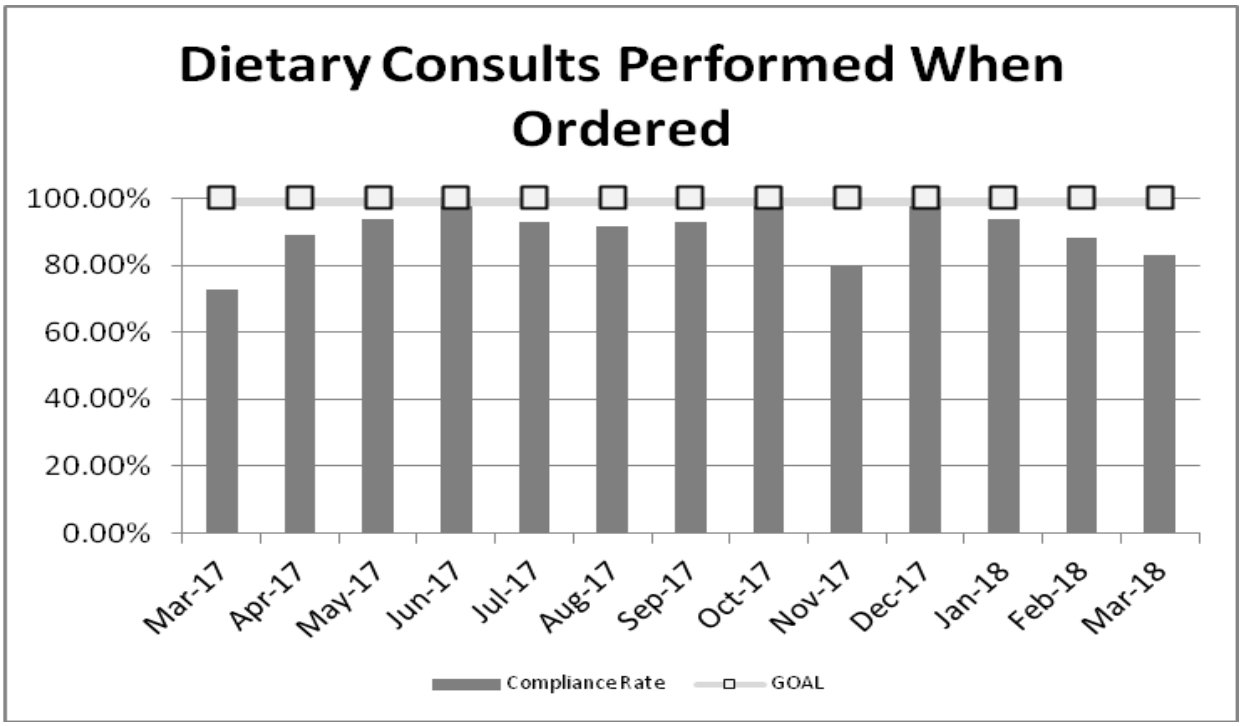


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

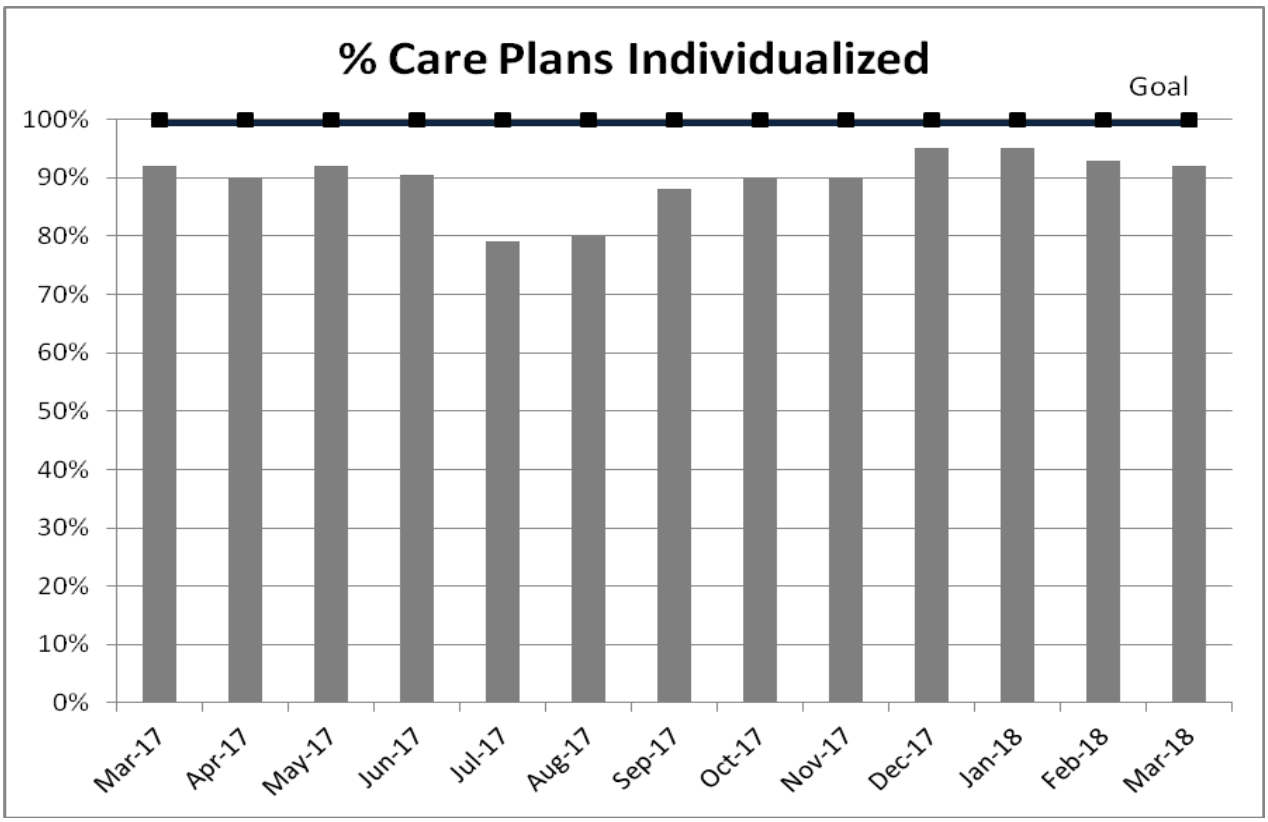
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    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.

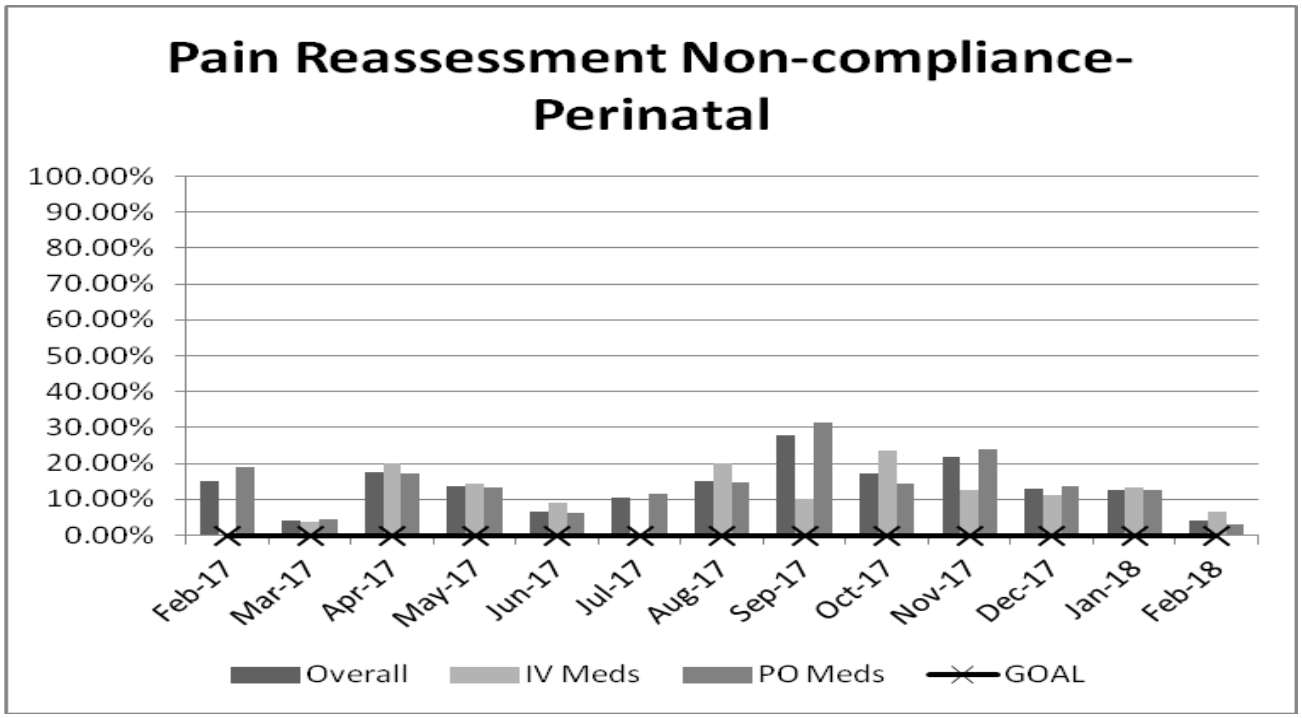


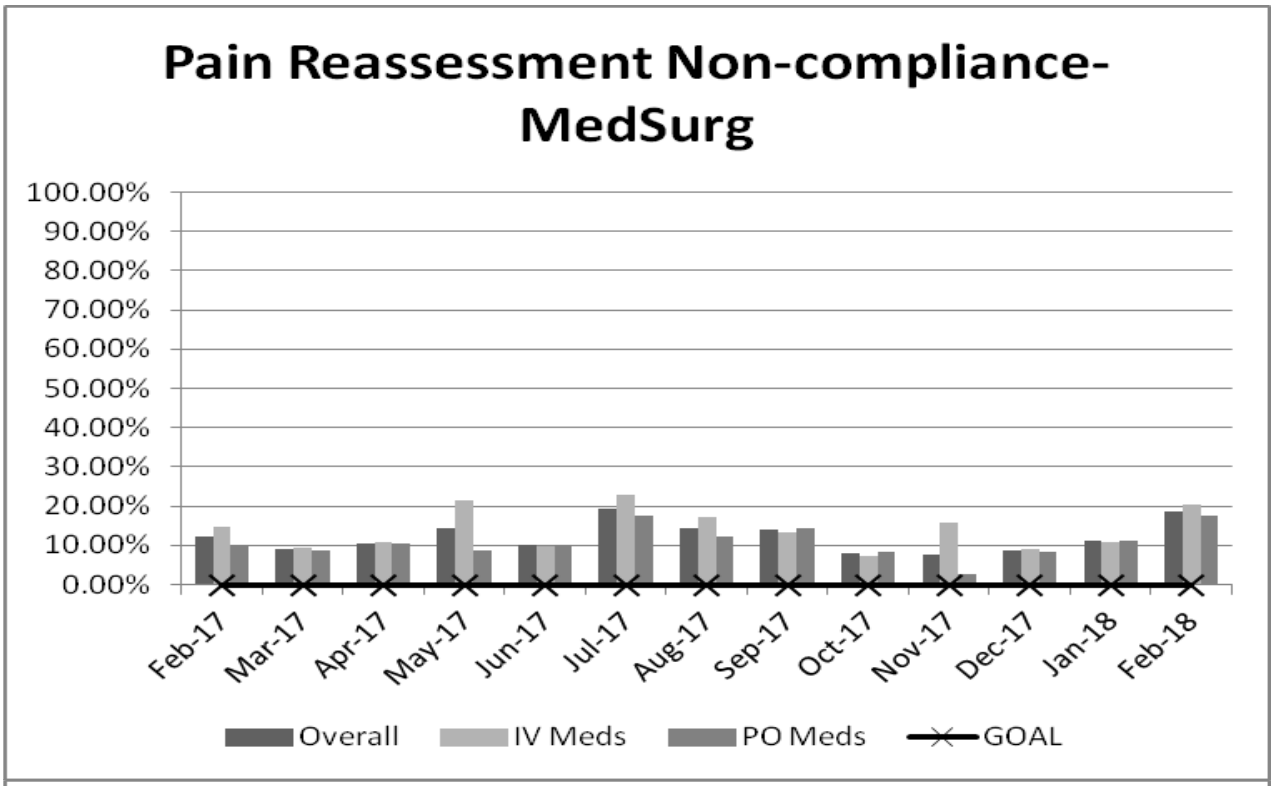
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

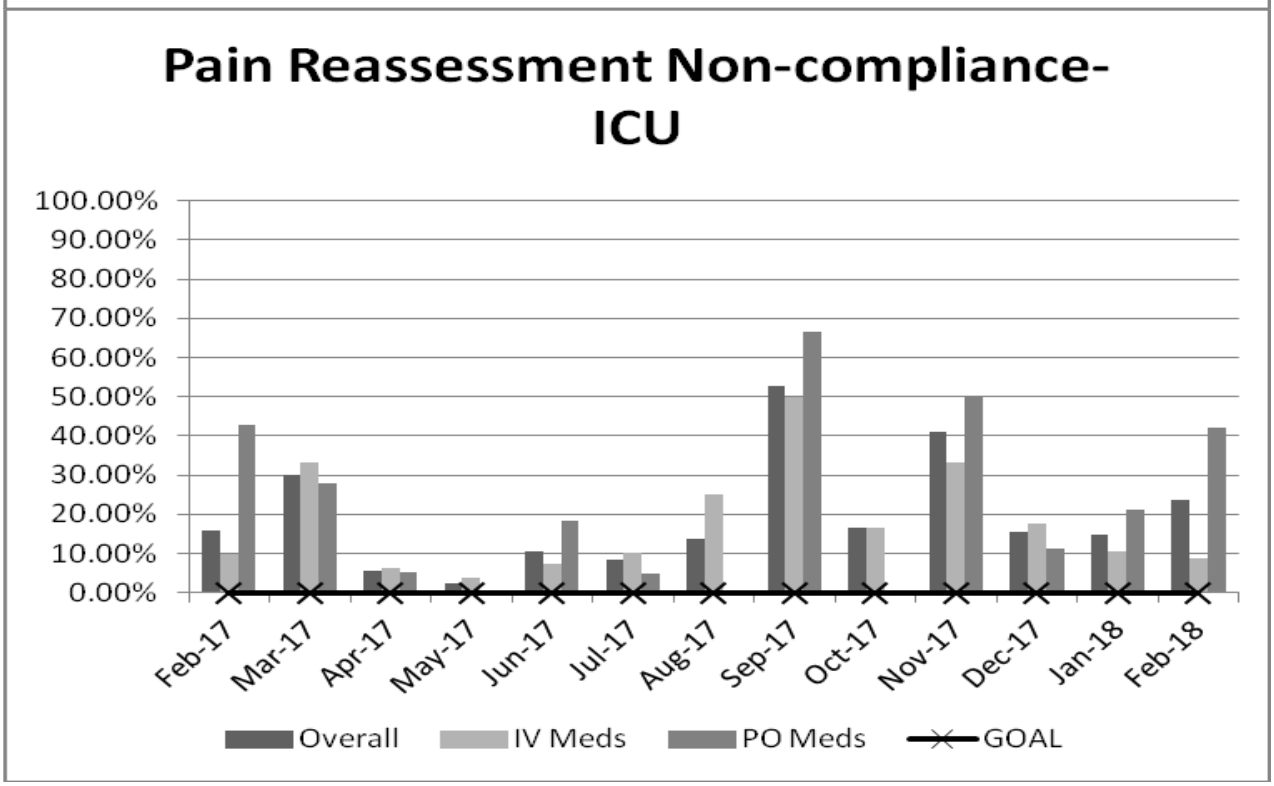


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

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.

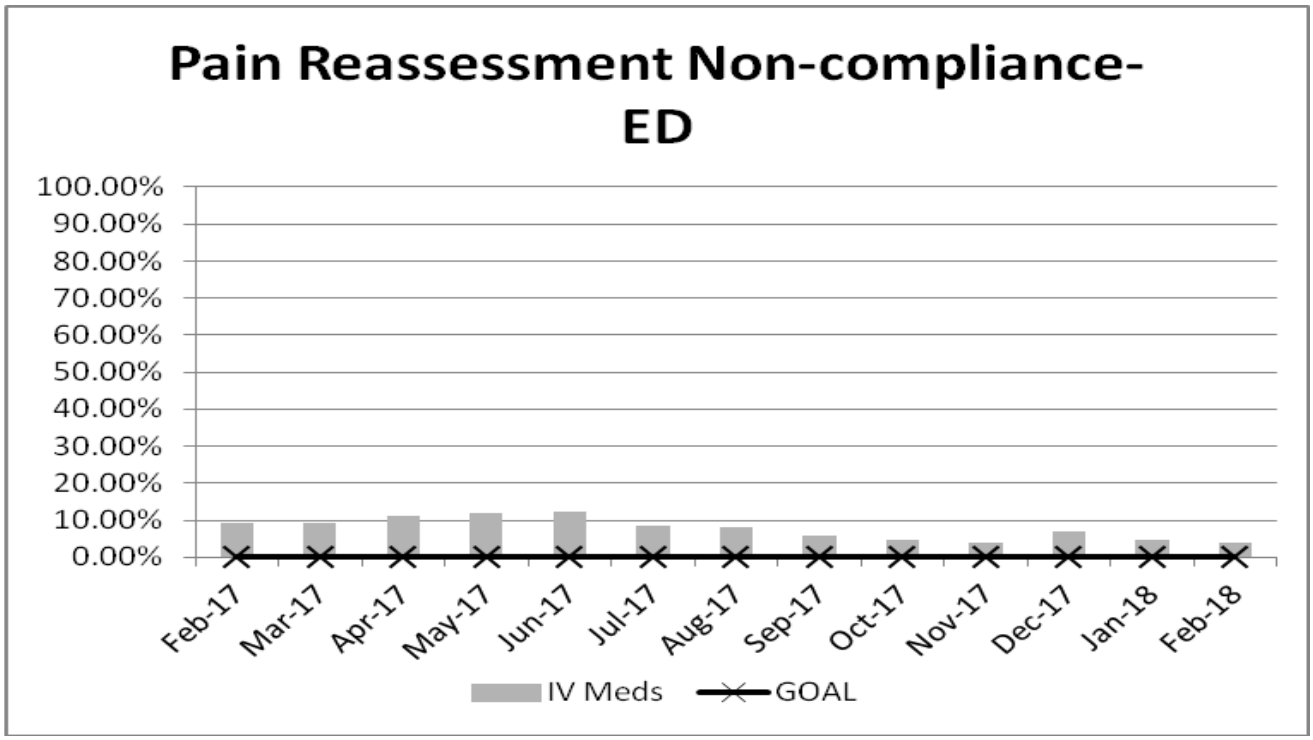


Table 6. Restraint chart monitoring for legal orders.

	Aug 2017	***Sept 2017***	***Oct 2017***	***Nov 2017***	***Dec 2017***	***Jan 2018***	***Feb* 2018***	***Mar 2018***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	3/3 (100%)	2/2 (100%)	3/3 (100%)	1/1 (100%)	3/3 (100%)	1/1 (100%)		2/2 (100%)	100%
Physician signed order within 24 hours	2/3 (66%)	1/2 (50%)	2/3 (66%)	1/1 (100%)	2/3 (66%)	0/1 (0%)		2/2 (100%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	1/3 (33%)	0/2 (0%)	2/3 (66%)	1/1 (100%)	1/3 (33%)	0/1 (0%)		1/2 (50%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	2/8 (25%)	0/2 (0%)	1/2 (50%)	N/A	2/6 (33%)	N/A		3/6 (50%)	100%
Orders are for 24 hours	11/11 (100%)	4/4 (100%)	5/5 (100%)	1/1 (100%)	9/9 (100%)	1/1 (100%)		8/8 (100%)	100%
Is this a PRN (as needed) Order	0/11 (0%)	0/4 (0%)	0/5 (0%)	0/1 (0%)	0/9 (0%)	0/1 (0%)		0/8 (0%)	0%

*indicates no patients in restraints for this time period

POLICIES TO THE BOD
ENVIRONMENTAL SERVICES

	POLICY & PROCEDURES TO THE BOARD	APRIL, 2018			
	EVS DEPT.				
	TITLE	TO BOD	APPROVED	COMMENTS	P&P UPDATED
1	Cleaning Procedures: Non-Clinical Areas: Entrances	4/18/2018			
2	Cleaining Procedures: Non-Clinical Areas: Hallways	4/18/2018			
3	Cleaning Procedures: Non-Clinical Areas: Lobbies and Waiting Rooms	4/18/2018			
4	Cleaning Procedures: Non-Clinical Areas: Offices	4/18/2018			
5	Cleaning Procedures: Non-Clinical Areas: Public, Staff Restrooms	4/18/2018			
6	Cleaning Procedures: Non-Clinical Areas: Storage Areas, Unlocked	4/18/2018			
7	Cleaning Procedures: Non-Patient Care Equipment: Cubicle Curtains and Drapes	4/18/2018			
8	Cleaning Procedures: Non-Patient Care Equipment: Furniture	4/18/2018			

COMPLIANCE DEPARTMENT

POLICY AND PROCEDURE ANNUAL APPROVALS

APRIL 2018

1. Minors with Legal Authority to Consent

Human Resources Policies
April, 2018

1 Your Job
2 Personnel Classifications
3 Introductory Period
4 Lockers
5 Time Off
6 Overtime
7 Standby
8 Payroll Deductions
9 Final Payroll Check
10 Payroll Advances
11 Leisure Time Benefits
12 Holidays
13 Sick Leave
14 Shift Differential
15 State Disability Insurance
16 Hospitalization and Medical Insurance
17 Pension Plan
18 Life Insurance and Long Term Disability Insurance
19 Educational Opportunities
20 Education Days Policy for Licensed Employees
21 Absence From Work
22 Excused Absence
23 Unexcused Absence
24 Paid Absence
25 Involuntary Leave of Absence
26 Parking
27 Employee Drug and Alcohol Testing
28 Wages - Exempt Employees

Title
Abuse Policy for Swing Bed Patients
Acute/Subacute Care Services Method of Practice: Patient Coordinated Care*
Admission Procedure of Pediatric Patient*
Admission Procedure to the Acute Sub Acute Department*
Admission, Discharge, Transfer of Patients: Continuum of Care
Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients*
Cardiac Monitoring*
Documentation of Patient Care
Education of Swing Bed Resident and Family
Gait Belt Policy*
HUGS/PEDZ Policy*
ICU Acuities
ICU Consultation Criteria
ICU Staffing
Insulin Continuous Subcutaneous Infusion Self Management Of The Patient In The Acute Setting
Intensive Care Service
Inter-disciplinary Swing Bed Care Plan
IV Medications For The Control Of Pain/Anxiety
LVN'S Providing Care For ICU Patients Guidelines
Medical Records Requirements of Swing Bed Admission/Discharge
Newborn & Pediatric Security and Abduction Policy*
Noting Physician Orders
Nutrition for Swing-Bed Patients
Opioid Administration*
Opioid Sedation Scale*
Pain Management and documentation*
Patient Valuables*
Patient Acuity - Patient Care Flow Sheet*
Patient Admission To ICU
Patient Complications/Emergencies
Patient Controlled Analgesia (PCA)*
Patient Mobility Assessment*
Patient Orientation To The ICU
Patient Restraints (Behavioral & Non-Behavioral)*
Pediatric Emergency Code System (Broselow-Hinkle)*
Pediatric Standards of Care and Routines*
Physician Guidelines For Utilizing The ICU
Post Operative Patient Care In The ICU
Qualifications For ICU RN
Recognizing and Reporting Swing Bed Resident Abuse/Neglect*
Rights of Swing Bed Patients*
Saline Lock For Blood Draw
Scope of Service Acute/Subacute*
Scope of Service Hospice*

Scope of Service Swing Bed*
Services for Swing-Bed Patients
Skin Assessment Using the Braden Scale
Standards of Care - SWING Bed Resident
Standards of care- Acute- sub acute services- adult patient*
Standards of Care in ICU
Swing Bed Patient Restraints*
Swing Bed Patients Inter-disciplinary Care Conference
Syringe Pump
Thrombolytic Therapy Consent
Total Parenteral Nutrition Protocol
Transducer System Procedure-vascular lines
Transfer & Transportation for Patients
Use Of The Peripheral Nerve Stimulator
Weights for Infant and Pediatric Patients*
Withholding Resuscitative Measures In The ICU

Title
A Quick Check
Admission / Classification and Charges
Admission Procedure of Hospice Inpatient*
Adoption Policy and Procedure*
Advanced Directives
Age Related and Population Specific Care
ANGEL FLIGHT*
Authorization of Hours Worked Beyond Regularly Scheduled Shift (Including Overtime Request)
Capacity Management Plan*
Clinical Consistency Oversight Committee (CCOC)
Clinical Decision Making-Medical Staff Practitioner Notification
Code of Ethics for Nurses*
Cognitive Assessment (MoCA)
Color-Coded Wristband Use
Competency Notebook
Confidentiality
Cross-Training of RN Staff
Daily Staffing Sheet / Nursing
Death-Disposition of Body*
Debriefing Sessions For Stressful Situations
Department Monthly Staff Meeting
Departments That Deliver Nursing Care to Patients
Deployment of Nursing Staff at Department Level and Patient Care Assignments
Development, Revision and Maintenance of Policies and Procedures
Direct Report Monthly Standing CNO Meeting
Discharge Planning for the Hospitalized Patient*
Documentation of Case Management Services*
Documentation of Nursing Care Flow Sheet
Drugs of Abuse Maternal and Infant
Durable Medical Equipment (DME) Provision for Patients at Discharge*
EASTERN SIERRA BREAST CANCER ALLIANCE
Education of Patient and Family*
Emergency Staffing*
End of Life Option Act*
Fall Prevention and Management*
Fatigue Management: Direct Caregivers
Floating Nursing Staff*
Follow-Up Phone Calls Post Discharge*
Guidelines for Licensed Nurses Nursing Students Giving Medications
Home Health Care
House Supervisor Shift Activity Report*
Informed Consent Policy
Interdisciplinary Plan of Care*
Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment*

Title
Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment*
Inyo Mono Advocates for Community Action (IMACA)
Legal Definition of Licensed Vocational Nurse
Legal Definition of Registered Nurse
Licensure of Nursing Personnel*
Management of Discharge Disputes from Medicare Patients*
Medical Clinical Alarm Equipment Safety*
Mission and Vision Statement for Nursing Services
Nurse Executive Council
Nursing Low Census Days
Nursing Administrative Coverage
Nursing Assessment & Reassessment*
Nursing Care Plan*
Nursing Certification*
Nursing Chain of Command in Resolving Patient Care Issues
Nursing Department Dress Code
Nursing Department Meetings
Nursing Management Huddle
Nursing PRN Per Diem Staff
Nursing Quality Assurance/Performance Improvement (QA/PI)*
Nursing Services Competency Plan
Nursing Services Jobs and Titles
Nursing Services Philosophy
Nursing Services Standing Committee Structure and Hospital Committee Participation
Nursing Services Standing Objective and Annual Strategic Focus
Nursing Standards*
Nursing Status, Guidelines for
Nursing Students Requesting Clinical Preceptorship Rotation*
Opening and Closing Nursing Departments
Organ/Tissue/Eye Donation*
Organization-Wide Assessment and Reassessment of Patients*
Orientation Competency Committee
Orientation to Nursing Departments*
Orientation/Cross Training Time Frames*
Pathways for Development, Review and Revision of Nursing Standards
Patient Locator
Patient Safety Attendant or 1:1 Staffing Guidelines*
Patient Visitation Rights
Pediatric Academic Education Policy*
Plan for the Provision of Nursing Care
Procedures Requiring Informed Consents
Professional Practice Council
Pronouncement of Death*
Responsibilities of Nursing Students and Hospital Staff

CALL TO ORDER

The meeting was called to order at 5:30 pm by John Ungersma MD, President.

PRESENT

John Ungersma MD, President
M.C. Hubbard, Vice President
Mary Mae Kilpatrick, Secretary
Jean Turner, Treasurer
Peter Watercott, Member At Large
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Huntsinger, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, Chief Nursing Officer
Evelyn Campos Diaz, Chief Human Resources Officer
Sandy Blumberg, Executive Assistant

OPPORTUNITY FOR PUBLIC COMMENT

Doctor Ungersma announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. No comments were heard.

APPROVAL OF NIHD FOUNDATION BOARD MEMBER

Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA requested approval of the appointment of Ms. Jane Thompson to the Northern Inyo Healthcare District (NIHD) Foundation Board of Directors. It was moved by Peter Watercott, seconded by Mary Mae Kilpatrick, and unanimously passed to approve appointment of Jane Thompson to the NIHD Foundation Board of Directors as requested.

QUARTERLY PILLARS OF EXCELLENCE REPORT

Chief Operating Officer Kelli Huntsinger reviewed the Hospital Wide Pillars of Excellence quarterly report, which includes performance data on the following:

- Patient satisfaction statistics
- Adverse Drug Event percentages
- Infection rate percentages
- Employee Turnover
- Financial indicators (including debt ratio, cash on hand, and accounts receivable days)

It was moved by Ms. Kilpatrick, seconded by Jean Turner, and unanimously passed to accept the Hospital Wide Pillars of Excellence quarterly report as presented.

CHIEF OPERATING OFFICER REPORT

Ms. Huntsinger also provided a Chief Operating Officer report which included updates on the following hospital departments:

- Dietary Services
- Diagnostic Imaging Services
- Environmental Services and Laundry
- Cardiopulmonary Services

- Health Information Management (Medical Records)
- Laboratory Services
- Pharmacy
- Quality and Performance Improvement
- Rehabilitation Services
- Safety

Ms. Huntsinger additionally reported that the Tahoe Carson Radiology group will begin providing radiology service coverage at NIHD as of April 1 2018.

CHIEF HUMAN RESOURCES OFFICER REPORT

Chief Human Resources Officer Evelyn Campos Diaz provided an overview of the results of the January 2018 NIHD Employee Satisfaction Survey. Ms. Campos Diaz's report included the following:

- Employee participation in the survey was 91% (an increase from the prior year's 80% response rate)
- The District's overall employee satisfaction score was 3.28 (out of a possible 4 points), an increase over the prior year score of 3.15

Ms. Campos Diaz reviewed employee job and organization engagement scores, as well as scores for employee satisfaction with pay and benefits. She additionally noted areas that District leadership will focus on in an effort to realize improvement in the upcoming year. The Employee Satisfaction Survey will be repeated in January 2019 in accordance with the District's Strategic Plan.

Ms. Campos Diaz additionally reported that 333 District employees have completed Workplace Violence Training, utilizing a Cal OSHA training tool specific to healthcare facilities.

CHIEF NURSING OFFICER REPORT

Chief Nursing Officer Tracy Aspel, RN provided an NIHD Nursing Department update which included the following:

- Information on employee trainings and educational opportunities
- Consideration of a new learning management program
- Improvements made to infection prevention measures
- Implementation of a safe injection practice program
- Improvements to the hospital water management plan
- Update on Employee Health services provided
- ICU RN training opportunities with Adventist Health
- Triage flow improvements in the Emergency Department
- Baby Friendly certification for the District

CHIEF FINANCIAL OFFICER REPORT

Chief Financial Officer John Tremble provided a financial update which included the following:

- ADP payroll implementation will take place in the month of April
- A new purchasing supply system will be implemented as part of the District's health information management system conversion in September
- Macro Helix software will be implemented for the District's 340B drug program

- Gross patient revenue was high in the month of January 2018, and the District realized a profit of $298,000 for the month
- Gross revenue for the fiscal year to date is over $1,000,000

DISTRICT BOARD RESOLUTION 18-01, NORTHERN INYO HEALTH LLC

Mr. Tremble also called attention to District Board Resolution 18-01, which would allow for creation of *Northern Inyo Health LLC*, to facilitate expansion of District services to include for-profit entities. It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve District Board 18-01 to establish *Northern Inyo Health LLC* as requested.

DISTRICT BOARD RESOLUTION 18-02

Mr. Tremble also called attention to proposed District Board Resolution 18-02 which would allow for adaptation to Book Entry Accounting for the segregation of Restricted and Specific Funds, in order to consolidate existing District funds more efficiently and reduce banking fees significantly. It was moved by Ms. Kilpatrick, seconded by M.C. Hubbard, and unanimously passed to approve District Board Resolution 18-02 as requested.

CHIEF EXECUTIVE OFFICER REPORT

Doctor Flanigan provided a Chief Executive Officer report, which included the following:

- Telehealth services with Adventist Health are moving forward and the District is working on setup for incoming telehealth specialties
- The Pioneer Medical Associates building was recently broken into. District leadership is currently making improvements to security measures at that location.
- Physician recruitment for family medicine and internal medicine providers continues
- Urology services will start up this week, and cardiology appointments are also being scheduled
- The District's Hospitalist Service continues to be successful, under the leadership of Joy Engblade MD
- Southern Inyo Healthcare District is promoting passage of measure "J" in an attempt to help provide financial aid for Southern Inyo Hospital (SIH). NIHD plans to send a general surgeon to SIH to provide part-time coverage.
- NIHD is currently promoting colorectal cancer awareness month, and a first annual fun run (fundraiser) has been scheduled for the upcoming weekend

NIHD BYLAWS REVIEW

Doctor Flanigan stated that he and Directors Hubbard and Ungersma made up an Ad Hoc Committee which recently completed a review of NIHD District Bylaws. Revisions have been made to the District Bylaws, and they are now ready for the review and approval of the full Board. It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve the revised District Bylaws as presented by the Ad Hoc Committee, including housekeeping changes noted by Director Kilpatrick.

CHIEF EXECUTIVE OFFICER

Doctor Ungersma called attention to a proposed Agreement for the Employment of Chief Executive Officer Kevin S. Flanigan MD, MBA, for a term of 4 years. It was moved by Ms. Kilpatrick, seconded by Mr. Watercott, and unanimously passed to approve the Employment Agreement with Kevin S. Flanigan MD, MBA as presented. It was noted that the agreement was previously approved by District legal counsel, and that it does not allow for a salary increase for the CEO.

ATHENA IMPLEMENTATION UPDATE

Director of Information Technology Robin Cassidy presented a status update on the District's Athena Health Information System implementation project, which will go live September 25 2018. The project includes implementation of the Athena system; Orchard Harvest; Jump Stock; ADP Payroll and HR programs; the GeauxTech archive solution; GE Centricity's perinatal product; 7 Medical Systems software; Intacct implementation (for general ledger); Dragon Medical One speech recognition; the Macro Helix 340B solution; and implementation of Protenus, a compliance privacy solution.

CONSENT AGENDA

Doctor Ungersma called attention to the Consent Agenda for this meeting, which contained the following items:

- Approval of minutes of the February 21 2018 regular meeting
- Financial and Statistical reports for January 2018
- 2013 CMS Survey Validation Monitoring for March 2018
- Policy and Procedure annual approvals

It was moved by Mr. Watercott, seconded by Ms. Turner, and unanimously passed to approve all four consent agenda items as presented.

CHIEF OF STAFF REPORT

POLICIES, PROCEDURES, PROTOCOLS, ORDER SETS

On behalf of Chief of Staff Richard Meredick MD, Doctor Flanigan reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Policies, Procedures, Protocols, and Order Sets:

1. *Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)*
2. *Collection of Aerobic and Anaerobic Cultures*
3. *Emergency Care Policy for Emergency Department Physician Assistant - Standardized Procedure*
4. *General Policy for Emergency Department Physician Assistant - Standardized Procedure*
5. *Intimate Partner Abuses Guidelines, for Victims of*
6. *Intravenous to Oral Route of Administration Opioid Conversion Protocol - Inpatient Adult*
7. *Medication/Device Policy for Emergency Department Physician Assistant - Standardized Procedure*
8. *Multidrug Resistant Organism (MDRO) Control Plan*
9. *N95 Mask Fit Testing Using PortaCount Pro*
10. *Opening and Closing Nursing Departments*
11. *Standards of Care in the ICU*
12. *Warfarin Protocol - Inpatient Adult*

It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve Policies, Procedures, Protocols, and Order Sets 1 through 12 as presented.

ANNUAL APPROVALS

Dr. Flanigan also reported following careful review and consideration the Medical Executive Committee recommends approval of the following annual approvals:

1. Utilization Review Critical Indicators
2. Pediatric Critical Indicators
3. Standardized Procedures and Protocols
    - *i. RN First Assistant*
    - *ii. Medical Screening Examination of the Obstetrical Patient*
    - *iii. CNM First Assist During Cesarean Sections*
    - *iv. Physician Assistant in the OR*

It was moved by Mr. Watercott, seconded by Ms. Kilpatrick, and unanimously passed to approve annual approvals 1 through 3 as presented.

MEDICAL STAFF ADVANCEMENT

Dr. Flanigan additionally reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff Advancement:

1. Uttama Sharma, MD (*family medicine*) - Dr. Sharma has undergone 50+ chart reviews and direct supervision Thursday through Saturday x 4 months by her proctor, Stacey Brown MD since her appointment in August 2017. Doctor Brown is happy to report Dr. Sharma has completed her focused professional practice evaluation (FPPE) and is recommending her for advancement from Provisional Staff to full Active Staff at NIHD.

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the Medical Staff advancement of Uttama Sharma, MD as requested.

MEDICAL STAFF APPOINTMENTS/ PRIVILEGES

Doctor Flanigan also reported the following applicants have undergone full credentialing and have been recommended for appointment to the Medical Staff by the Credentials and Medical Executive Committees in the appropriate category:

1. Michael H. Abdulian MD (*Orthopedic Surgery*), Provisional Consulting Staff
2. David B. Huddleston MD (*General Surgery*), Provisional Active Staff
3. Kristin Irmiter MD (*Pediatrics*), Provisional Active Staff
4. Daniel Firer, MD (*Family Medicine / Emergency Department*), Provisional Active Staff
5. Sandra Althaus MD, *Tahoe Carson Radiology* (*Interventional Radiology*), Consulting Staff
6. Ryan Berecky MD, *Tahoe Carson Radiology* (*Neuroradiology*), Consulting Staff

7. Nicholas Carlevato MD, *Tahoe Carson Radiology* (*Interventional Radiology*), Consulting Staff
8. David Landis MD, *Tahoe Carson Radiology* (*Diagnostic Radiology*), Locum Tenens
9. Stephen Loos MD, *Tahoe Carson Radiology* (*Diagnostic Radiology*), Active Staff
10. Keith Shonnard MD, Tahoe Carson Radiology (*Interventional Radiology*), Consulting Staff
11. Gary Turner MD, *Tahoe Carson Radiology* (*Neuroradiology*), Consulting Staff

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

TELEMEDICINE STAFF APPOINTMENTS/ PRIVILEGES

Doctor Flanigan also requested approval of the following Telemedicine Staff Appointments/Privileges, credentialing by proxy:

1. *As per the approved Telemedicine Physician Credentialing and Privileging Agreement and as outlined and allowed by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions*:
   i. Azadeh Majlessi, MD (*rheumatology*), distant site: Adventist Health (Glendale), Telemedicine Staff
   ii. Nilem Patel, MD (*endocrinology*), distant site: Adventist Health (Glendale), Telemedicine Staff

It was moved by Mr. Watercott, seconded by Ms. Kilpatrick, and unanimously passed to approve both Telemedicine Physician Credentialings and Privileging as requested.

TEMPORARY LOCUM TENENS PROVILEGES

Doctor Flanigan also reported the following physician has undergone the full credentialing process and has been recommended for temporary/locum tenens privileges for up to 60 days in 2018, unless extended and approved for good cause:

1. Arsen Mkrtchyan MD, Internal Medicine (*hospitalist*), Temporary/ Locums tenens (*up to 60 days in 2018*)

It was moved by Ms. Hubbard, seconded by Ms. Turner, and unanimously passed to approve Dr. Mkrtchyan's temporary/locum tenes privileges for up to 60 days in 2018 as requested.

ADDITIONAL PRIVILEGES, ALLIED HEALTH PROFESSIONAL

Doctor Flanigan also reported the following Allied Health Professional has applied for privileges in the Emergency Department. In times of heavy patient volume, the ED physician on duty may call upon the applicant to assist with patient care. The applicant will be working under approved Standardized Protocols and will undergo an initial period of monitoring:

1. Jennifer Figueroa, PA-C, *Emergency Department*, Allied Health Professional

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and

unanimously passed to approve Jennifer Figueroa, PA-C to assist with patient care in the ED as requested.

CHANGE IN STAFF CATEGORY

Doctor Flanigan additionally reported following careful review and consideration the Medical Executive Committee recommends a change in Staff Category for Edmund P. Pillsbury III, MD (*radiology*) - application for change in Staff category from Consulting Staff to Active Staff. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the change in Staff category for Edmund P. Pillsbury III, MD as requested.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to report on any items of interest. Director Watercott submitted his resignation from the NIHD Board of Directors effective March 31 2018, following more than 20 years of dedicated service. Mr. Watercott thanked the District for the privilege of serving on the Board, stating his intention to continue serving on the NIHD Foundation Board of Directors. Mr. Watercott's fellow members of the Board and the District Chief Officers thanked him for his countless hours of service to the District and to area residents. Mr. Watercott also expressed his hope that the individual appointed to his Zone vacancy bring increased diversity to the Board of Directors. Doctor Ungersma also distributed a handout on the *Role and Responsibilities of Trustees*, and Director Hubbard reported that progress is being made toward achieving ACHD certification for NIHD. Director Kilpatrick reported the NIHD Foundation has approved a donation of $8,000 for NIHD website improvement.

ADJOURNMENT TO CLOSED SESSION

At 8:06 pm Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to:

A. Conference with Labor Negotiators; Agency Designated Representative Kevin Dale; Employee Organization: AFSCME Council 57 (pursuant to Government Code Section 54957.6).
B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation, 3 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).
D. Discussion of a real estate negotiation (pursuant to Government Code Section 54956.8).
E. Discussion of a personnel matter (pursuant to Government Code Section 54957).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:50 pm the meeting returned to open session. Doctor Ungersma reported the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 8:51 pm.

John Ungersma, President

Attest:

Mary Mae Kilpatrick, Secretary

BOARD MEETING ATTENDANCE, 2018 CALENDAR YEAR

	J.UNGERSMA, MD *President*	M.C. HUBBARD *Vice President*	MARY MAE KILPATRICK *Secretary*	JEAN TURNER *Treasurer*	PETER WATERCOTT *Member at Large*
January 17, 2018 Reg.	√	√	√	√	√
January 25, 2018 Sp.	√	√	√	√	√
February 21, 2018 Reg.	√	√	√	√	√
March 21, 2018 Sp.	√	√	√	√	*√ (Submitted Resignation)*
April 12, 2018 Sp.					
April 18, 2018 Reg.					
April 20, 2018 Sp.					
May 16, 2018 Reg.					
June 20, 2018 Reg.					
July 18, 2018 Reg.					
August 15, 2018 Reg.					
September 19, 2018 Reg.					
October 17, 2018 Reg.					
November 21, 2018 Reg.					
December 19, 2018 Reg.					

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: Richard Meredick, MD, Chief of Medical Staff
DATE: April 3, 2018
RE: Medical Executive Committee Report

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

A. Policies/Procedures/Protocols/Order Sets (*action items*)
    1. *Bite Guidelines, Animals*
    2. *DI – Timely Performance Standards*
    3. *Discharge Instructions Emergency Department*
    4. *Pediatric Order Verification Overnight*
    5. *Radiology Critical Indicators for Chart Review Policy*
    6. *Safely Surrendered Baby Policy and Procedure*
    7. *Scope of Service for the Emergency Department*
    8. *Standards of Care for the Emergency Department*

B. Annual Review (*action items*)
    1. Emergency Room Service Critical Indicators

C. Medical Staff Appointments/Privileges (*action items*)
    1. Gabriel Overholtzer, DDS (dentistry) – Provisional Active Staff (limited license practitioner)
    2. Kinsey R. Pillsbury, MD (radiology) – Consulting Staff

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Bite Guidelines, Animals	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Dept. Manager	Effective Date: 04/1992

PURPOSE:
The primary role of the Emergency Department in preventing rabies is in accurately reporting to the County Health Department and Animal Control and to provide proper acute wound management.

POLICY AND TREATMENT GUIDELINES:

A. All "at risk" wounds should be thoroughly cleansed with antibacterial soap and water, sutured by physician as needed and covered with dressing.
B. Tetanus immunization should be updated as needed.
C. All animal bites, including family's own pet must be reported to:

1. Inyo County Animal Control
   a. Monday- Friday 8 AM- 5 PM (760) 873-7852
   b. Weekends and after 5 PM
      -Inyo County Sheriff (760) 873-7887
2. Mono County Sheriff's Department (760) 932- 7549

D. If local health officials cannot provide information, call
1. California State Department of Health (415) 540-2000

E . Rabies Prophylaxis:

1. Animal not able to be captured:
   a. If high risk species (raccoon, bat, skunk, coyotes, etc.)

- Treat with Rabies Immune Globulin (RIG) per American Hospital Formulary Service (AHFS) recommendations.
  - Dose infiltrated into wound should be performed by physician.
- Also treat with Human Diploid Cell Rabies Vaccine (HDCV) per AHFS recommendations.
- Vaccine is available in the NIHD pharmacy.
- Antibiotics as needed per emergency room physician
- Advise to follow up at Inyo County Health Department.

   b. Low risk species (dog, cat, rabbit, rodents, birds)

- Consult with local animal control officer as to presence of rabies in species.
- Consider treatment if animal attack was bizarre, abnormal, or totally unprovoked.

2. If animal captured: (Follow treatment according to Animal Control guidelines)
   a. If high risk animal or abnormal behavior - start treatment unless animal test is done immediately. (This normally takes 2-3 days).

- If positive, start above treatment protocols.
- If negative, do not treat.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Bite Guidelines, Animals	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Dept. Manager	Effective Date: 04/1992

DOCUMENTATION:
1. Note on medical record when Animal Control was contacted.
2. Document discharge instructions on wound care and any needed follow up with Animal Control and primary physician.

REFERENCE:
Inyo County Animal Control Rabies Policy

CROSSREFERENCE:

Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	
Last Board of Director Review	6/21/17

Developed: 4/92
Revised: 3/98, 03/09/04 MR
Reviewed: 08/2010as; 09/2012as, 1/18 gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Timely Performance Standards – Hospital Based Patients	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE: To define terms and time frames for the timely performance of Diagnostic Imaging Department procedures

DEFINITIONS:
Timely performance will be measured for hospital based patients in three separate increments as defined below:

- Tech time – The time interval between the an order being placed for an exam and the technologist completing the examination
- Radiologists time – The time interval between the technologist submitting the exam for interpretation and the radiologists providing a final signed report to ordering physician
- Total Turnaround Time – The time interval between the order being placed for an exam and a final signed report being available to the referring physician.

POLICY:

1. It is the goal of the Diagnostic Imaging department to meet the following guidelines for exams or procedures ordered as stat exams.
    1. **Tech time - < 60 minutes**
    2. **Radiologists time (could be preliminary report for stat exams) - < 60 minutes**
    3. **Total Turnaround time - <120 minutes**
2. It is the goal of the Diagnostic Imaging department to meet the following guidelines for exams or procedures ordered as ASAP exams.
    1. **Tech time - < 180 minutes**
    2. **Radiologists time (could be preliminary report for ASAP exams)- < 120 minutes**
    3. **Total Turnaround time - <300 minutes**
3. It is the goal of the Diagnostic Imaging department to meet the following guidelines for exams or procedures ordered as routine exams.
    1. **Tech time - < 12 hours**
    2. **Radiologists time - < 12 hours**
    3. **Total Turnaround time - < 24 hours**

REFERENCES:

1. ACR guidelines for timely completion of exams
2. Joint Commission Standard PC.02.02.01 EP 17

CROSS REFERENCE P&P:

1. Diagnostic Imaging – Patient Priority
2.
3.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: DI - Timely Performance Standards – Hospital Based Patients	
Scope:	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

Approval	**Date**
CCOC	**03-26-18**
Radiology Services Committee	**03-07-18**
Medical Executive Committee	**04-03-18**
Administration	
Board of Directors	

Developed: 3-2018
Reviewed:
Revised:
Supercedes:

Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Discharge Instructions Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date:

PURPOSE:
To ensure that all patients discharged from the Emergency Department (ED) have thorough, appropriate and consistent discharge instruction and directions for follow-up care.

POLICY:
Discharge instructions are mandatory for all patients discharged from the Emergency Department. These instructions will be in a typed written format utilizing the Computerized Discharge Instruction System. The generated discharge instructions will be verbally reviewed with the patient or responsible party and the patient or responsible party will sign a copy of same indicating that the nurse has reviewed the instructions with them and that any questions have been answered. The patient will be referred to their own or other physician as appropriate for follow-up care, or may return to the Emergency Department if needed.

All topics will be reviewed and approved by the Chief of Emergency Services or Designee before being entered into the Discharge Instruction Computer database.

EQUIPMENT:
Discharge instructions can be generated from the computers located in the Main Room of the Emergency Department, the ER Office, and in the ER Nurse Managers Office using the Computerized Discharge Instructions System.

PROCEDURE:
1. The ED Physician will write his/her discharge instructions in the template, the first page of the ED chart, or in their dictated note.
2. Discharge instructions for each patient will be generated from the Computerized Discharge Instructions Systems.
3. database as directed by the Physician utilizing topics in Illnesses; Medications; Follow-Up; Activity Limitations; Devices, Equipment and Treatment; Diets; Dressings, Drains and Wound Care; Lifestyle and Environment; Procedures, Tests and Preps; and Health and Wellness Promotions.
4. The instructions will be reviewed with the patient and/or responsible party by a Registered Nurse. All questions will be addressed and a signature will be obtained indicating that all questions have been answered. The original discharge instructions will be given to the patient, family or responsible party. The copy will become part of the Medical Record after being signed and timed by the Registered Nurse.
5. Any special instructions such as School or Work Releases will be created if needed and a copy of same will be retained in the Medical Record.
6. Discharge instructions can be printed in Spanish during the printing process.

DOCUMENTATION:
As well as signing the discharge instructions provided to the patient, a note will be made in the narrative record addressing the patient discharge.

REFERENCES:

1. Emergency Nurses Association. (2017). Safe Discharge From the Emergency Setting Position Statement. Retrieved from https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/safedischargefromed.pdf?sfvrsn=998ee45f_6

CROSS REFERENCE P&P:
1. Standards of Care in the Emergency Department

Committee Approval	Date
Clinical Consistency Committee	1/29/18
Emergency Services Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Discharge Instructions Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date:

Last Board of Director review	6/21/17

Developed:
Reviewed: 12/15as
Revised: 12/17gr
Supersedes:
Index Listings:

Title: Pediatric Order Verification Overnight	
Scope: Emergency Room	Department: Emergency Room
Source: Interim Pharmacy Director	Effective Date:

PURPOSE:

The intent of this policy is to minimize risk of dose related medication errors occurring for pediatric orders.

POLICY:

1. During the overnight shift (17:01 - 06:29), emergency room staff will be required to call the on-call pharmacist to verify pediatric (patient is <= 18 years old or <=36 kg)(1) medication orders. Due to max dosing restrictions on select drugs, this policy is not meant to replace clinical judgment on a clinician's interpretation of a pediatric order. Pharmacists do not need to be called on the following oral medications:
    a. Ibuprofen
    b. Acetaminophen
    c. Diphenhydramine
    d. Amoxicillin
    e. Amoxicillin/Clavulanic acid
    f. Dexamethasone
    g. Prednisolone
    h. Ondansetron
    i. Azithromycin
    j. Cefdinir
    k. Cefixime
    l. Cephalexin
    m. Penicillin
    n. Sulfamethoxazole/Trimethoprim
    ~~n.~~o. Albuterol nebulized solution*

2. All pediatric medications orders in the electronic health record will be built to have a mg/kg ordering format except for albuterol nebulized solution. If further medications are deemed to be clinically inappropriate to have a mg/kg ordering format, the appropriate committees will review the medications in question.
3. Only one concentration of a given liquid medication may be available in the Omnicell.

References:

1. Pediatric Definition. Accessed 3/27/18
2. Meeting with Northern Inyo Associate Pediatric Department 3/13/2018.
3. Paragon ordering system review Quarter 1, 2018.

CROSS REFERENCE P&P:

1. High alert medications policy and procedure.

Approval	**Date**
~~**ER Medical**~~**Emergency Room Service Committees**~~**	03/14/18
MEC	04/03/18
Board of Directors	

Developed: 3/13/2018

Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiology Critical Indicators for Chart Review**	
Scope: Multi-departmental	Department: **Medical Records, Medical Staff, Performance Improvement, Radiology**
Source: Director of Diagnostic Services	Effective Date:

Purpose:
To identify critical indicators that will generate automatic review of medical charts for quality of care and deviation of standard of care assessment.

Policy:
Any patient or procedure with the following outcomes will be flagged for chart review in order to identify areas for process improvement.

1. Death within 24 hours of invasive procedure
2. Admission to ED within 24 hours of invasive procedure
3. Severe Contrast Reaction
4. Code blue within the DI department
5. Patient called back for having wrong procedure performed
6. Staff concerns with breach of protocol

Preliminary screening of the chart for review will be conducted by the Radiology Director.

Radiology Director will discuss all cases with the Chief of Radiology.

Chief of Radiology will review and determine cases to be reviewed at the Radiology Committee meeting.

Following committee review, the committee may conclude:
Care within accepted standard of care
Care acceptable with questions
Care unacceptable

Action is then determined as follows:
No action
Changes in process/procedure recommended
Discuss variance with physician
Refer to another department/Executive Committee
Other action as appropriate to situation

Document review will be place in physician's peer review file.

Approval	**Date**
Radiology Committee	**3/7/18**
Medical Executive Committee	**4/3/18**
Administration	
Board of Directors	

Revised:
Reviewed:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

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

PURPOSE:

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

POLICY:

1. The Emergency Department shall be designated to be responsible for accepting physical custody of a minor child who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who surrenders the child.

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

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

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

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

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

5. A Nursing Supervisor shall be notified as soon as possible.

6. The Nursing Supervisor shall notify Social Services.

7. Social Services or the Nursing Supervisor shall notify Child Protective Services of the safe surrender as soon as possible, but no later than 48 hours after the physical custody of a child has been accepted.

8. Any medical information pertinent to the child's health, including, but not limited to, information obtained pursuant to the medical information questionnaire shall be provided to child protective services without obtaining a HIPAA release. However, any personal identifying information that pertains to a parent or individual who surrenders a child shall be blacked out from any medical information provided to child protective services or the county agency providing child welfare services.

9. Since child protective services will assume temporary custody of the child immediately on receipt of notice, NIHD employees will surrender physical custody of the child to the agency upon demand.

10. Should the person who surrendered the newborn request that the hospital return the newborn to him/her before child protective services assumes custody of the child, then, NIHD personnel will either return the child to the parent or individual or contact the child protective agency if NIHD personnel know or reasonably suspect that the child has been the victim of child abuse or neglect. The voluntary surrendering of a child is not in and of itself a sufficient basis for reporting child abuse or neglect. The child will not be returned to the requesting person if the hospital has been notified that a dependency petition has been filed in juvenile court.

11. The person requesting the return of the newborn must present positive identification or evidence that the requesting person is the person who surrendered the child.

PROCEDURE:

1. At the time of the presentation, attempt to verify the age of the newborn by physically examining the infant, specifically looking for presence of umbilical cord.

2. When the newborn is surrendered to the Emergency Department staff they will immediately call the Perinatal Unit and the ED physician and notify them that they have a surrendered newborn and request their assistance.

3. The Perinatal nurse will bring a radiant warmer and ID bands to the Emergency Department.

4. The ED physician will perform a “medical screening examination”.

5. Notify the Supervisor and Social Service Worker of the surrendered newborn.

6. Place an identification bracelet on the infant’s wrist and ankle.

7. Make a duplicate bracelet with identical numbers to give to the person surrendering the baby in case the person wants to reclaim the child at a later date.

8. The identification band will contain the following information:

    a. The infant’s name or baby boy/girl Doe if no name.

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

b. Tag number
c. Sex of infant
d. Date and time of birth, or the admit date and time if birth data is unknown

9. Ask the person surrendering the newborn to complete a family medical history questionnaire.

10. Admit the newborn to the Perinatal Department Nursery.

11. Notify the on-call pediatrician of the admission.

12. The admitting nursery nurse will follow policy and procedure for *Admit Newborn to Nursery*.

DOCUMENTATION:

1. The confidential identification will be handled per medical records guidelines.
2. The medical screening examination, treatment and transfer from the Emergency Department will be the usual documentation.
3. Discharge documentation: Social Services obtain release of minor documentation, and CPS credentials.
4. The nurse will chart according to "Surrendering to CPS Policy and Procedure.

REFERENCES:

1. http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1001-1050/ab_1048_bill_20100930_chaptered.pdf
2. California Department of Social Services. (2006). *Safely Surrendered Baby Law* Retrieved from http://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby

CROSS REFERENCE P&P:

1. *Surrendering to CPS Policy and Procedure*
2. *Admit Newborn to Nursery*

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

Committee Approval	**Date**
Clinical Consistency Committee	1/29/18
Emergency Room Medical Care Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	
Last Board of Director review	6/21/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Scope of Service for the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Manager - Emergency Department	Effective Date: 6/30/16

Purpose:

To offer emergency services to patients whose emergent medical needs can be met within the capabilities of the hospital staff and facilities

Department Description:

The Emergency Department (ED) is an 8-gurney department on the first floor of the hospital with separate ambulatory patient and ambulance entrances. The department has a triage room, a 2-bed trauma room and 6 other treatment rooms. One treatment room has been designed for OB/GYN. The unit has two patient bathrooms, one with a shower. There is also a decontamination shower with an entrance adjacent to the ambulance entrance. There is also a door leading into the main ED. Within the ED is a Radiology/Fluoroscopy room.

Mission:

Improving our communities one life at a time. One team. One Goal. Your Health.

Vision:

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with trusted regional partners.

Scope:

The ED provides basic emergency services for patients of all ages on a 24 hour a day basis. An ED physician will provide a medical screening exam on all patients, regardless of the ability to pay. The ED Unit serves as a Base Station for Inyo County ambulances and directs pre-hospital care via the Base Station radio following appropriate protocols

A dedicated triage nurse will triage all patients using the Emergency Severity Index (ESI) 5-level triage system. Following emergency assessment, diagnosis and treatment, patients may be admitted to the hospital, transferred to a tertiary care center or discharged home.

Patients transferring to a tertiary center are primarily transported by fixed wing or if appropriate by ground ambulance transport. Transfer agreements are in place.

Staffing:

The department is staffed with at least one physician experienced in emergency care twenty four hours a day, seven days a week.

Nursing staff includes:

Emergency Department Manager

Emergency Department Assistant Manager

RNs

Clerk/Technician

Care is delivered under the direction of the ED Physician on duty and/or private MD in attendance if properly credentialed.

The ED management is a joint function of the Medical Staff and Nursing Department and requires close cooperation with: ED Physicians, Attending Medical staff, Nursing units staff, Respiratory Therapy, Lab, Pharmacy, EKG, Dietary and Radiology departments, Information Technology, and Admission Services.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Scope of Service for the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Manager - Emergency Department	Effective Date: 6/30/16

Ages Serviced:

The ED provides care across the life span
Neonate: birth -28 days
Pediatrics: 28 days to <13 years
Adult: 13 to 65 years
Geriatric: > 65 years

Quality Assurance/ Performance Improvement (QA/PI) :

The ED Manager and Assistant Manager with the assistance of the QAPI representatives, integrates all nursing quality assurance/improvement functions on the unit, tracks identified problems, assist the ED nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares reports concerning ED nursing performance improvement programs for the Nurse Management Performance Improvement Committee. Activities of the Emergency Department Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the QA/PI department quarterly.

Pillars of Excellence will be developed by:

1. Involving all nursing staff members in problem identification, determination of process system failures, development of solutions and in promoting quality patient care.
2. To periodically review and revise nursing indicators for the ED.
3. To analyze the information collected through ongoing monitoring of patient care provided by nursing staff, establish priorities in targeting areas of patient care for review
4. To identify problems or trends through analysis of the collected information.
5. To provide recommendations for actions to resolve identified problems.
6. To continue to follow up and review the results of action taken to determine if a problem has been resolved or if there is a need for further action.

REFERENCES:
Emergency Severity Index: A triage Tool for Emergency Department, Version 4

CROSS REFERENCES:
EMTALA Policy
Evaluation a d Medical Screening of Patients Presenting to the Emergency Department
Triage Protocol
Standards of Care in the Emergency Department

Approval	**Date**
NEC	2/21/18
Emergency Room Service Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	
Last Board of Director review	6/21/17

Developed:
Reviewed: 02/2018 gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Scope of Service for the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Manager - Emergency Department	Effective Date: 6/30/16

Revised: 05/2016 as

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Care for the Emergency Department	
Scope: Emergency Department (ED)	Manual: Emergency Department Standards of practice
Source: Manager - Emergency Department	Effective Date: 09/05/06

PURPOSE:
To provide consistent standards for patients evaluated and treated in the Emergency Department.

POLICY:
Emergency nursing is provided using an interdisciplinary team approach based on the assessment of patient needs, problems, capabilities, limitations, interventions, and patient response.

1. Patient expectations as defined will be met for each patient.
2. Patient and family members are included in patient care planning and discharge planning.
3. The patient age specific population served is:
   a. Newborn to geriatric

PROCEDURE:
The ED patient and or significant other can expect:

A. On Admission to ED:

1. Each patient will be assessed and triaged on arrival by an RN and will be categorized based on the Emergency Severity Index (ESI) Triage System Level 1-5. Categorization is based on degree of urgency and ED resource consumption. The triage level will be entered into electronic tracking board.
2. The RN will determine English language proficiency, and document resources offered or provided for any patient that rates their language proficiency lower than "very well."
3. Baseline information shall be obtained by the Triage Nurse or Primary Nurse (if patient taken straight to Treatment).
   a. Chief complaint
   b. brief history of present illness
   c. allergies
   d. medications
   e. past medical history
4. Other information obtained:
   a. Vital Signs: All patients presenting to the ED will have vital signs obtained and documented on the electronic health record (EHR) Vital Signs will include:

   Blood Pressure:

   Children under the age of 5 years require blood pressure determination when presenting with risk of fluid volume deficit, including sepsis, dehydration, polyuria, decreased urinary output or fluid intake, drug ingestion or overdose, trauma, alteration in neurological status, or per physician order.

   If any patient is hemodynamically compromised, as evident by hypotension or hypertension, reassess and document q15 minutes or more frequently as needed.

   If an automated blood pressure device is used, the print out of trends may be attached to the PCR or transcribed onto the PCR.

   Temperature: Temperatures will be obtained based on the following age-specific guidelines.

   Newborn to 2 years- rectal or temporal

   Above 2 years- rectal, temporal, tympanic or oral as condition warrants.

   Heart Rate: Heart rate will be obtained based on the following age-specific criteria

   Apical pulses will be obtained on all patients newborn to age 2.

   A peripheral pulse will be assessed for all patients over age 2, unless condition warrants an apical assessment (i.e. irregular rate, medications)

   Respirations:

   Assess respirations and document rate, quality and signs of potential respiratory compromise.

   Pulse Oximetry:

   Obtain SpO2 on all patients.

Age-specific oximetry probes will be utilized.

Vital signs reassessment:

Triage Level 1 or 2 patients will have vital signs reassessed a minimum of every 15 minutes or more frequently as needed, based on nursing judgment.

Triage Level 3 patients will have vital signs reassessed every 1 (one) hour as needed, based on nursing judgment.

Triage Level 4 or 5 patients will have vital signs reassessed every 2 hours, prior to discharge, or as needed based on nursing judgment.

All patients will have vital signs taken at time of discharge, **except**:

Patients with stable vital signs taken within 2 hours prior to discharge
Patients returning for wound rechecks or suture removals
Patients with simple strains or sprains
Patients with simple lacerations

Skin Assessment-

All patients will be evaluated for skin color, temperature and moisture.

Pain-

Pain will be assessed on all patients on admission and discharge with re-assessment as needed.
Age-appropriate pain scales will be utilized.
Alternate pain scales will be utilized for non-English speaking or sensory impaired patients.
The pain scale utilized will be documented on the PCR.

Weight-

All patients age 14 and under will be weighed and the result documented in kg.
All other patients will have a weight stated by the patient, estimated by the RN(if patient unable to state or stand for scale) or taken by a scale and documented in kg. Patients requiring weight related medication dosages or have known medical conditions like CHF or Renal failure that require weight monitoring will be weighed on a scale if patient condition permits, and as nursing judgment dictates.

Cardiac Monitoring

All patients placed on a cardiac monitor will have a strip generated in leads II and V.

Height-

Heights will be obtained when warranted.

Finger-stick Blood Glucose (FSBS)-

FSBS will be obtained on any patient with a pertinent complaint, ALOC or when medical history indicates.

Mental Status-

The Glasgow Coma Scale will be used on admission to the ED to evaluate neurological status, and will be reevaluated as indicated by chief complaint, medical history or as nursing judgment dictates

5. Triage protocols may be initiated by triage nurse or primary nurse based on patient assessment and severity range according to ESI level.
6. All patient care will be individualized and planned in accordance with the patients' special needs, age and complaints.
7. Assessments and patient needs are communicated to the Emergency Physician or Qualified Medical Person (QMP).
8. A multi-disciplinary approach will be utilized to coordinate care with in-hospital entities and community based agencies.
9. All patients are seen, treated and stabilized as appropriate without regard of ability to pay.
10. Patients will be oriented to the ED room and environment.

11. Nursing care will be provided in a safe and therapeutic environment.
12. The patient will receive safe administration of medications and treatments prescribed.

B. Throughout Stay:

1. All patients will be continually assessed for change and progress towards meeting outcome goals and discharge objectives.
2. Changes in patient condition are appropriately charted in the electronic health record (EHR)and communicated to QMP and treatment changes carried out accordingly.
3. Evaluations of patient response to interventions and outcomes are documented in EHR.

C. On Admission to the Hospital:

1. Admission Procedure of Emergency Room Patient to the Hospital Policy will be followed.
   a. Patients admitted to the Intensive Care Unit will be accompanied by an ACLS qualified RN and placed on a cardiac monitor during transport.

D. On Transfer to another Facility:

1. The EMTALA policy will be followed when transferring ED patients to another facility for higher level of care.
2. All patients should be provided a medical screening examination (MSE) and stabilizing treatment within the capacity of the facility before transfer.
   a. If a competent patient requests transfer before the completion of the MSE and stabilizing treatment, these services should be offered to the patient and informed refusal documented.
3. The QMP is responsible for informing the patient or responsible party of the risks and the benefits of transfer and document these. Before transfer, patient consent should be obtained and documented whenever possible.
4. Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer.
5. All pertinent records and copies of imaging studies will accompany the patient to the receiving facility or be electronically transferred as soon as is practical.
6. Proper personnel and equipment, as well as necessary and medically appropriate life –support measures must accompany the patient during transport.
7. Assessments and patient needs will be continually assessed and treated in the ED while patient is awaiting transfer to another facility.
8. Family or responsible person will be apprised of ongoing care and status of patient transfer.

E. On Discharge:

1. The patient and family will receive education to promote understanding of his/her diagnostic condition, and after Care instructions.
2. Discharge instructions will be given according to Discharge Instructions in the ED policy.
3. Discharge instructions will be generated in the Computerized Discharge Instructions Program with information on Diagnosis, Medications if appropriate, Follow- up, any equipment, wound care or custom instructions according to Emergency Physician
3. Multidisciplinary and community resources shall be utilized to improve patient recovery as needed.
4. Patients are discharged to self, family, or responsible party.
5. Patients from assisted living facility or extended care facility will receive verbal after care instructions from primary ED RN along with typed instructions.
6. If there are pending cultures or results on patient discharge, patient follow up call will be done by ED physician or ED RN under physician's direction..
   a. The triage nurse will check daily for any positive lab results. The present ED physician is notified of positive results and given a chart copy for medications or treatment on patient's previous discharge.
   b. Any changes in treatment or medications will be ordered by present ED physician and patient shall be notified by phone of any recommended physician changes if any. Three attempts will be made to notify patient. If unable to notify patient, results will be sent to primary doctor. If no local primary doctor, notification will be done by mail.
   c. Any notes or addendums will be charted in final lab copy and sent to Medical Records
   d. All results and follow up calls will be noted in " To Be Check" binder.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Care for the Emergency Department	
Scope: Emergency Department (ED)	Manual: Emergency Department Standards of practice
Source: Manager - Emergency Department	Effective Date: 09/05/06

F. On Expiration:

1. All deaths in the Emergency Department are reported to the Nursing Supervisor.
2. If possible, a nurse should accompany doctor when family is notified.
3. Social Services will be notified of any deaths in ED for family support.
4. Where appropriate, Social Services can offer and/or arrange for community support follow-up for relatives, i.e., social worker, psychiatric help.
5. Any patient belongings are returned to family if available.
6. Disposal of body and notifications for organ procurement are done by the House Supervisor.
7. Policy and procedure will be followed for Coroner's cases.

REFERENCE:

1. EMTALA: A Guide to Patient Anti Dumping Laws. (2009)
2. JCAHO NC3.1.2 2005/ *Emergency Nursing and Quality Improvement Standards of Care;* W.B. Saunders 1994
3. Potter PA, Perry AG. *Basic Nursing; Essentials for practice*. 6th edn. Mosby; St Louis.2007.

CROSS-REFERENCE:

1. Admission Procedure of the Emergency Room Patient to the Hospital
2. Patient Admission Procedure to ICU
3. EMTALA Policy
4. Evaluation and Screening of Patients Presenting to Emergency Department.
5. Patients Rights
6. Plan for the Provision of Nursing Care
7. Coroner's Cases

Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	
Last Board of Director review	

-

Initiated: 12/96
Revised: 02/20, 03/06, 09/06 (AS), 1/2018 gr
Reviewed:

Emergency Room Service Critical Indicators

2018

1. Physician and Staff Concerns
2. All non-5150 Transfers
3. Formal Patient Complaints
4. ~~Pt. Refusal of Treatment,~~ AMA~~, or Elopements~~
5. Unscheduled Return or Admit Seen Within 48 Hours
6. All Codes, Deaths, and Critical Patients

~~7. ED Acquired Infections~~

~~8.~~7. Death Within 24 Hours of Visit

~~9.~~8. Laceration Repair With Recheck Concern

~~10.~~9. Specific Procedures

a) ~~Procedural~~ Moderate and Deep Sedation

~~11.~~10. All Incoming Transfers

~~12.~~11. Suicide or Attempted Suicide in the ED

~~13. Nosocomial Infections (For Referral)~~

~~14.~~12. Concern Regarding Quality of Pre-Hospital Care

~~15.~~13. Unscheduled ED Visit of Pt. Discharged Within 72 Hours

Approvals:

Emergency Room Service Committee: ~~1/10/2018~~ 3/14/2018
Medical Executive Committee: ~~2/6/2018~~ 4/3/18
Board of Directors: 2/21/2018