February 18 2020 Regular Meeting

February 18 2020 Regular Meeting - February 18 2020 Regul

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

February 18, 2020 at 6:00 p.m.

2957 Birch Street, Bishop, CA

1. Call to Order (at 6:00 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, and speakers are limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda.
3. Pioneer Home Health quarterly report (*information item*).
4. Strategic Plan update, Quality Committee report (*information item*).
5. New Business:
   A. Care Shuttle Program presentation (*information item*).
   B. Fiscal year budget for 2019/2020 (*action item*).
   C. Pioneer Medical Associates Lease (*information item*).
   D. Board Resolution 20-02 Investment Authorization of Chief Officers (*action item*).
   E. Update on responses to NIHD Legal Services RFP (*information item*).
6. Old Business:
   A. Governance consultant update (*information item*).
7. Reports (*information items*):
   A. RHC Building update
   B. Compliance Department quarterly report
   C. RHC Annual Report
8. Chief of Staff Report, William Timbers, MD:
   A. Policy and Procedure approvals (*action items*):
      1. *Practitioner Re-Entry Policy*
      2. *MetaNeb Policy*
      3. *Standards of Care in the Perioperative Unit*
      4. *Heparin Dosing Protocol*

B. Medical Staff appointments (*action items*):
    1. Joe Miller, MD (*urology*) – Provisional Consulting Staff
    2. Louis Rivera, MD (*surgical oncology*) – Provisional Consulting Staff
    3. Andrew Tang, MD (*internal medicine/hospitalist*) – Locums/Temporary Staff

C. Telemedicine Staff appointments – credentialing by proxy (*action item*):
    1. Muhammad Alim, MD (*pulmonology, Adventist Health Bakersfield*) – Telemedicine Staff

D. Temporary Privileges for 120 days (*action item*):
    1. Ruhong Ma, DO (*internal medicine/hospitalist*) – Locum tenens/Temporary Staff

E. Additional Privileges in surgery (*action items*):
    1. Jon Bowersox, MD (*general surgery*) – addition of privileges in EGD and colonoscopy
    2. Jeannie Pflum, DO (*obstetrics and gynecology*) – addition of outpatient core privileges in obstetrics and gynecology

F. Additional Privileges in Mammography (*action items*):
    1. Farres Ahmed, MD (*radiology*)
    2. John Erogul, MD (*radiology*)
    3. Carly Harvey, MD (*radiology*)
    4. Jared Kasper, MD (*radiology*)
    5. Stephen Loos, MD (*radiology*)
    6. Edmund Pillsbury, MD (*radiology*)
    7. Kinsey Pillsbury, MD (*radiology*)

G. Advancement (*action item*):
    1. Samantha Jeppsen, MD (*emergency medicine*) – recommendation for advancement from Provisional Active Staff to Active Staff

H. Annual Reviews (action items)
    1. Critical Indicators
        i. Emergency Medicine
        ii. Anesthesia
        iii. Surgery

I. Chief Medical Officer job description (*action it*em).

J. Physician recruitment update (*information item*)

Consent Agenda (action items)

9. Approval of minutes of the January 15 2020 regular meeting
10. Approval of minutes of the January 8 2020 special meeting
11. Approval of minutes of the January 21 2020 special meeting
12. Financial and statistical reports as of December 2019
13. Policy and Procedure annual approvals

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14. Reports from Board members (*information items*).
15. Adjournment to Closed Session to/for:
    A. Discussion of a real estate negotiation regarding price, 152 Pioneer Lane, Bishop, California, Agency negotiators Kevin S. Flanigan MD, MBA and Pioneer Medical Associates partners (*pursuant to Government Code Section 54956.8*).
    B. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
    C. Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
    D. Conference with Legal Counsel regarding existing litigation, Inyo County Local Agency Formation Commission and Northern Inyo Healthcare District v. Southern Mono Healthcare District (pursuant to Government Code Section 54956.9).
16. Return to Open Session and report of any action taken in Closed Session.
17. 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.

2020 Fiscal Budget for Northern Inyo Healthcare District

February 18, 2020

Overview of 2020 Budget

- **Patient Volumes & Services**
- **Salaries & FTEs**
- **Supplies & Purchased Services**
- **Capital**
- **Net Revenues**
- **Policies for Consideration**
- **Management Request**

2019/20 Expansion of Services

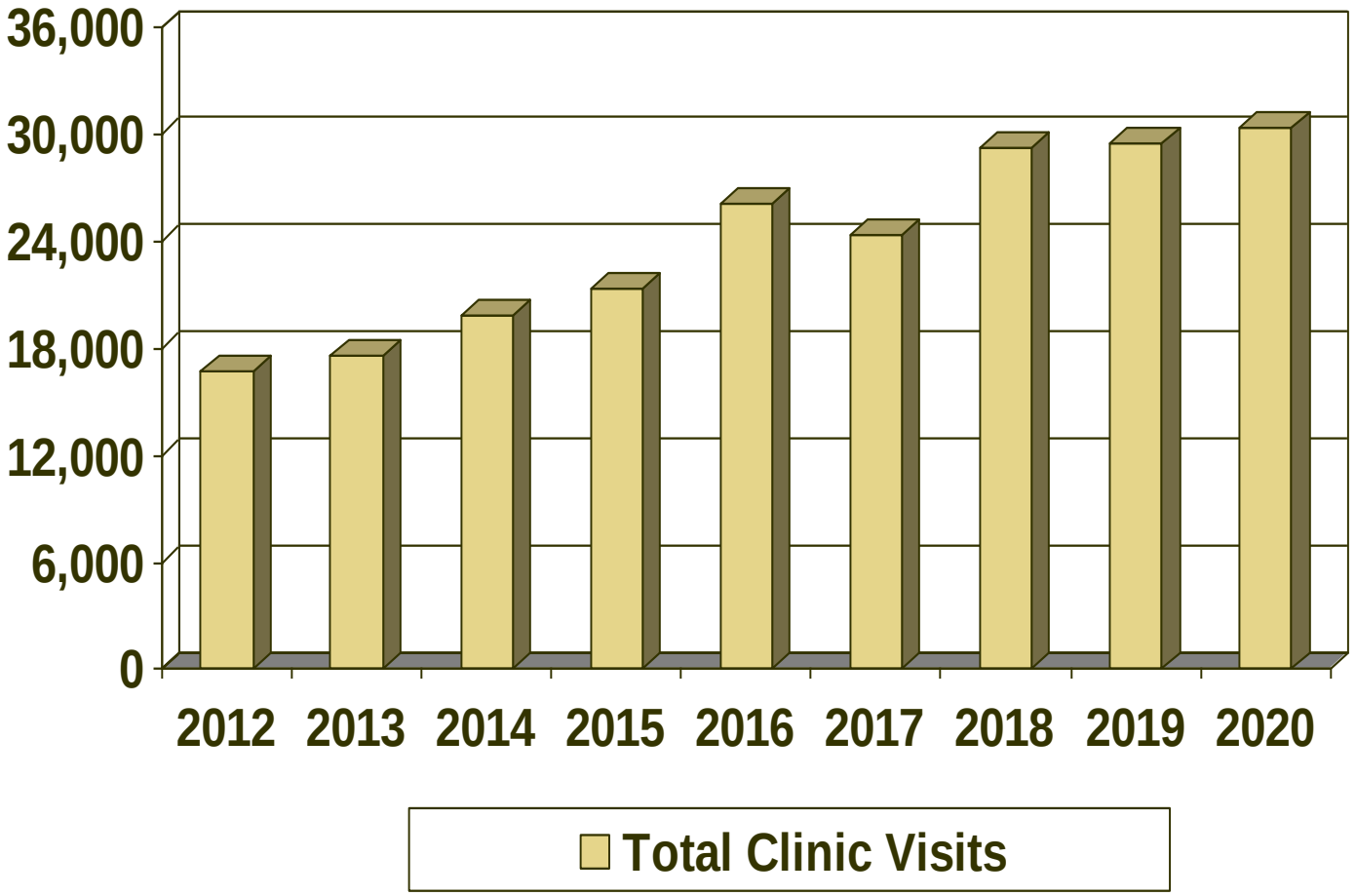
- **Add Physician Assistant to add Same Day Services to be six days a week.**
- **Urology to be 8 days a month on site**
- **Requests for added: RHC Care Coordinator and Surgery Manager.**
- **Outpatient revenues increases to 73% of Gross Patient Revenues**

2019/2020 Recruitment Request

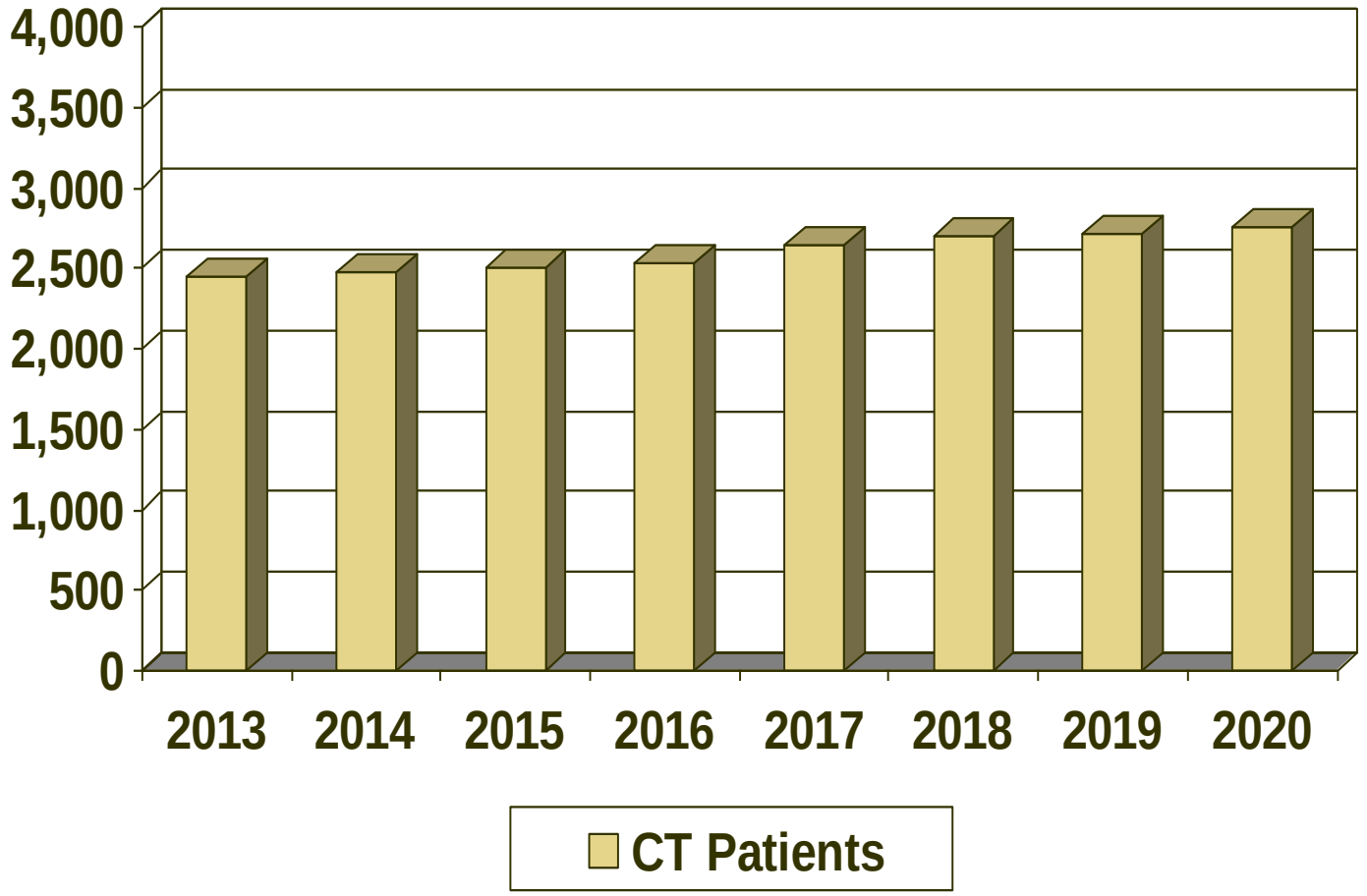
- **Fill Existing open Positions**
  - **1 Physician Assistant for Same Day Clinic hours (days) coverage**
  - **2 Physical Therapists**
  - **1 Occupational Therapist**
  - **1 Speech Language Therapist**

As Economics and Patient Demand Support

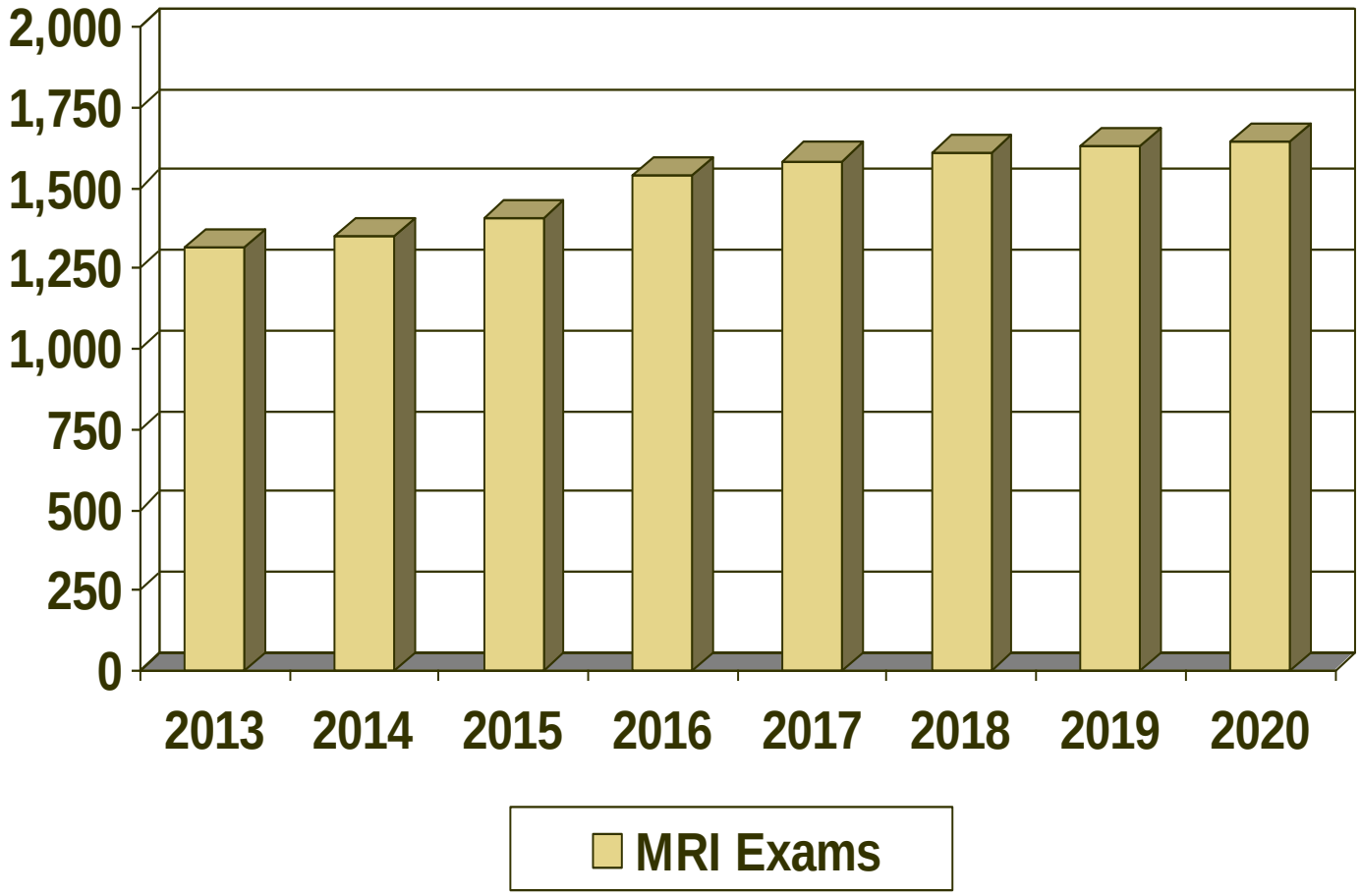
Rural Health Clinic



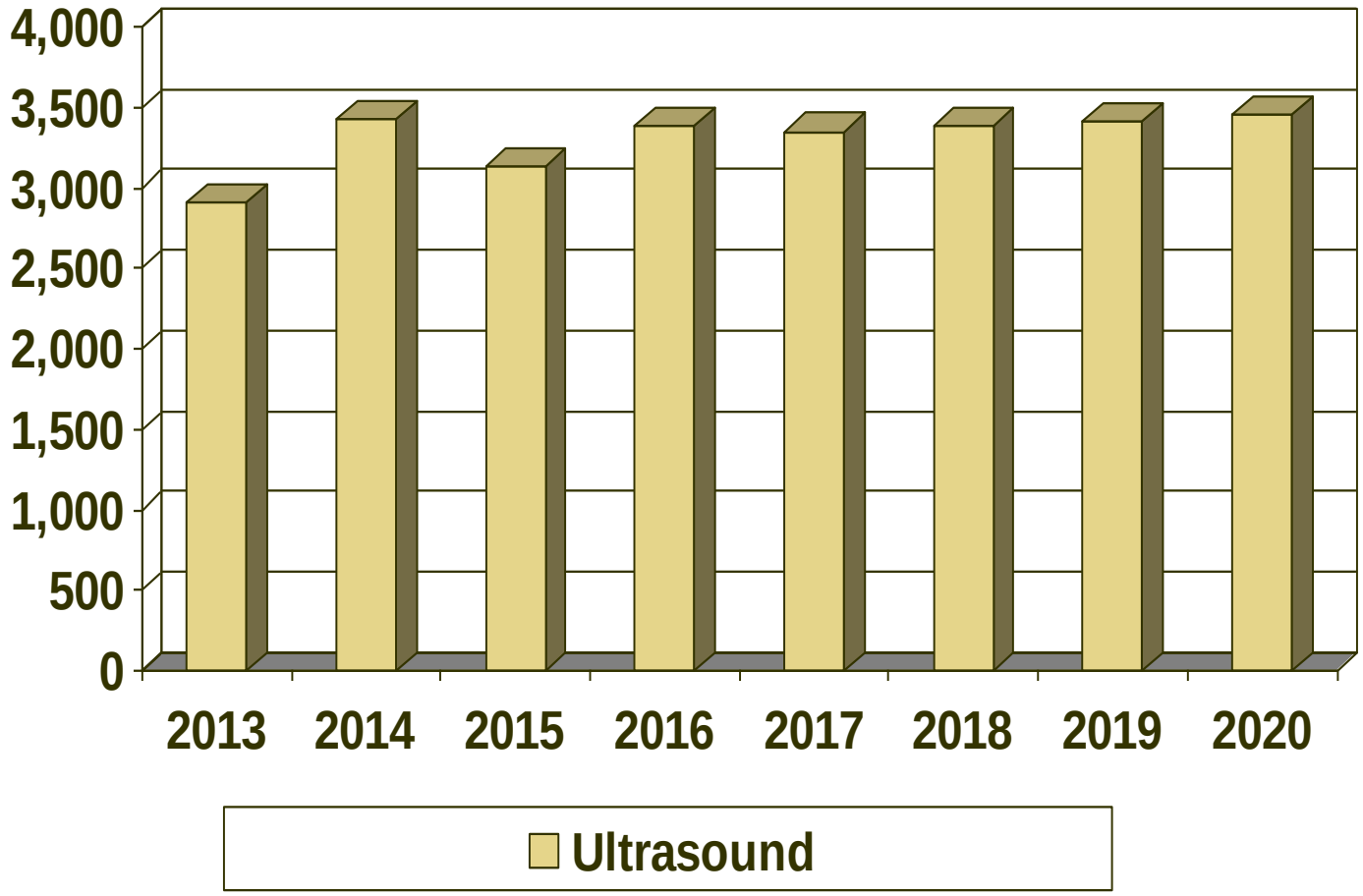
Diagnostic Imaging



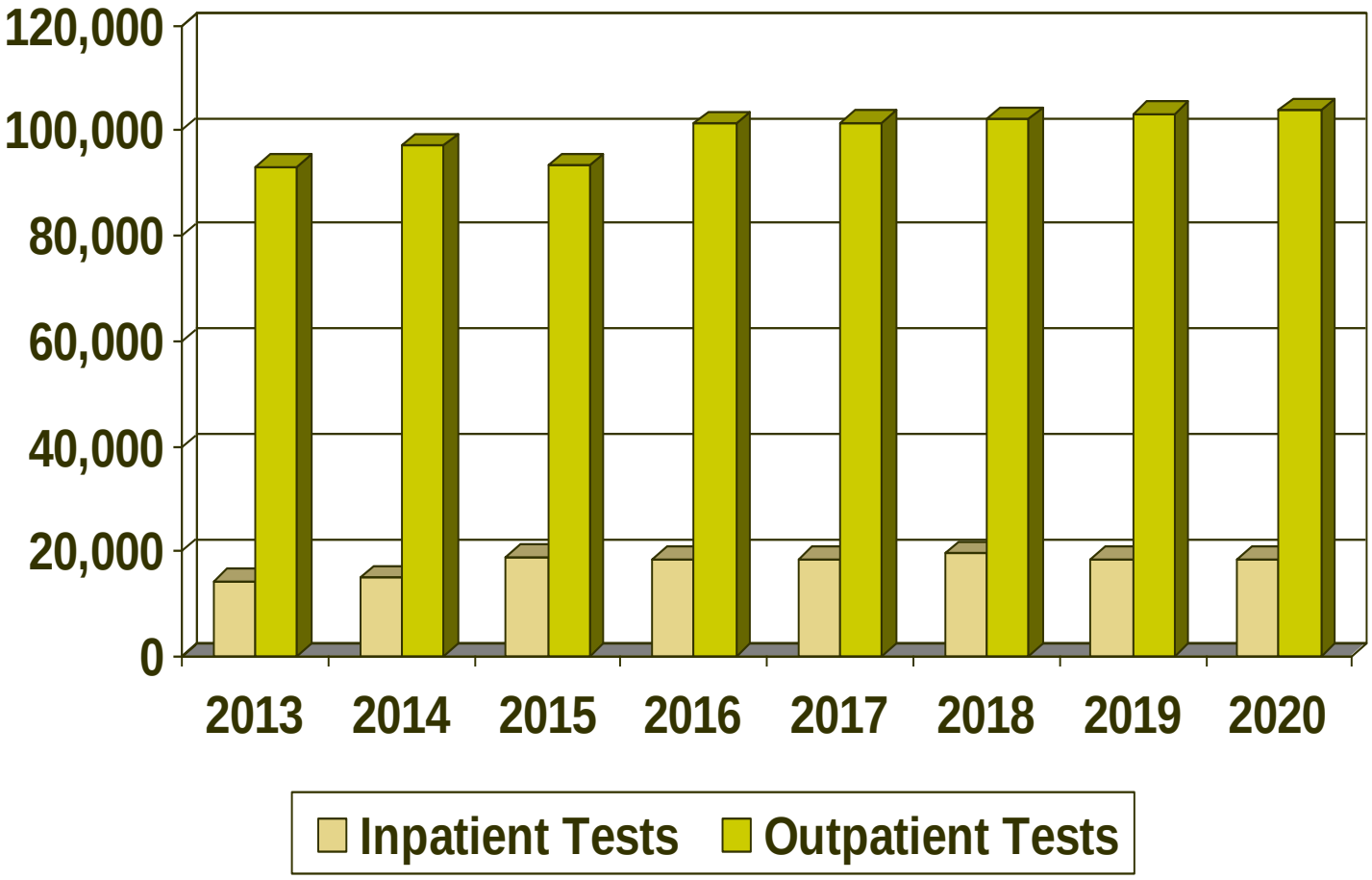
Diagnostic Imaging



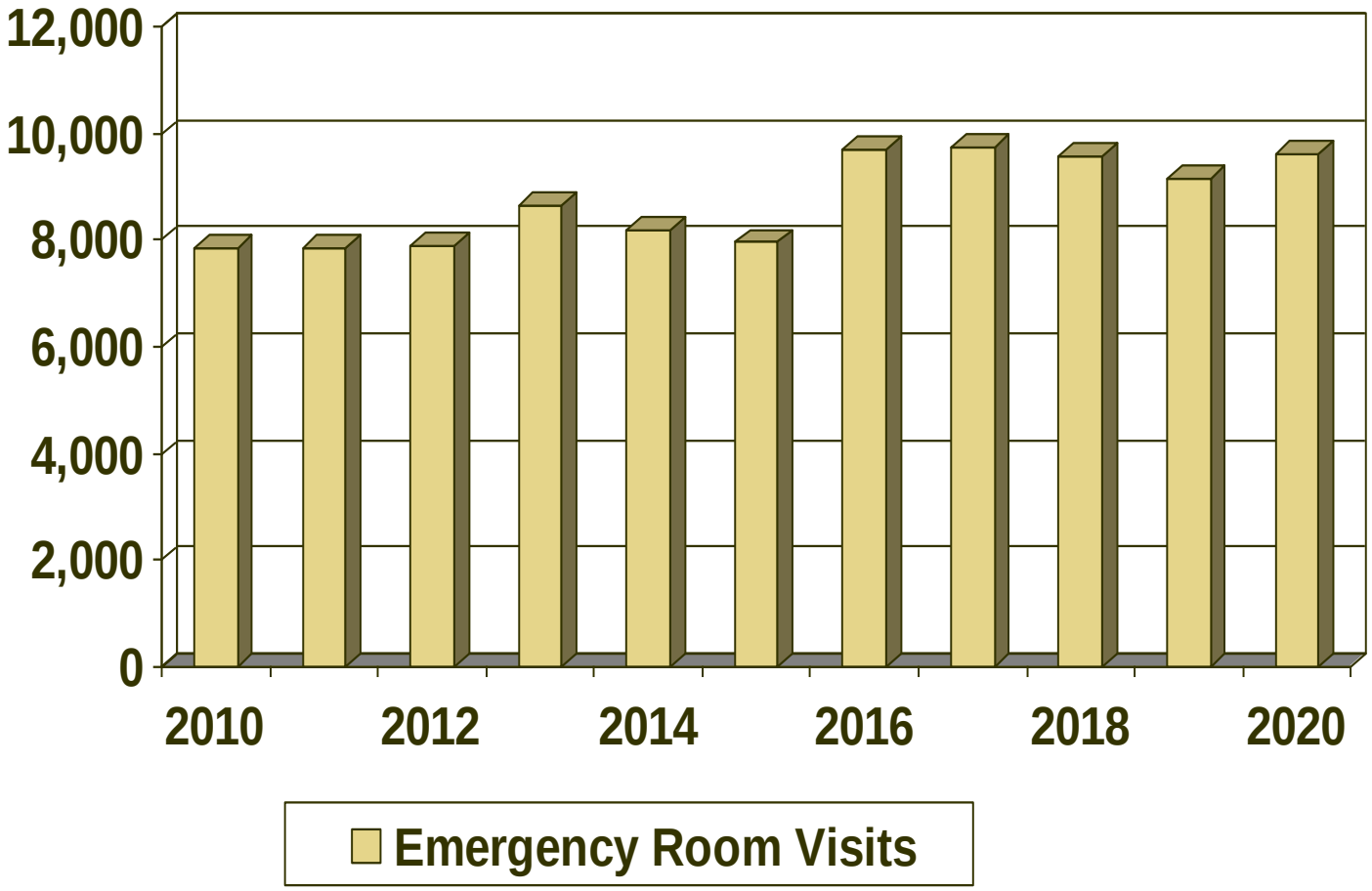
Diagnostic Imaging



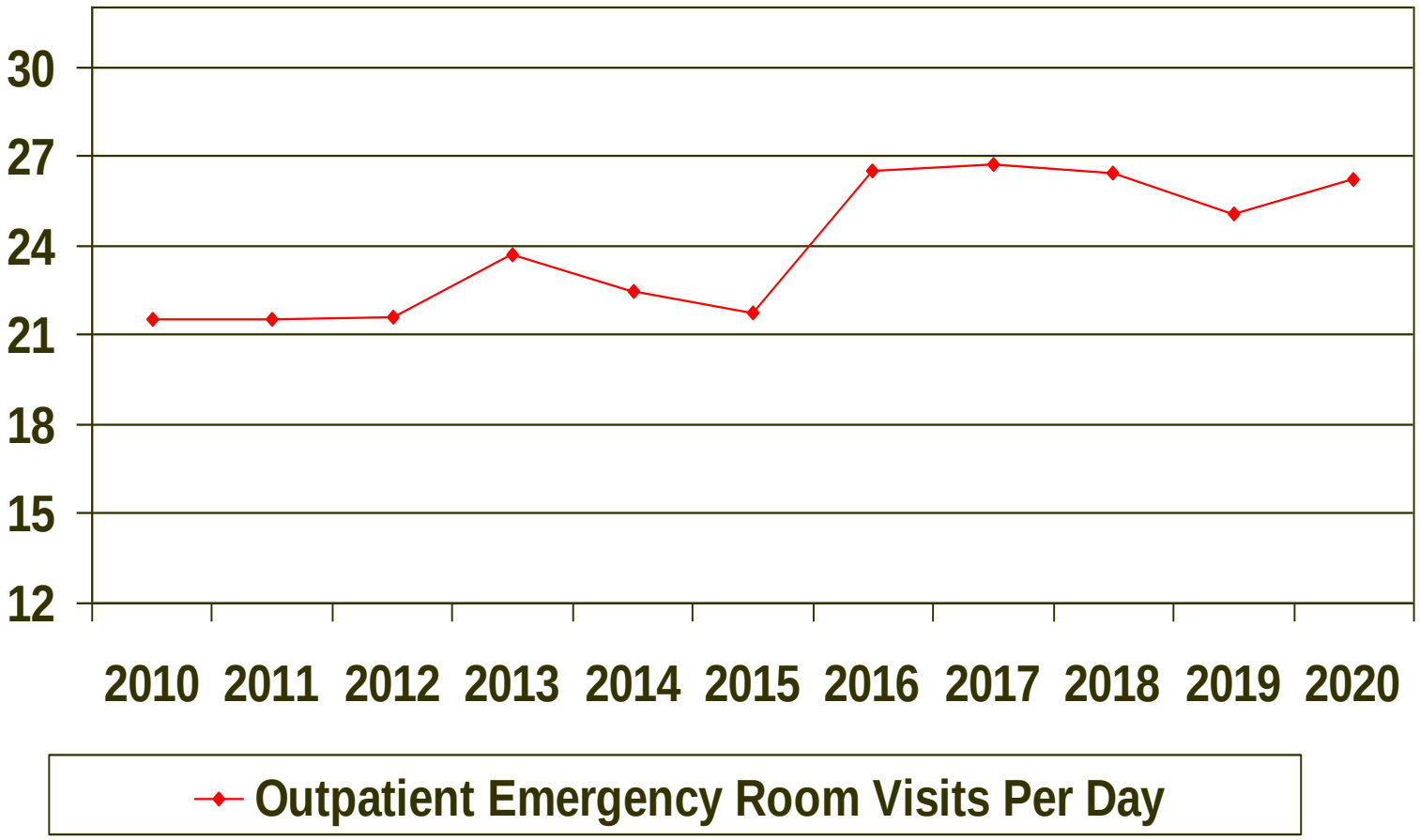
Laboratory Services



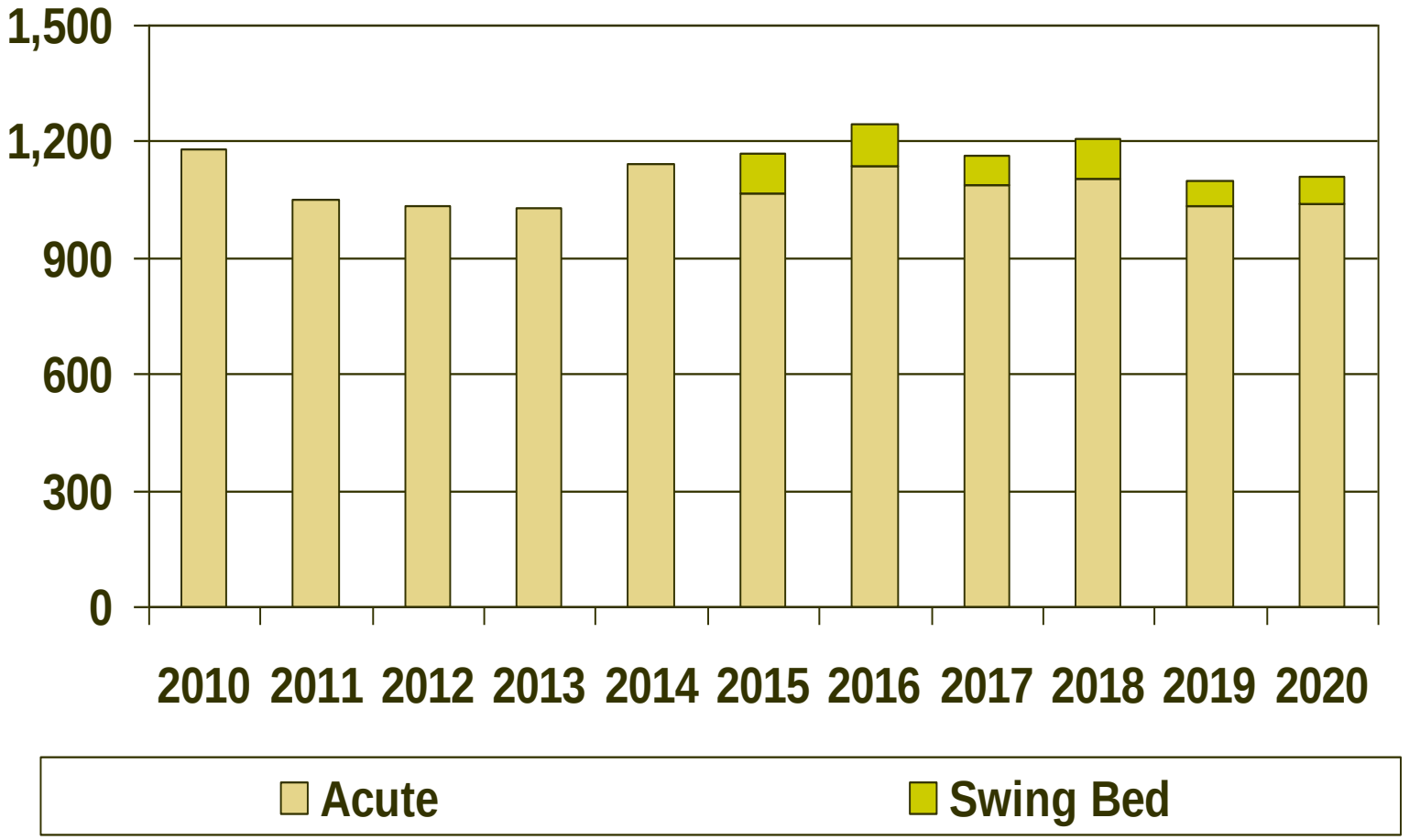
Emergency Room - Visits



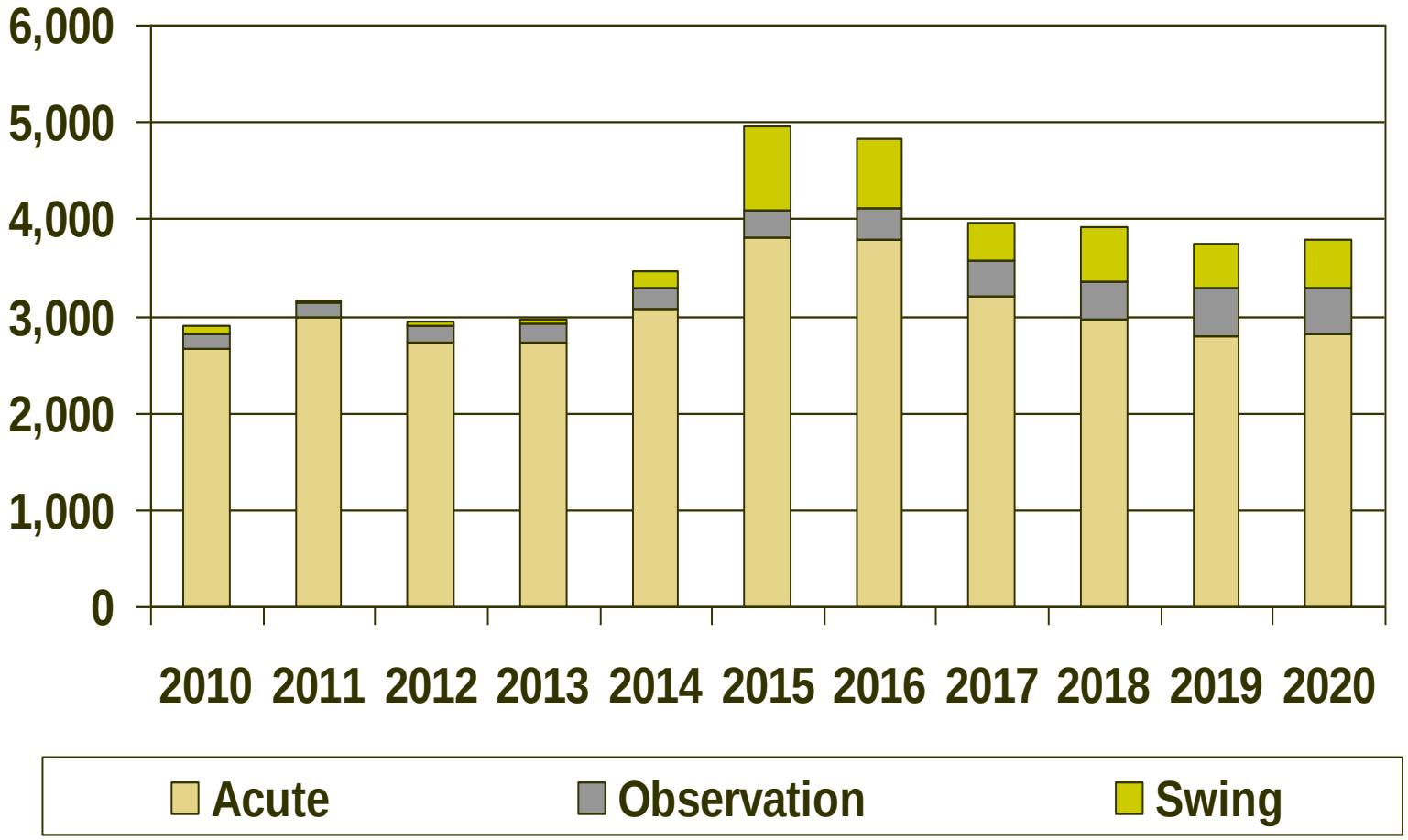
Emergency – Visits Per Day



Inpatient – Discharges



Inpatient Days



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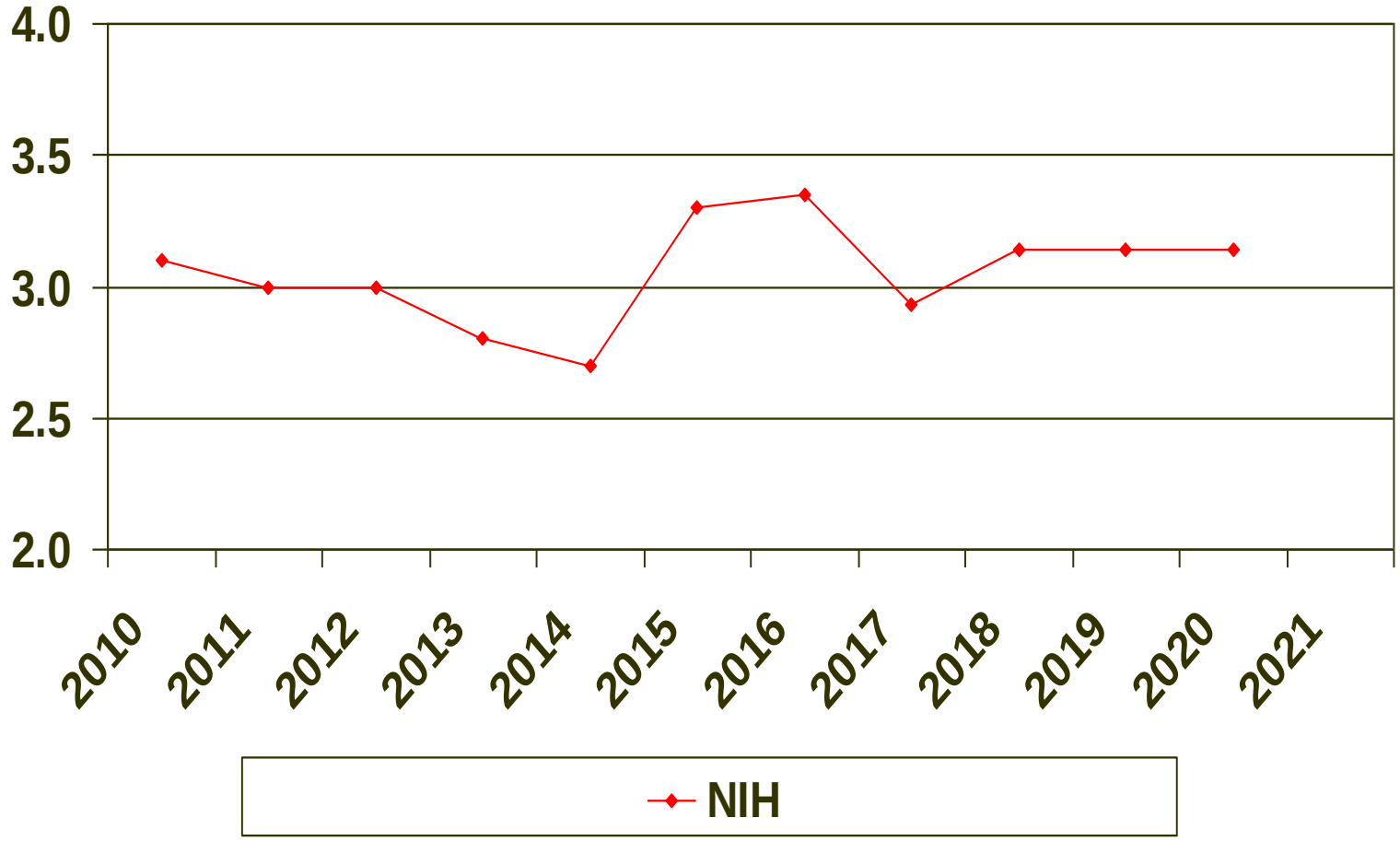
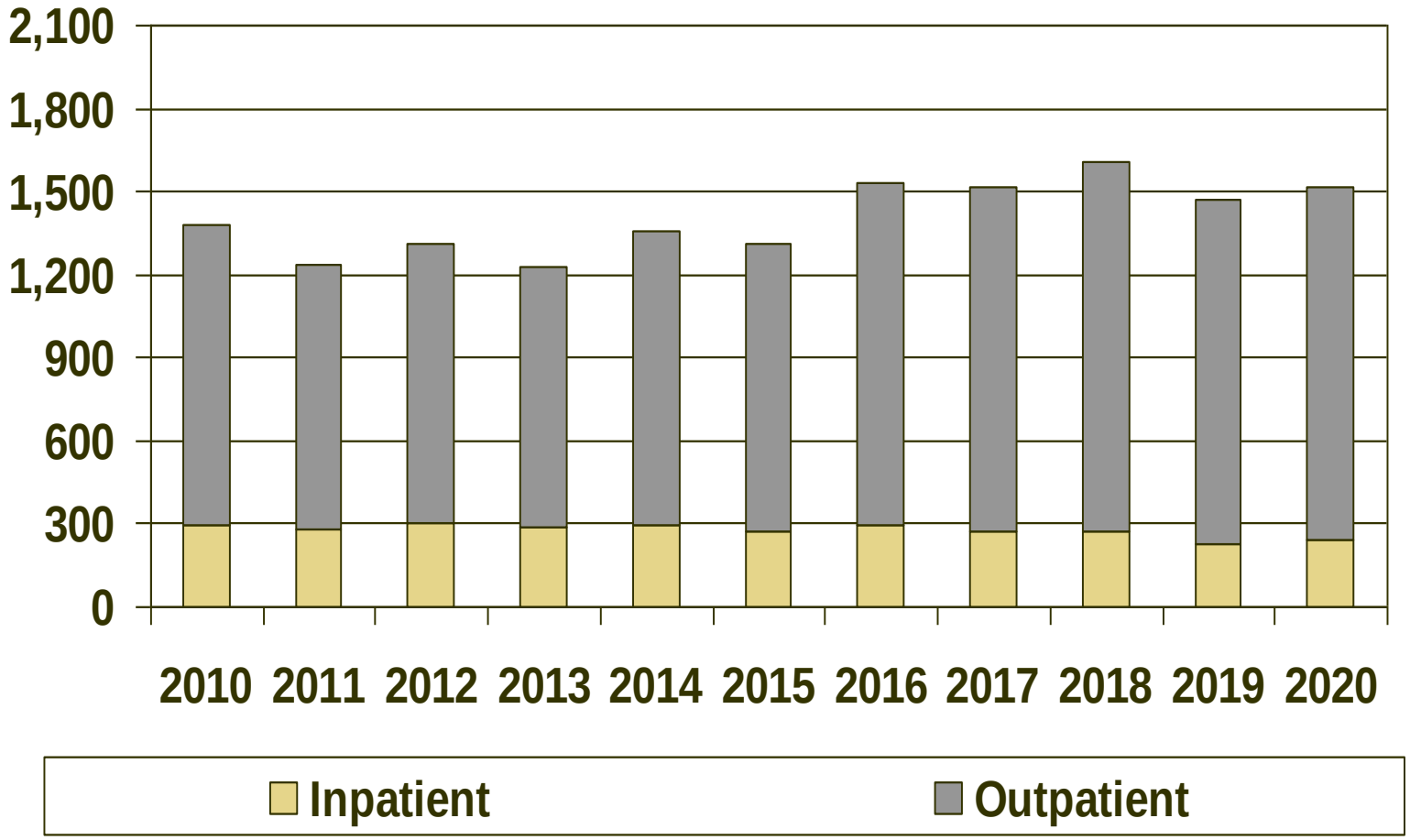
Inpatient - Length of Stay

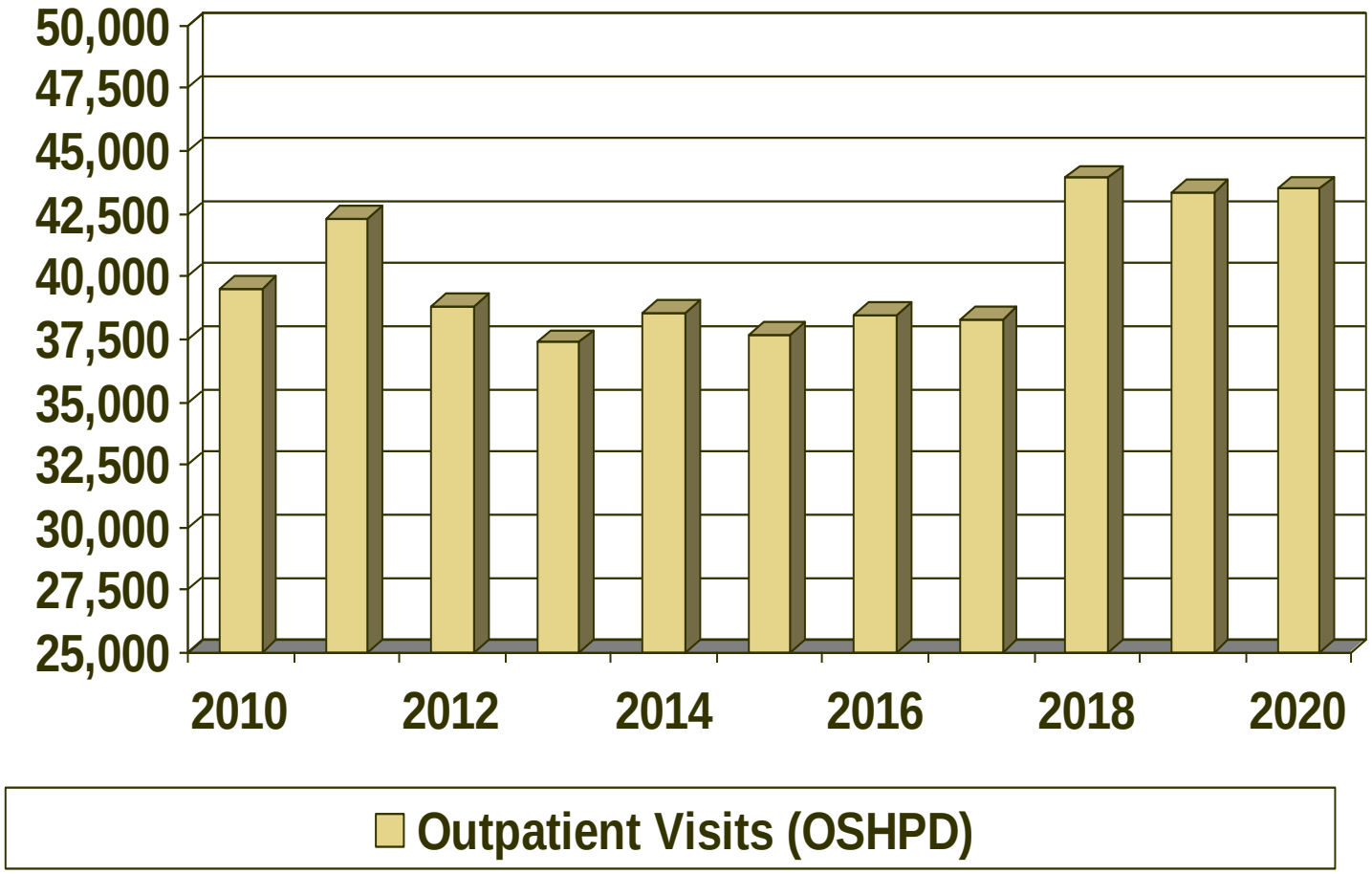


Surgical Cases



Budget includes 36 Urology cases

Outpatient Visits



2020 Budget Challenges

- **Low growth in traditional services, particularly inpatient, obstetrics, general surgery, imaging, laboratory and procedures**
- **Increase in base wages without more growth is increasing our cost per day**
- **ER Physician, Hospitalists & Anesthesia new contract rates**

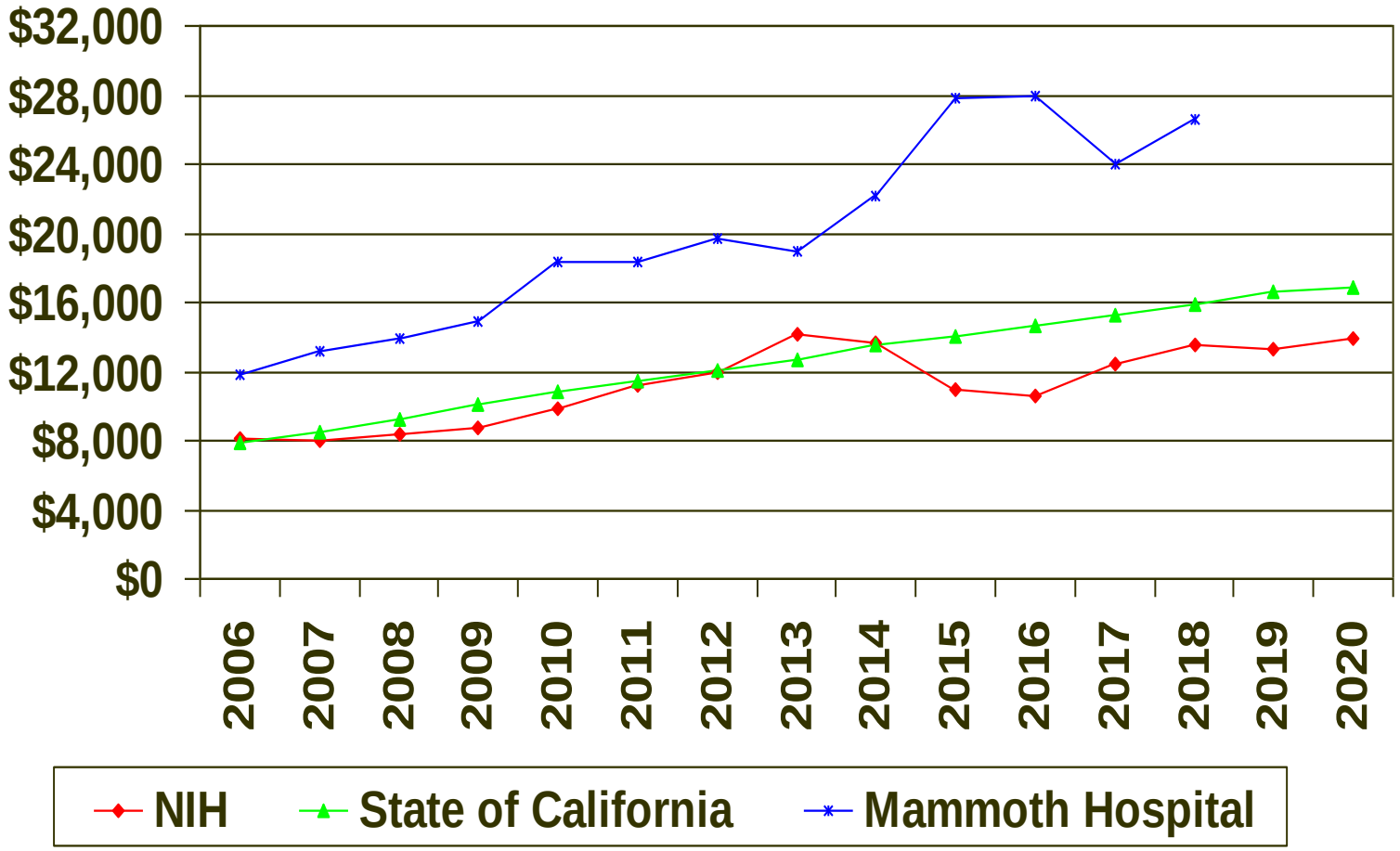
- **No expectation of Athena Net Cash Flow Add**

2019/2020 Revenues

- **Assumes 2017/2018/2019 outpatient visit growth is permanent**
- **Does not account for any departures from the medical staff**

- **Added 4.0% increase in fees, 3.2% net(excluding xray facility) and 60% increase in swing bed per day rate. (in response to Medicare inquiry)**

Average Daily Inpatient Charge



Assumes 4% Rise for California 2017 -2019

Intergovernmental Transfers

Intergovernmental Transfers are playing an ever increasing part of the payments for serving Medi-Cal patients and supporting District Hospitals in California.

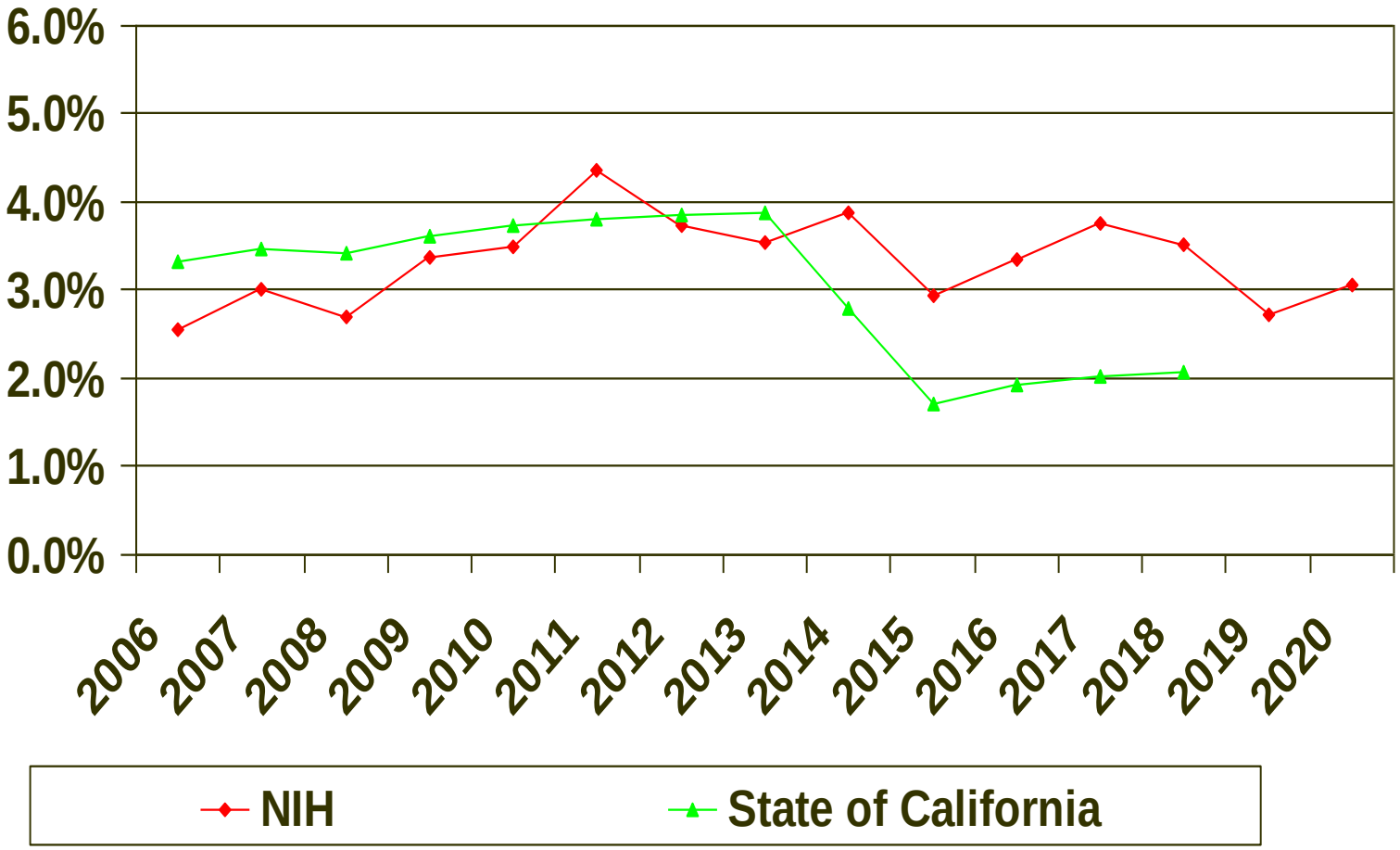
- General support from the State will be $131,940.
- Annual Medicaid IGT net grant of $271,800.
- Total Direct Grant of $1,042,000 for District Hospitals.
- Medi-Cal Managed IGT remains at $7,570,000 from $5,414,000 in the fall of 2018.

- Prime Incentive program (Non-Operating Donation) was $1,980,000 in October, 2018. Reduces to $1,782,000 in October, 2019 and $1,514,000 in October, 2020.

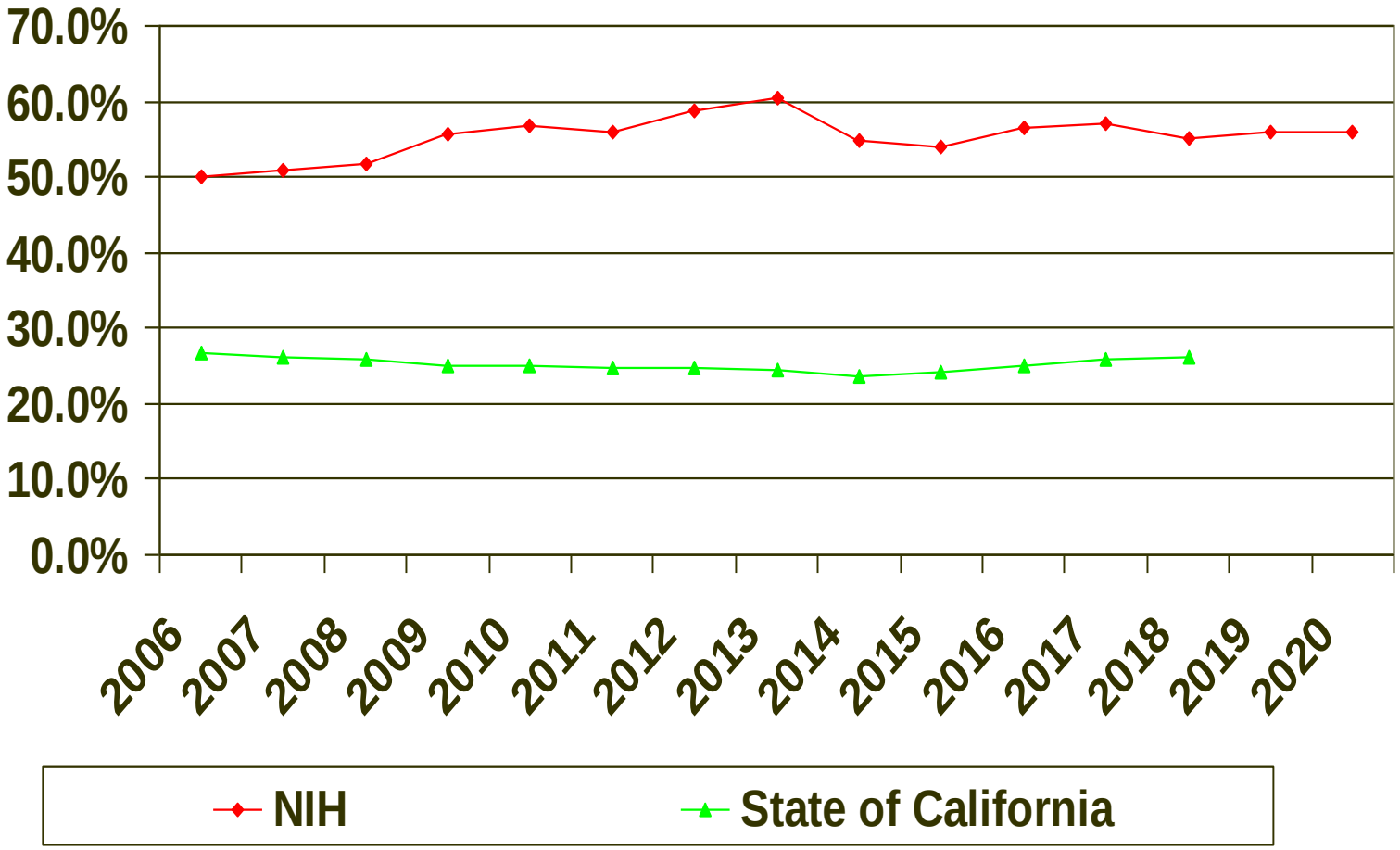
Policies for Fiscal 2020

- Continuation of the California mandated Charity Care for patients whose income is less than 300% of Federal Poverty Guidelines is budgeted for $1,959,000 including Medicaid unpaid Medicare deductibles and coinsurances
- Continuation of the 25% discount for residents of the District who pay their first statement within 30 days – (Budget value of $360,000)
- Continuation of the 50% discount for employees for their non-insurance covered portion of services from NIHD paid within 30 days of statement date (Budget value of $108,000)
- Continuation of General Discount (Budget value of $132,000)
  - 20% discount for private pay portion of bill paid with first statement for non-District patients
  - 30% discount for patients without insurance who pay promptly
- Total Charity Care & Voluntary Discounts of $2,559,000

Uncompensated Care Costs



Overall Cost to Charge Ratio



2019 rate is 55.85%[27]

Salary and Benefits

Salary Increases of 2.2% (Merit, CA Minimum and Technical)

Benefits

Continuation of Health Plan as is for 2020.

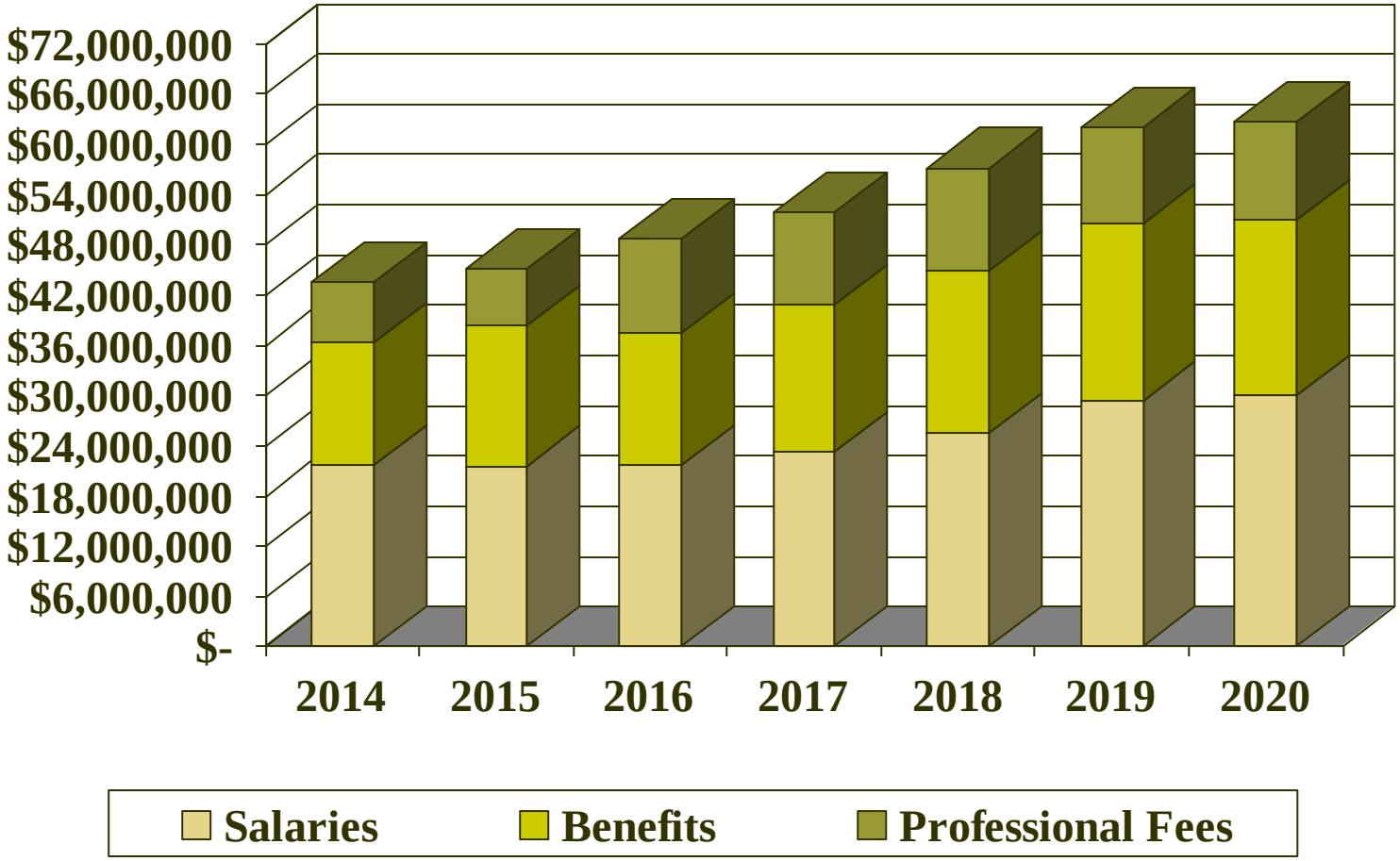
Other benefits (dental, life & pension) will remain at current levels. Monthly contribution of $500,000 into the Defined Benefit retirement plan. Worker's compensation costs are increasing 4%.

As employee turnover occurs, the percentage of employees on the defined benefit pension plan decreases and is expected to drop to under 50% during 2020. Defined Contribution rate to remain at 7%.

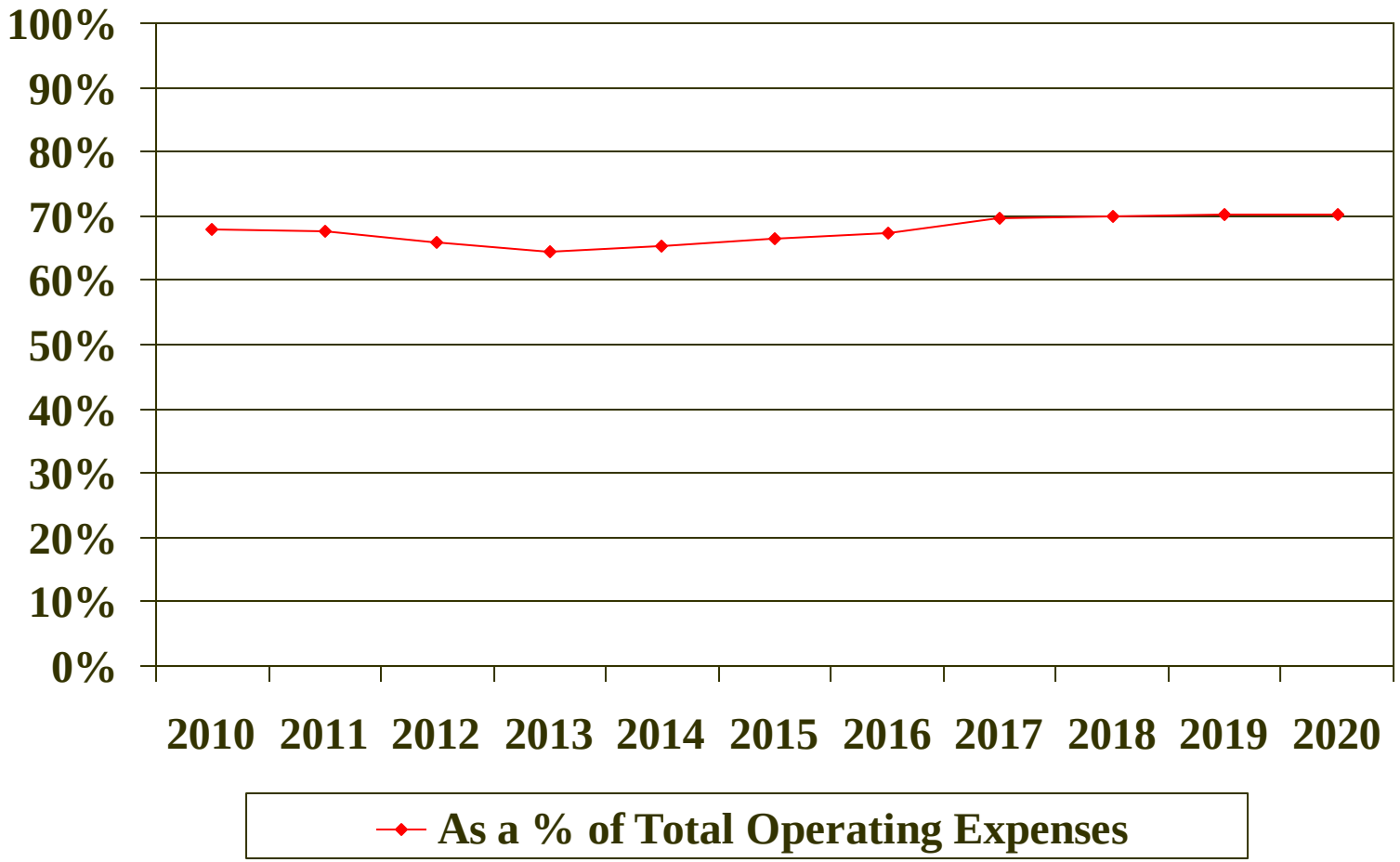
FTEs

Total FTEs including contracted staff of 446.70, 15.1 per adjusted patient day consistent with 2019.

Salaries & Benefits



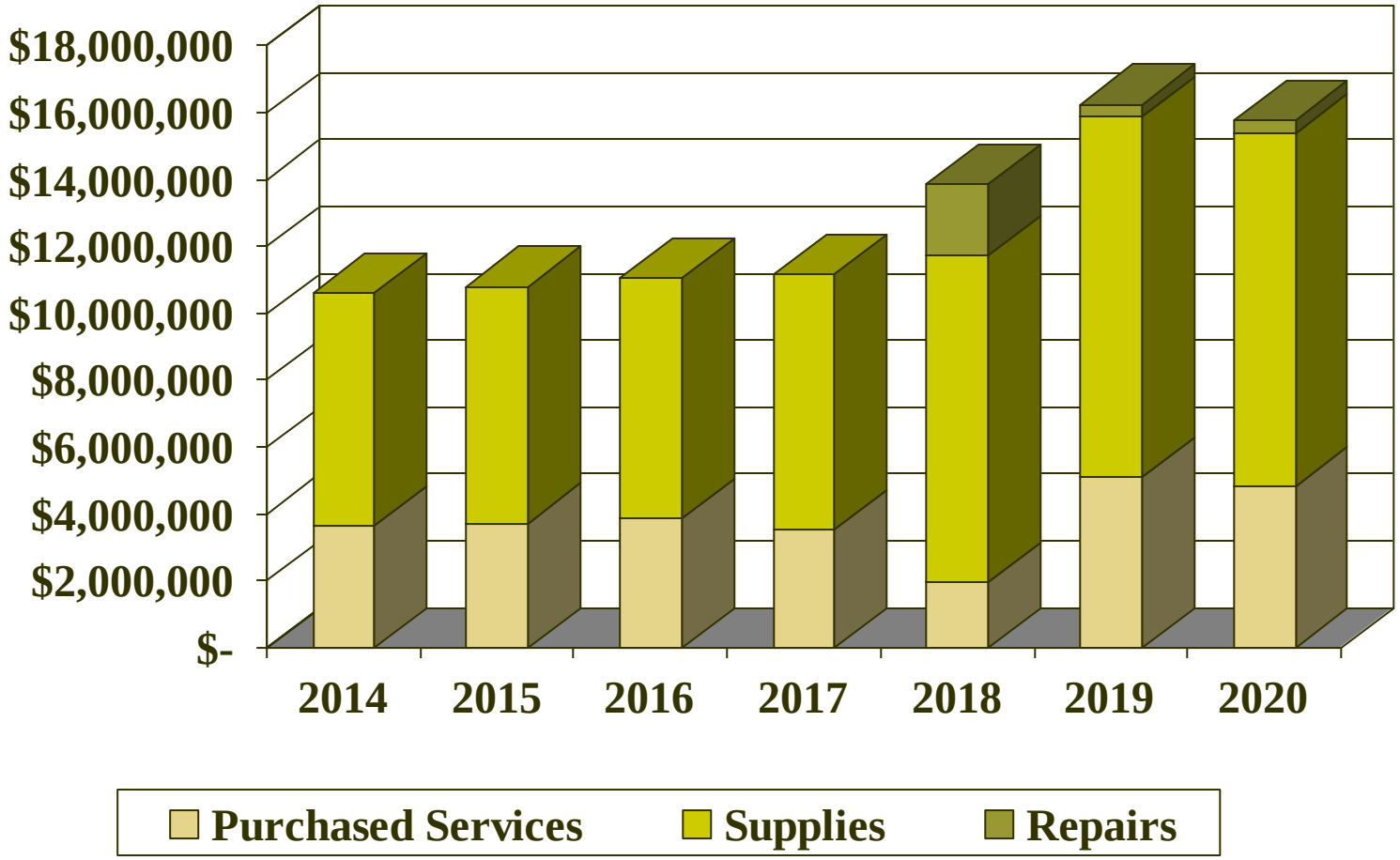
Salaries, Benefits & Professional Fees



Purchased Services

- **Athena added for 366 days of net AR at 1.6% of net revenue**
- **Other service contracts budgeted by month of implementation**

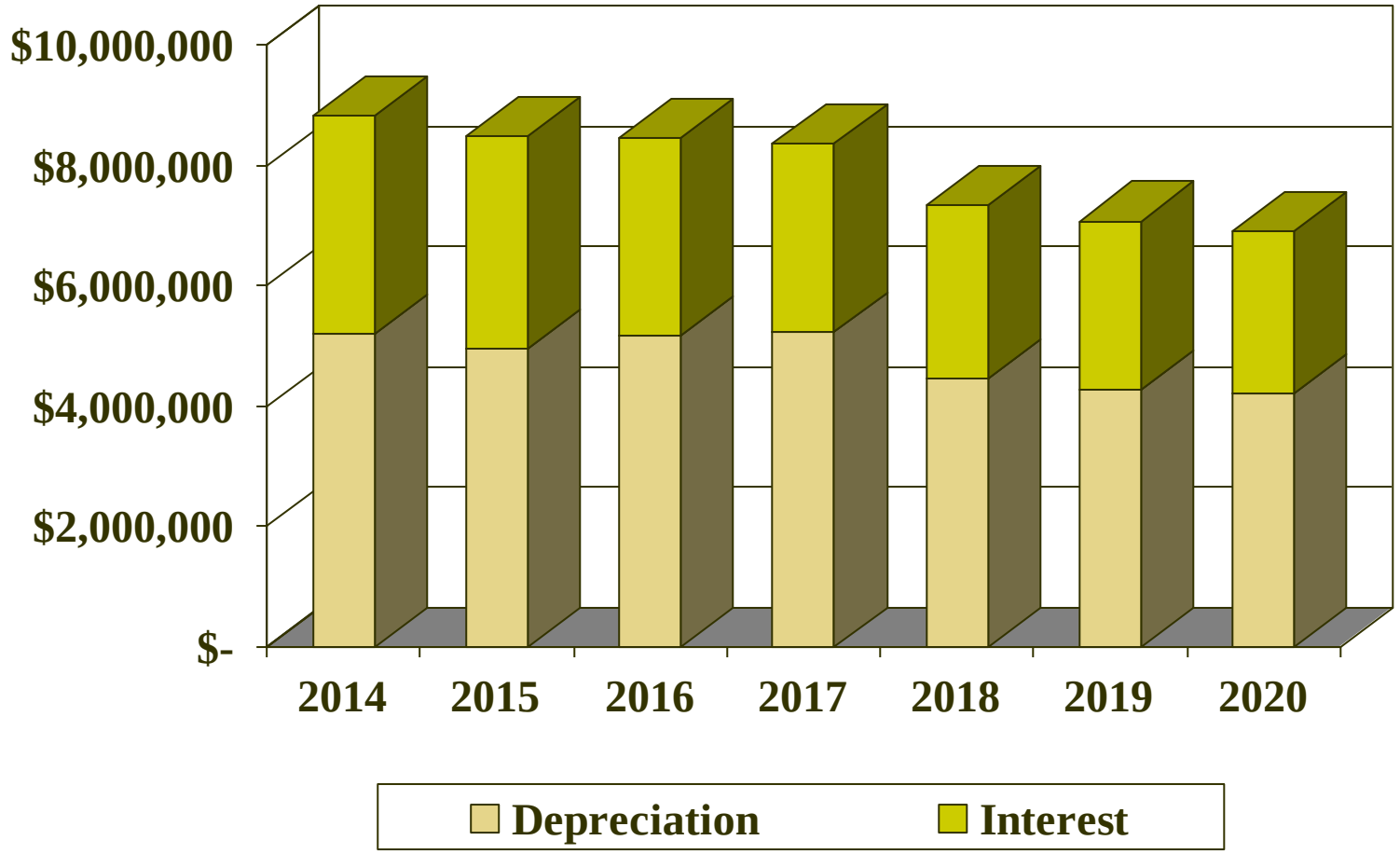
Purchased Services & Supplies



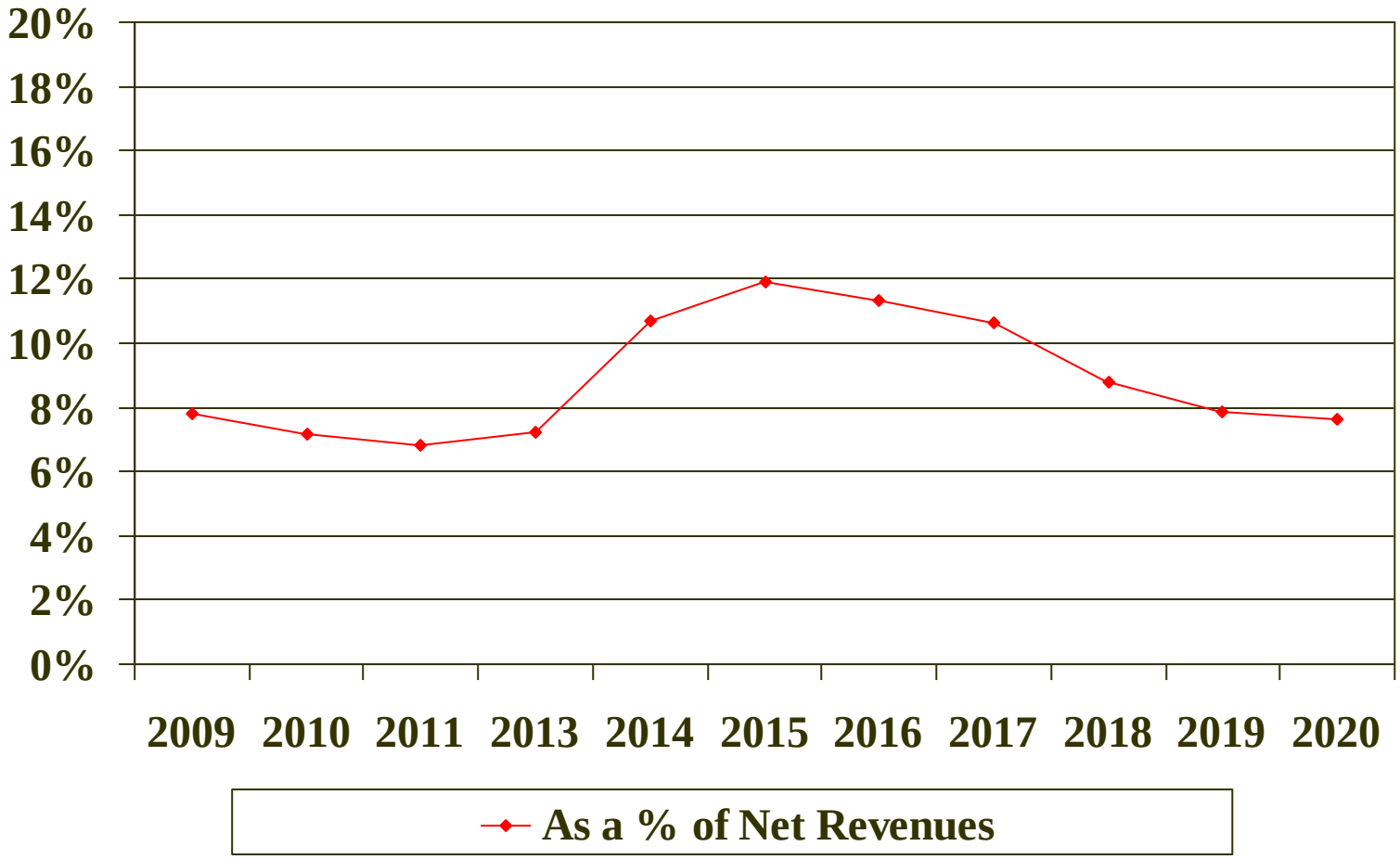
Capital

- **New expenditures of $2,072,000 budgeted in depreciation and limited capital associated with Athena changes. Completion of the delayed 2018 building separation project.**
- **No gain or loss on disposal of fixed assets budgeted in 2020**

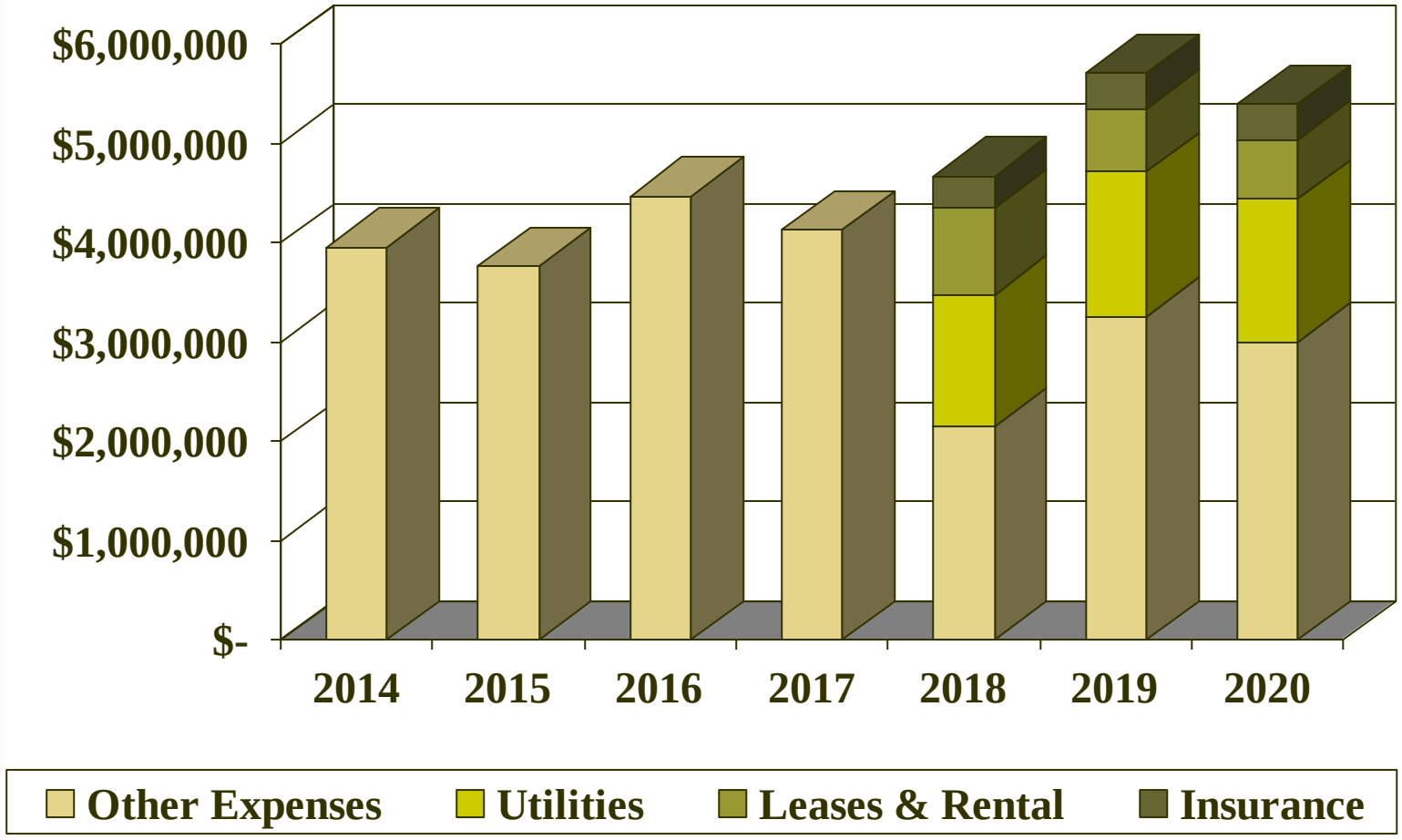
Depreciation, Amortization & Interest Expense



Depreciation, Amortization & Interest Expense



Other Expenses



Includes $300,000 of staff development (1.0% of wages)

2019/20 Revenues

	Budget 2020	Actual 2019	Budget 2019
Inpatient Revenue	33,905,600	32,378,337	46,182,472
Price Change	1,084,000	1,342,000	1,847,299
Gross Inpatient Revenue	34,989,600	33,720,337	48,029,771
Revenue Per IP Patient Day	**$ 11,950**	**$ 12,030**	**$ 14,708**
Patient Days without newborns	**2,928**	**2,803**	**3,140**
Average Daily Acute Census	**8.00**	**7.67**	**8.60**
Outpatient Revenue	111,433,200	107,207,991	106,185,037
Price Change	3,564,000	4,288,000	4,247,400
Gross Outpatient Revenue	114,997,200	111,505,991	110,432,437
Observation Adj, Days	**500**	**485**	**500**
ER Visits (all visits)	**9,240**	**9,153**	**9,860**
Outpatient Visits	**42,520**	**42,380**	**47,520**
Revenue Per OP Visit	**$ 2,704**	**$ 2,631**	**$ 2,324**
All Surgeries	**1,490**	**1,470**	**1,556**
RHC Encounters	**30,600**	**29,446**	**35,400**
Total Gross Patient Revenues	157,186,600	152,010,388	158,462,208
Total Adjusted Patient Days	**12,661**	**12,365**	
Adjusted Average Daily Census	**34.6**	**34.6**	
Paid FTEs Per Adjusted Patient Day	**15.1**	**14.8**	
Equivalent FTEs Per Adj Patient Day	**18.0**	**18.1**	

2019/2020 Operating Expenses

	6/30/2020	06/30/2019	06/30/2018
Operating Expenses	Budget	Actual	Actual
Repairs and Maintenance	390,000	382,730	2,115,416
Leases and Rental Expenses	600,000	633,212	868,174
Salary & Wages	30,012,000	29,313,248	25,697,886
Benefits	21,360,000	21,295,107	20,356,883
Non-Benefit Expenses	168,000	162,015	215,708
Professional Fees	11,640,000	11,239,910	13,193,098
Supplies	10,400,000	10,784,508	9,805,557
Contract Services	4,800,000	5,078,940	1,940,460
Other Department Expenses	1,200,000	1,197,130	864,873
Hospital Insurance Expenses	360,000	357,156	328,948
Utilities	1,440,000	1,461,951	1,335,358
Depreciation and Amortization	4,200,000	4,267,097	4,456,698
Other Fees	1,800,000	2,057,617	1,351,940
Interest Expense - Operating	2,700,000	2,806,976	2,892,775
Total Operating Expenses	91,070,000	91,037,597	85,423,774
Total Net Operating Profit (Loss)	1,767,000	2,017,263	1,790,885

2019/20 Other Operations

Non-Operating Revenue	6/30/2020	06/30/2019	06/30/2018
Other Income	Budget	Actual	Actual
Tax Payer General Support	630,000	582,377	681,324
Bond/ Tax Payer Bond Support	1,718,400	1,660,198	1,543,646
Investment Income	60,000	127,510	0
Fin Chgs-Pt Ar - Int Incm-Payors	21,000	21,223	48,403
Interest Income	450,000	584,157	311,058
Interest on Patient Account	0	2,765	0
Total Other Income	2,879,400	2,978,230	2,584,431
Grant Revenue	1,760,000	2,118,948	1,559,430
Other Non-Operating Income	12,000	24,155	25,349
Net Medical Office Activity	(6,000,000)	(6,210,601)	(4,800,520)
340b Net Activity	324,000	327,613	546,069
Donations	15,600	21,950	0
Rental Income	42,000	40,192	47,162
Gain - Investments - Other Income	0	39,203	(52,546)
Total Non-Operating Revenue	(967,000)	(660,310)	(90,625)
Non-Operating Expenses	(300,000)	(398,206)	0
Total Net Non-Operating Profit	(1,267,000)	(1,058,516)	(90,625)
Total Net Income	500,000	958,747	1,700,260

Net Operations

- **Net Income of $500,000, .6 % net margin**
- **Negative cash flow of ($1,200,000) related to payment timing of 2005 Bonds and final completion of building separation project (delayed since 2018)**
- **Adequate Financial Ratios**
- **Reduce A/R Days to below 90**
- **Days Cash on Hand at a minimum of 90 by end of Fiscal year**
- **Cost of Capital equal to 5.21%**

Request from Management

- **Approve the Operating Budget for 2019/20**
- **Authorize the creation of any other appropriate documents and resolutions as required to implement the Operating Budget**

RESOLUTION NO. 20-02
Of the
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS

WHEREAS, on February 17, 2016, the Northern Inyo Healthcare District Board of Directors authorized the Hospital Administrator (CEO) and the Chief of Fiscal Services to invest the cash reserves and operations funds of the Hospital District in legal forms of investment as specified in Government Code section 53635; and

WHEREAS, the Board of Directors of Northern Inyo Healthcare District now desires to authorize the Chief Executive Officer (CEO), the Chief Financial Officer (CFO), the Chief Nursing Officer (CNO) and Chief Operating Officer (COO) to invest the cash reserves and operations funds of the Hospital District in legal forms of investment as specified in Government Code section 53635.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 18th day of February, 2020, that the Chief Executive Officer (CEO), the Chief Financial Officer (CFO), the Chief Nursing Officer (CNO) and Chief Operating Officer (COO) be authorized to invest the cash reserves and operations funds of the Hospital District in legal forms of investment as specified in Government Code section 53635; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____
Jean Turner, President

_____
Jody Veenkar, Secretary

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
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Compliance Report
February 2020

1. Comprehensive Compliance Program review
    a. As February 8, 2020, 98.1% District's employee (including temporary, traveler, and contract workers) workforce have reviewed the Compliance Program. This number fluctuates due to employee turnover.
    b. 92% of District workforce, including providers, have completed HIPAA training for CY 2019 (updated 11/2019, waiting for 2019 totals).
2. Breaches
    a. Calendar Year (CY) 2019 (Charts and graphs will return in future reports)
        i. 65 alleged breaches of PHI (Protected Health Information) potentially affecting approximately 500 patients have been investigated by the Compliance Office
        ii. 7 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and/or the Office of Civil Rights (OCR)
            1. CDPH has completed investigation of five cases. All 5 were substantiated, but assigned no deficiency.
            2. Two cases are still pending CDPH investigation.
            3. Several cases from prior years are still pending letters of findings, indicating that at least several may incur some level of deficiency and penalty.
        iii. 6 reported potential breaches/privacy concerns are currently under investigation by the NIHD Compliance Department.
3. Issues and Inquiries
    a. CY 2019 – Several hundred requests for research and input on a wide variety of compliance, ethics, and regulatory topics have been made to the Compliance Department.
    b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2019, Compliance has verified several hundred providers. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.

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   i. Compliance has identified two referring providers on an exclusions list in 2019. We have notified Administration, and have properly addressed the issues.

4. Audits
   a. Employee Access Audits (see tables, attachment A) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees access records only on a work-related, "need to know," and "minimum necessary" basis.
      i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
      ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
      iii. Compliance has updated the methodology to ensure audits are done within days of patient visits rather than the beginning of the following month, as previously performed. This allows for thorough auditing within days of any event.
      iv. Compliance performs between 250-500 audits monthly.
         1. Each audit ranges from hundreds of lines of data to thousands of lines of data.
      v. Protenus has been selected to provide semi-automated auditing software services to NIHD, however, Athena is unable to meet its requirements for the data feeds. Protenus will be reassessed following implementation of a new EHR.
   b. Business Associates Agreements (BAA) audit
      i. Contracts will be reviewed in 2020 to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
      ii. We currently have approximately 140 Business Associates Agreements.
   c. PACS (Picture Archival and Communication System) User Access Agreements – Compliance is now processing access agreements for external entities/providers to gain access to the NIHD PACS Portal (electronic Imaging system).

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d. HIMS scanning audit – small sample audit of patient charts demonstrated 100% compliance with scanned document locations (12/2019)
e. Language Access Services Audit – Small sample audit of limited English proficiency (LEP) patient charts for 5-7 areas of documentation each found 0 charts with 100% correct documentation (11/2019). Compliance and Language Access Services working to develop plans for tools and additional education for workforce.
f. HIPAA Security Risk Assessment – Completed November 2019 (requires collaboration between Compliance Officer and Security Officer)
    i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.
    ii. Risk Management plan is currently in development
    iii. NIHD is currently in a "soft roll out" of the VendorMate (GHX) vendor credentialing software. This allows us to be compliant with our Vendor Credentialing Policy, and several facility security elements of 45 CFR 164. Hard go-live is tentatively scheduled for March 2020.
g. An audit of the 340B plan has been conducted. The report will go to the Compliance and Business Ethics Committee in February 2020 to provide a recommendation to NIHD Executive Team.
h. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is currently underway. This will provide organized historic data to the Board and allow the Board to determine if appropriate follow up has been taken for Action items and Resolutions.

5. Conflicts of Interest questionnaires
    a. Compliance will send the 2020 Conflict of Interest Questionnaires out in the month of March.
6. CPRA (California Public Records Act) Requests
    a. The Compliance office has responded to 21 CPRA requests in CY 2019.
        i. 4 requests throughout the year for companies that harvest purchasing data from healthcare organizations to aid their marketing products.
        ii. 1 request is from Transparent California
        iii. 9 are from District residents
        iv. 7 requests have been from the ASCFME organizer or their legal representatives.

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   b. The Compliance office is responding to 3 CPRA requests in CY 2020.
      i. 1 from the Center for Contract Compliance - Construction
      ii. 1 request is from a local journalist
      iii. 1 is from a local District resident
7. Compliance Workplan (attachment B)
   a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
   b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.
   c. The attached work plan was updated in February 2020 for progress and is scheduled for review in the Compliance and Business Ethics Committee.
8. Unusual Occurrence Reports (UOR) (Attachment C)
   a. All unusual events are reported through the UOR system. (complaints, med errors, unusual events, Corrective Action Plan tracking items, etc)
   b. See attached reports – please note while data has been validated, we are still getting the reports "dialed in"
      i. Some labeling needs to be corrected
      ii. Some layout features need to be corrected
   c. ComplyTrack- tracking software – system went live on 4/15/2019 and will be transitioning to Nursing Quality in April of 2020.
9. CDPH Licensing Survey Response Monitoring (Attachment D)
   a. Compliance has been working with Department leadership teams to follow corrective actions and monitor for sustained compliance. Those metrics will be reported here, no less than annually. Metrics that have already been reported to the Board of Directors as completed have been removed from this list.
      i. E 239 - Referral arrangements from non-staff ordering providers. – Monitoring in progress 11/2019
      ii. E 242 - Pediatric Consultations – Monitoring in progress 11/2019
      iii. E1363 - Expired supply in crash cart - Monitoring in progress 11/2019
      iv. E 2150 - Infection Prevention Program monitoring – Monitoring in progress 10/2019

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1. Cleaning Wet time – ongoing monitoring 11/2019

v. E 2151 - Workforce N95 mask fit testing – Goal achieved. Quarterly monitoring for 2 additional quarters.

10. The Joint Commission Survey Response
    a. Submitted and accepted
    b. Monitoring will be submitted to the Board in May 2020 Report.
11. Compliance and Business Ethics Committee
12. Auditing and Monitoring for CDPH 00580957 (ends March 2020)
    a. Audit of Surgeons for printing documents for intra-facility transport:
    No documents were printed for transport between office and Hospital between April 2018 and January 2020.

Employee Access Audits

A

	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
TOTAL ED SAME LAST NAME ENCOUNTERS	234	240	37	12	107	53
AUDITED ED SAME LAST NAMES ENCOUNTERS	234	240	37	12	107	53
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL ED HIGH PROFILE PT ENCOUNTERS	4	5	5	1	13	7
AUDITED ED HIGH PROFILE ENCOUNTERS	4	5	5	1	13	7
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL ED - EMPLOYEE ENCOUNTERS	2	10	13	7	8	17
AUDITED ED - EMPLOYEE ENCOUNTERS	2	10	13	7	8	17
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP SAME LAST NAME ENCOUNTERS	22	24	16	12	11	12
AUDITED IP SAME LAST NAMES ENCOUNTERS	22	24	16	12	11	12
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP HIGH PROFILE PT ENCOUNTERS	0	0	2	0	0	0
AUDITED IP HIGH PROFILE ENCOUNTERS	0	0	2	0	0	0
% AUDITED	#DIV/0!	#DIV/0!	100.0%	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL IP - EMPLOYEE ENCOUNTERS	0	0	10	3	0	2
AUDITED IP - EMPLOYEE ENCOUNTERS	0	0	10	3	0	2
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	100.0%
TOTAL OP SAME LAST NAME ENCOUNTERS			144	56	28	232
AUDITED OP SAME LAST NAMES ENCOUNTERS			144	56	28	232
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP HIGH PROFILE PT ENCOUNTERS			18	7	11	26
AUDITED OP HIGH PROFILE ENCOUNTERS			18	7	11	26
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP - EMPLOYEE ENCOUNTERS			91	125	128	178
AUDITED OP - EMPLOYEE ENCOUNTERS			91	125	128	178
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL NEW (<90 DAY) EMPLOYEES	2	6	16	7	11	15
AUDITED NEW (<90 DAY) EMPLOYEES	2	6	16	7	11	15
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FOR-CAUSE AUDITS	5	9	2	0	4	3
Total # monthly audits	269	294	354	230	321	545

Compliance changed the methodology to provide more effective and efficient auditing of high risk records in August of 2019.

Annual Compliance Workplan

No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Completed Jan 2020
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17) Educational and instructional information on Board Oversight and Fiduciary Responsibilities sent to Board in December 2019 and January 2020.	Colin Coffey, Jan 2019. "Takeaways" from monthly HCCA magazine
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		In progress
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Annual review conducted on regular monthly schedule Throughout the year
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		
9.	Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access.	R-BAT created 7/2018. Currently working with Athena to update RBA controls.	Stalled due to lack of granularity of Athena access control security
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce	Completed at Orientation. Need to send to Med Staff. PPM and Relias for current workforce.	

Annual Compliance Workplan

	referrals and other current legal standards.		
Compliance Communication			
11.	Review investigation UORs. Prepare summary report for Compliance Committee on types of issues reported and resolution	Update for Complytrack	Feb 2020
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.		
13.	Document test and review of Compliance Hotline.		Completed 4/2019
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Completed 01/2020
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new providers. MSO verifies all medical staff. Accounting verifies all vendors.	Current through 02/2020
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		
17.	Audits		
	a. Telehealth audits		
	b. 340B Program	In progress	01/2020
	c. EMTALA		
	d. Cost reports	Wipfli	Completed at BOD 1/2020
	e. Payment patterns	PEPR report out in April	
	f. Bad debt/ credit balances		
	g. OPS – Home health and DME	HHS OIG target	
	h. PHH Annual Compliance Audit		02/2020
	i. Audit of District Board Agendas, Minutes, and Resolutions		12/2019 - ongoing
	j. Travel Reimbursement Audits		01/2020-ongoing
	k. Contract Audits		
	l. BAA audit		12/2019
	m. HIMS Scanned Document accuracy		12/2019

Annual Compliance Workplan

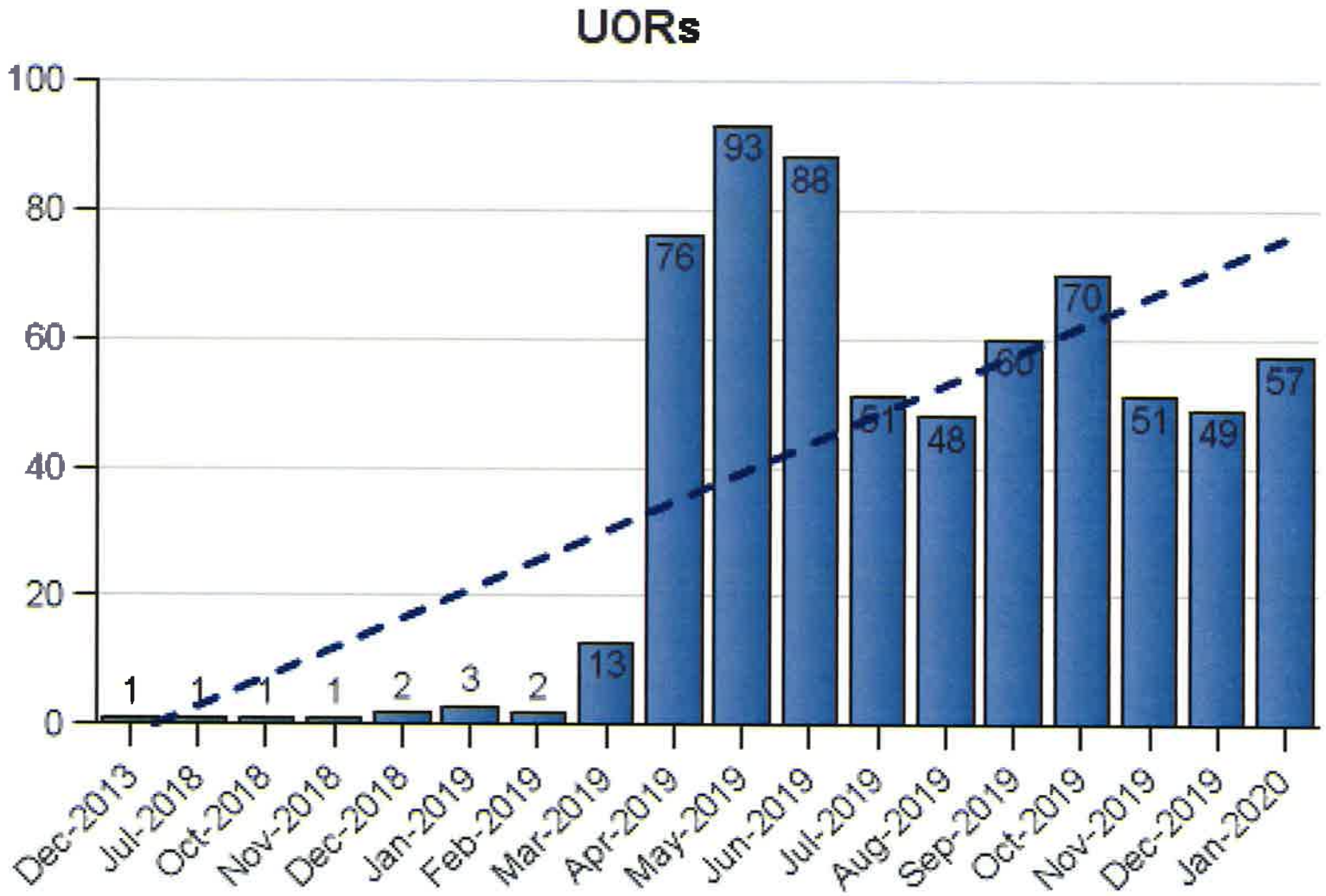
	n. Language access documentation accuracy		11/2019
	o. TJC corrective action plan		02/2020
	p. CMS Survey Corrective action plan		02/2020
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	Review of ABN usage, Authorizations in progress 02-2020
	Rehab services	HHS OIG workplan	
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		
	a. Annual Security Risk Assessment		Security Risk Assessment Completed 11/2019
	b. Periodic update to SRA		
	c. Monthly employee access audits		Current through 02/01/2020
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		
22.	Implement automated access monitoring/auditing software (Protenus)	On hold	Starts ~~January 2019~~ when we have an EHR that has the ability to interface data feeds.
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		01/2020
25.	Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC		See TJC and CDPH monitoring plans - ongoing
26.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.	Working with WJ, MET, HIMS dept to review all audits, recoupments	02/2020
27.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function on the Compliance Department.	Complytrack – live 04/2019	UORs moving to Informatics/Nursing Quality
	a. Provide trend feedback to leadership to allow for data driven decision-making		On-going
	I. Overall UOR process		12/2019
	II. Workplace Violence		01/2020
	III. Sharps		02/2020
	IV. Overweight laundry		02/2020

Annual Compliance Workplan

29.	Patient complaints	On-going	moving to Informatics/Nursing Quality
30.	Breach Investigations	On-going	On-going – see Compliance report

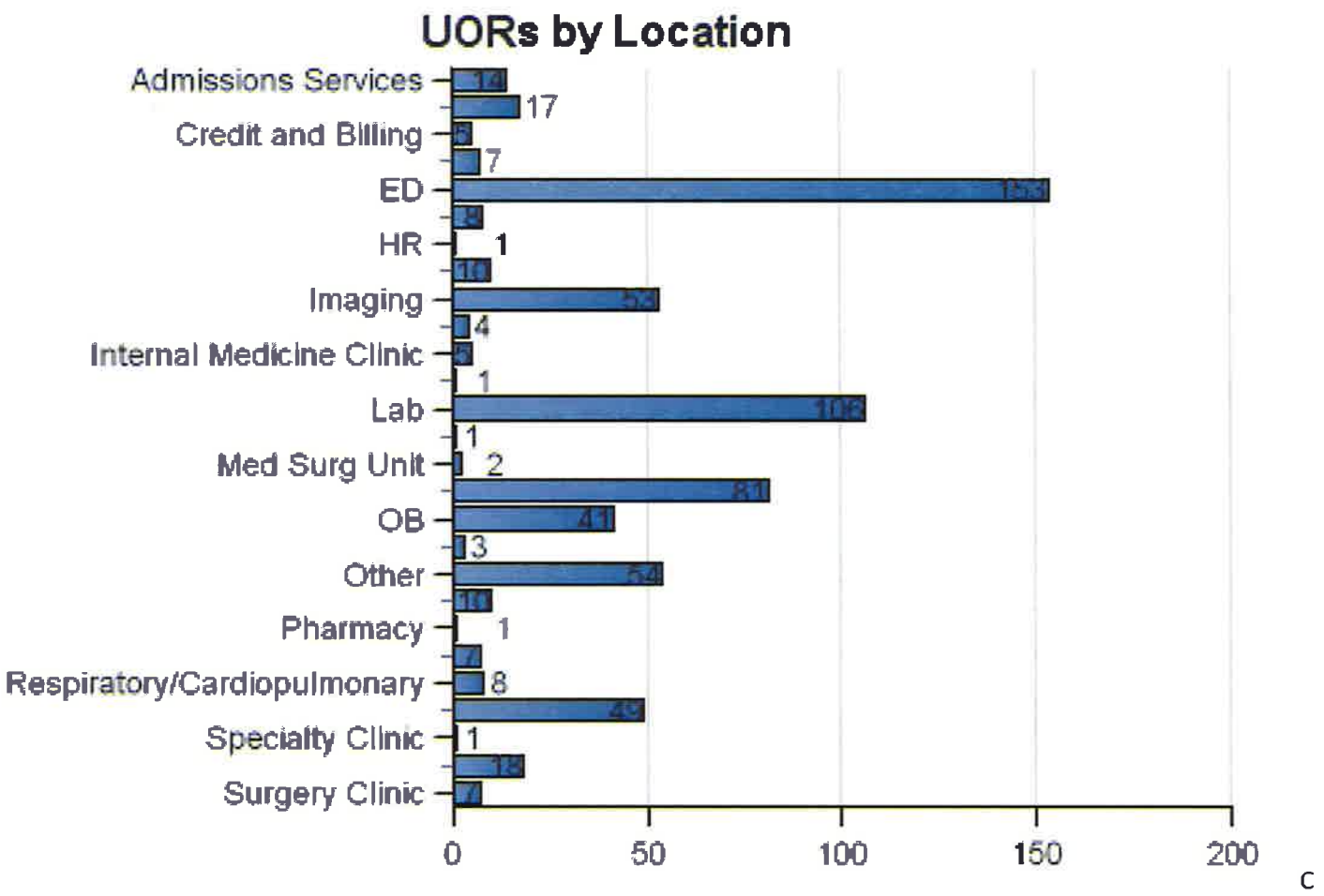
2020 Compliance Work Plan – updated 02/2020

Unusual Occurrence Trends



AMA is no longer a critical indicator for the ED, which explains the drop in reports following the June 2019 decision by Medical Staff.

Unusual Occurrence Trends



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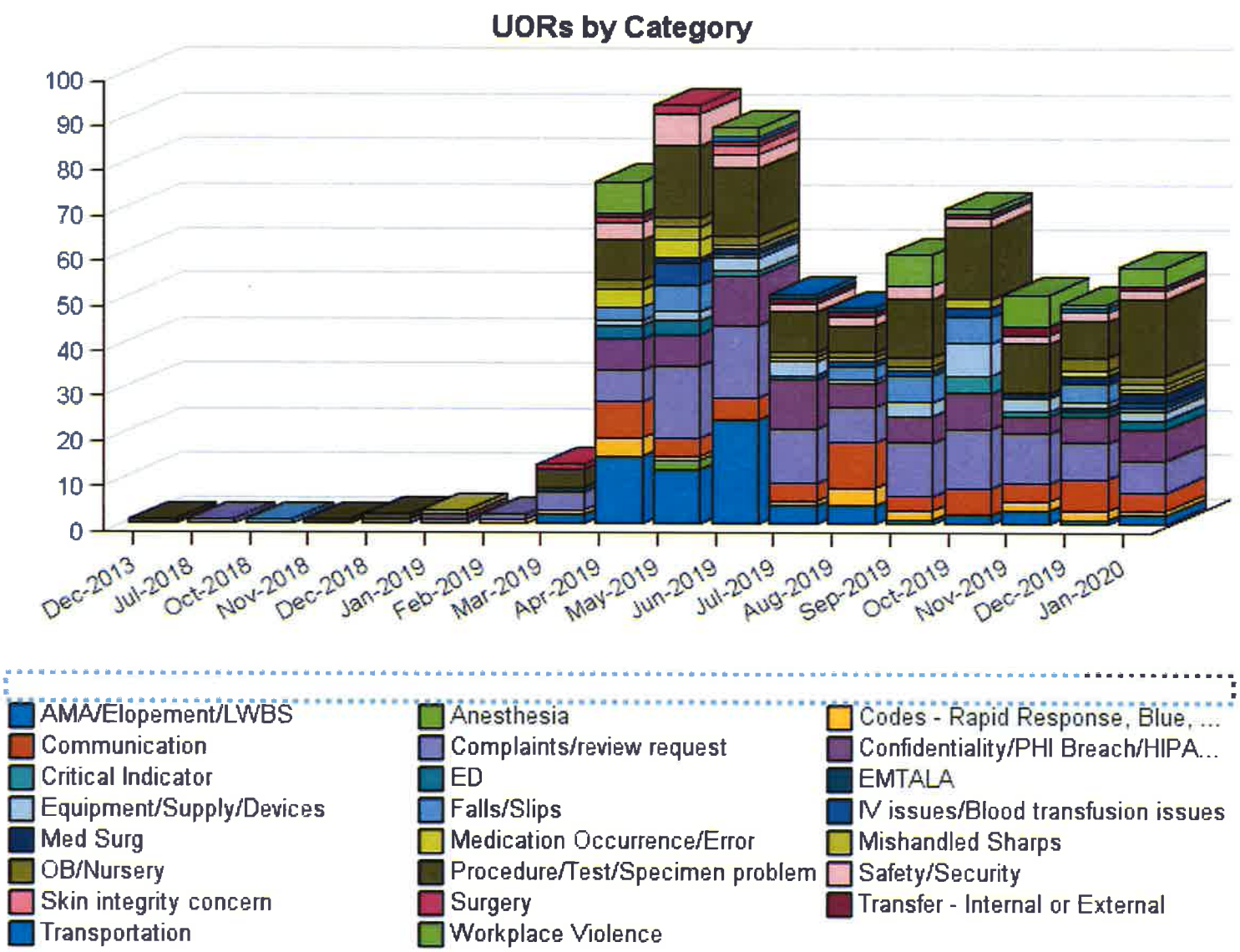
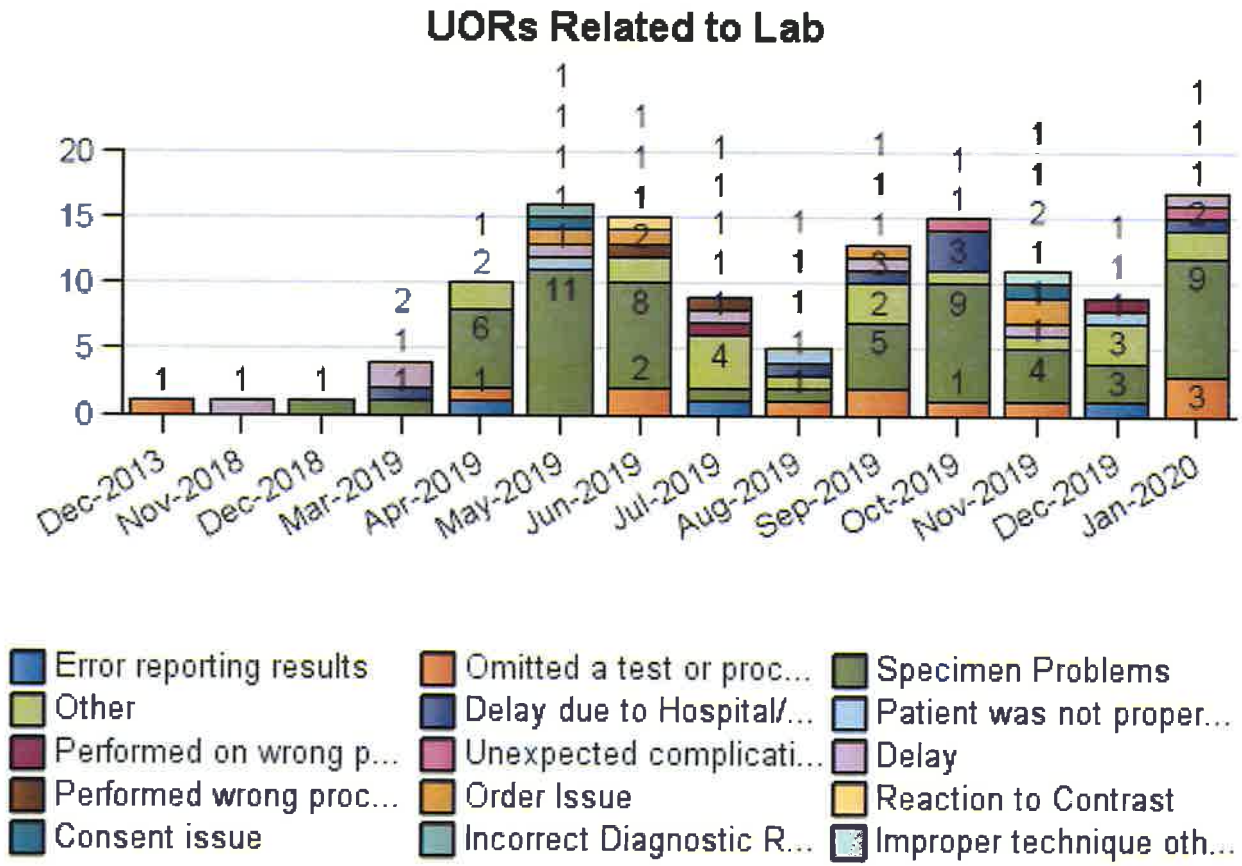


Chart data on following page

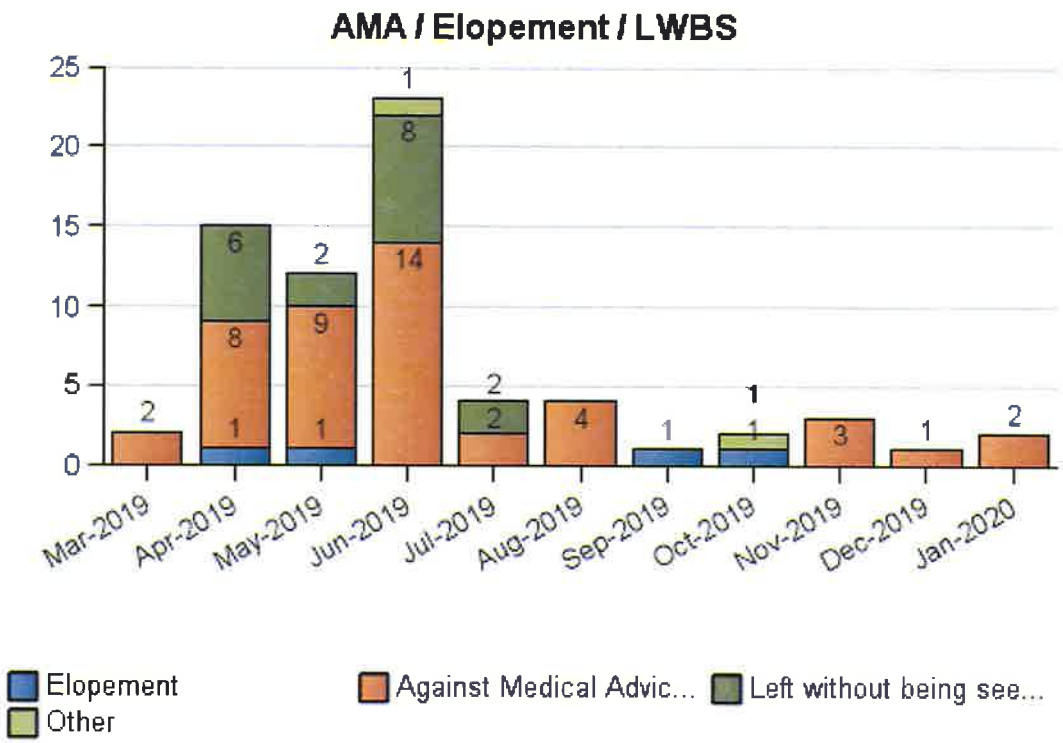
Unusual Occurrence Trends

	Dec-2013	Jul-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Total
AMA/Elopement/LWBS								2	15	12	23	4	4	1	2	3	1	2	69
Anesthesia										2									2
Codes - Rapid Response, Blue, Deescalation							1	1	4	1		1	4	2		2	2	1	19
Communication									8	4	5	4	10	3	6	4	7	4	55
Complaints/review request		1			1	1	1	4	7	16	16	12	8	12	13	11	8	7	118
Confidentiality/PHI Breach/HIPAA violation						1			7	7	11	11	5	6	8	4	6	7	73
Critical Indicator											1				4	1			6
ED									3	3		1					1	2	10
EMTALA																	1		1
Equipment/Supply/Devices									1	2	3	3	1	3	7	3	1	2	26
Falls/Slips			1						3	6	1		3	6	6		4	1	31
IV issues/Blood transfusion issues								1		5			1	1	2			1	11
Med Surg										1	1					1	2	2	7
Medication Occurrence/Error									4	4							1	1	10
Mishandled Sharps						1				3	1	1	1	1	2			1	11
OB/Nursery									2	2	2	1	1	2			3	2	15
Procedure/Test/Specimen problem	1			1	1			4	9	16	15	9	6	13	16	11	8	17	127
Safety/Security									4	7	3	2	2	3	2	2	2	2	29
Skin integrity concern											2								2
Surgery								1	1	2	1								5
Transfer - Internal or External									1			1	1		1	2		1	7
Transportation											1	1	1				1		4
Workplace Violence									7		2			7	1	7	1	4	29
Total	**1**	**1**	**1**	**1**	**2**	**3**	**2**	**13**	**76**	**93**	**88**	**51**	**48**	**60**	**70**	**51**	**49**	**57**	**667**

Unusual Occurrence Trends



Unusual Occurrence Trends



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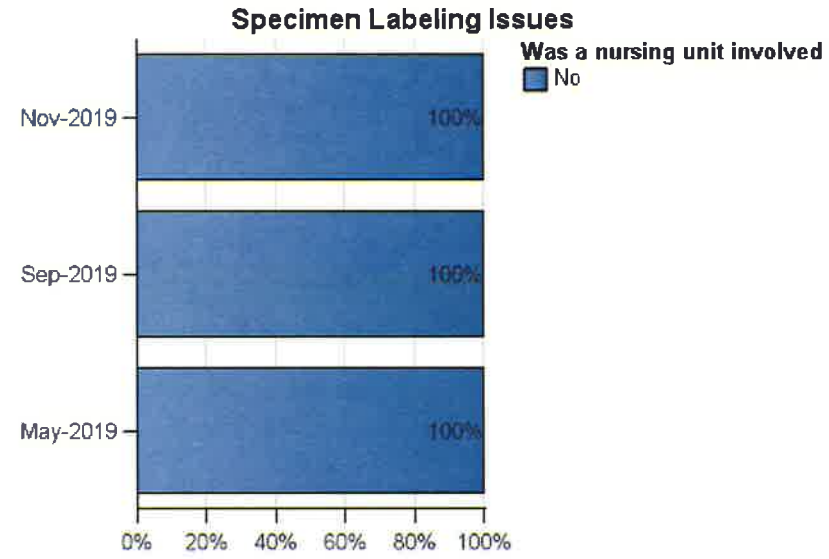

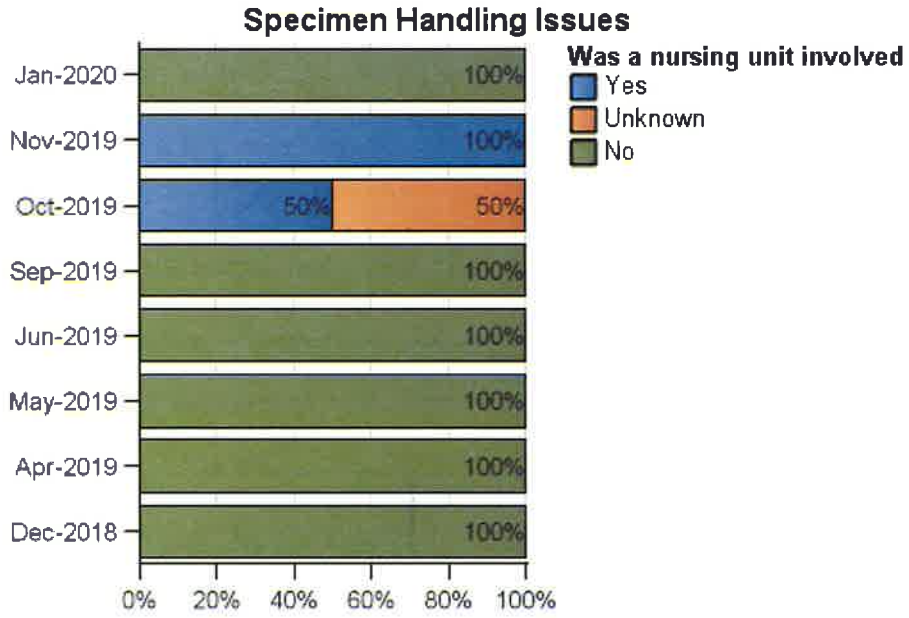

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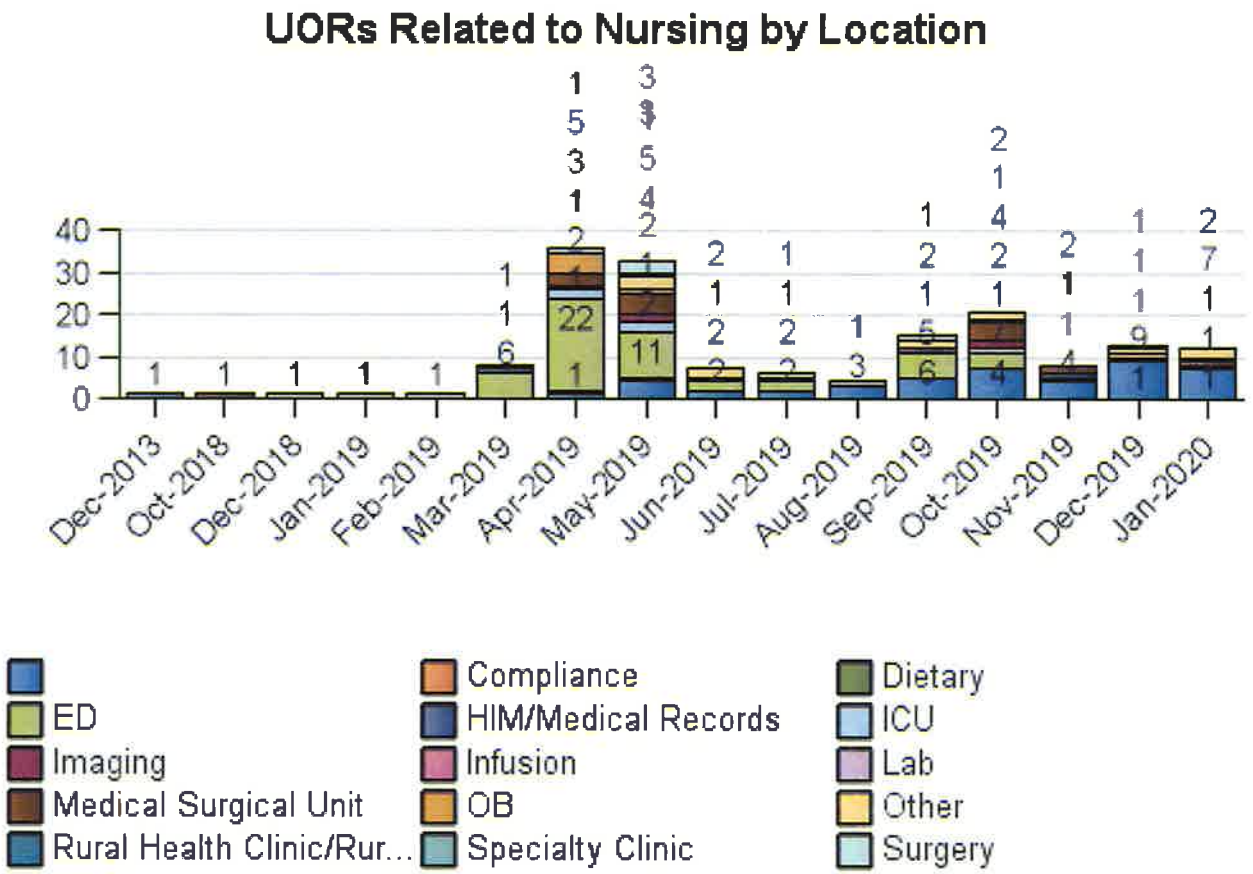
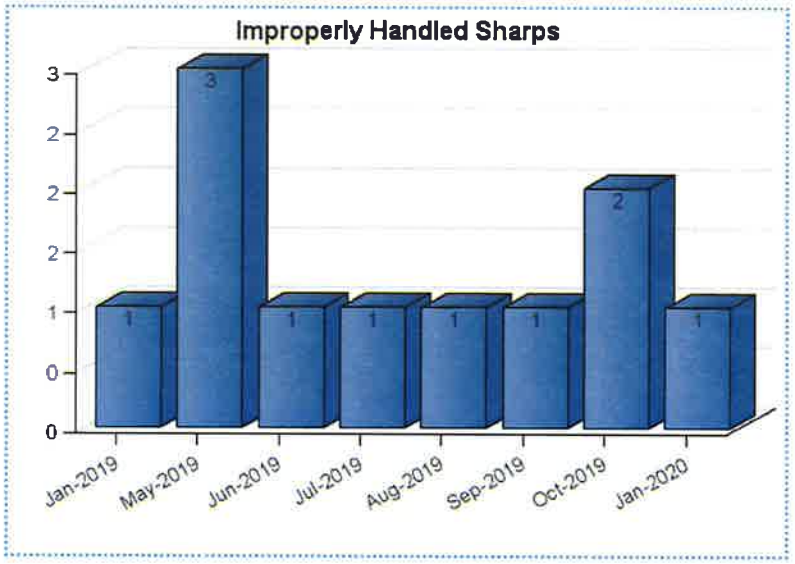
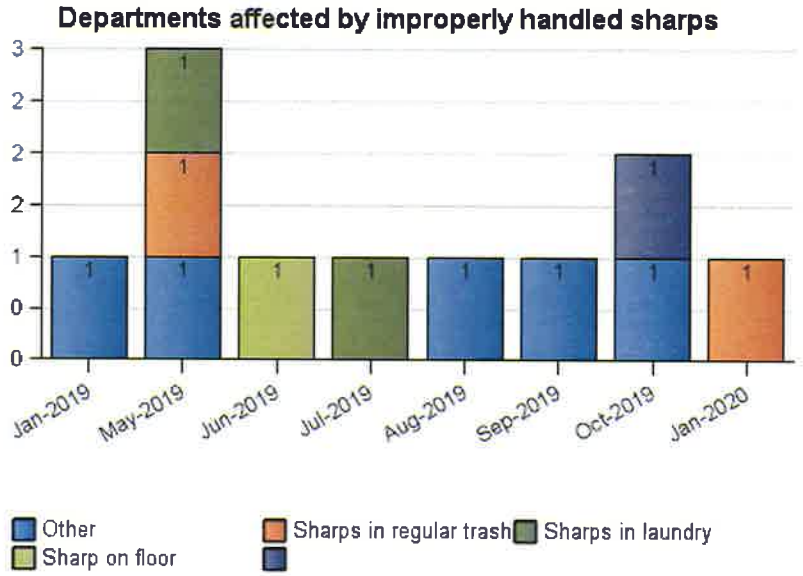


Working on labeling issues.

Unusual Occurrence Trends





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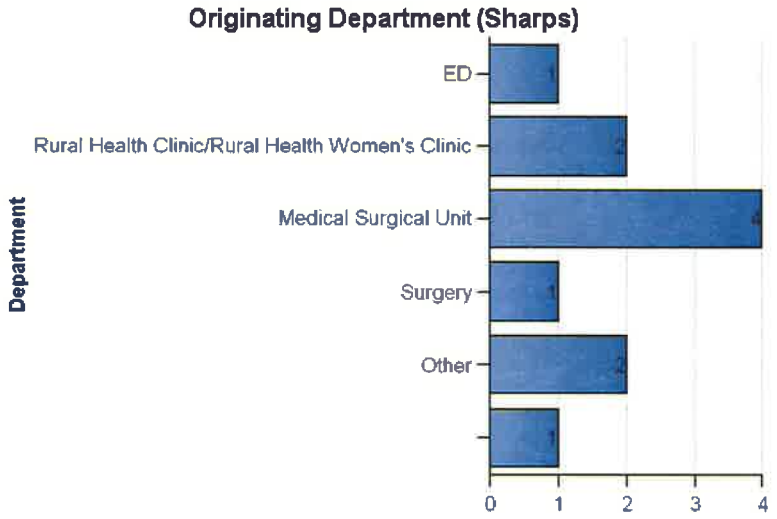

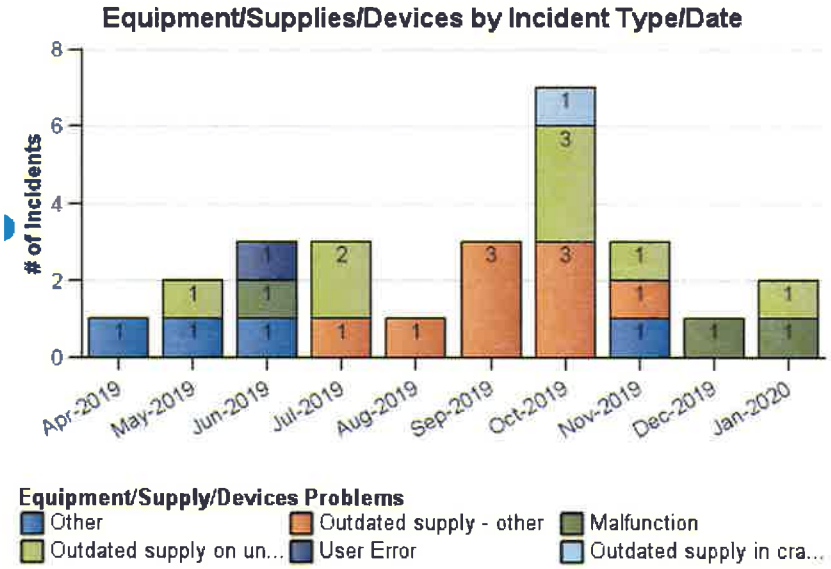

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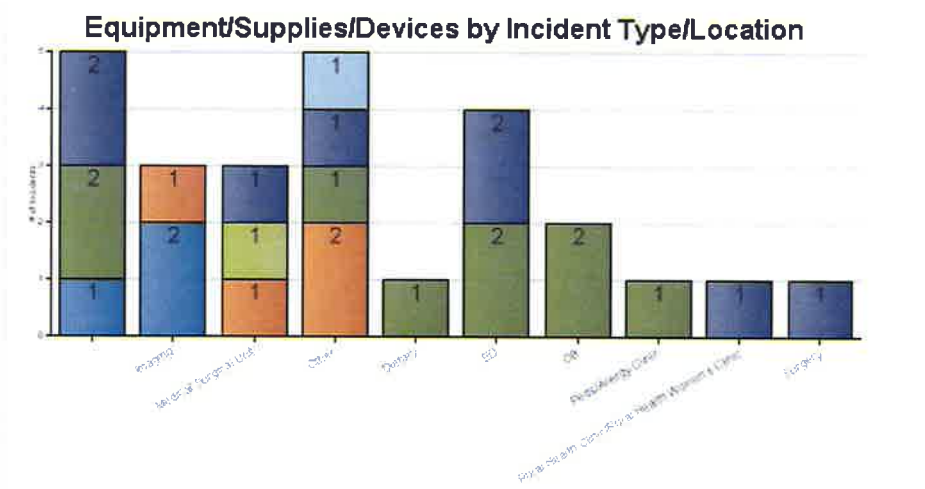

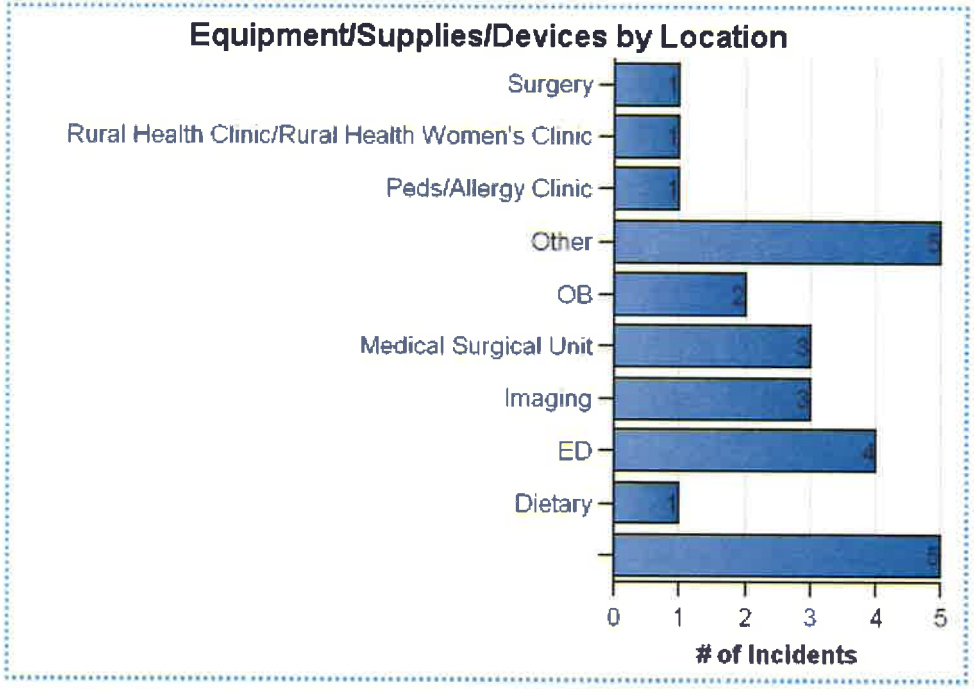

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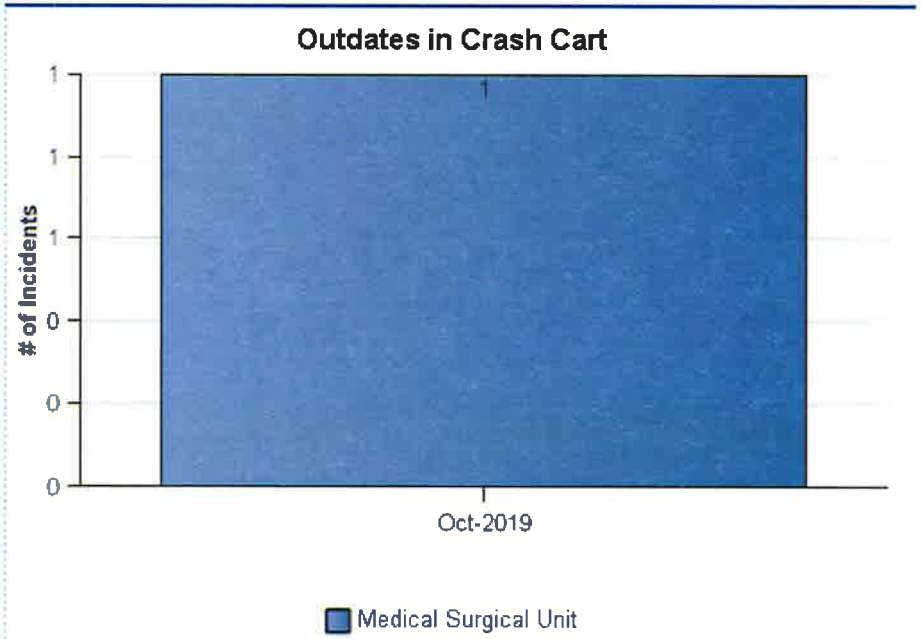
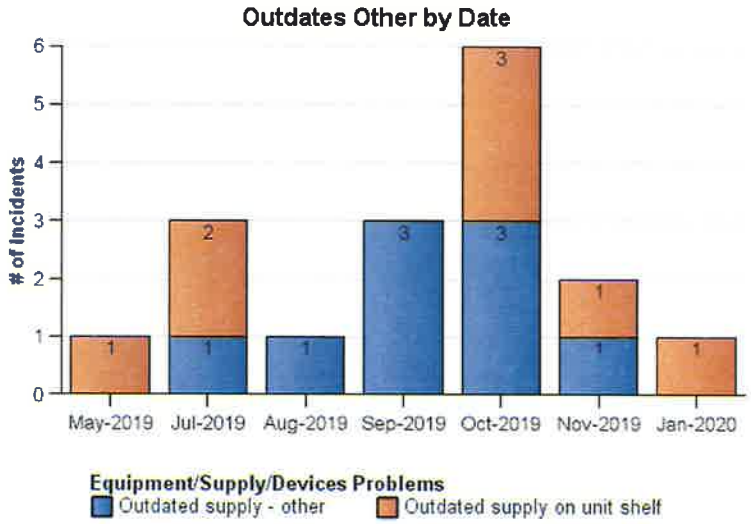
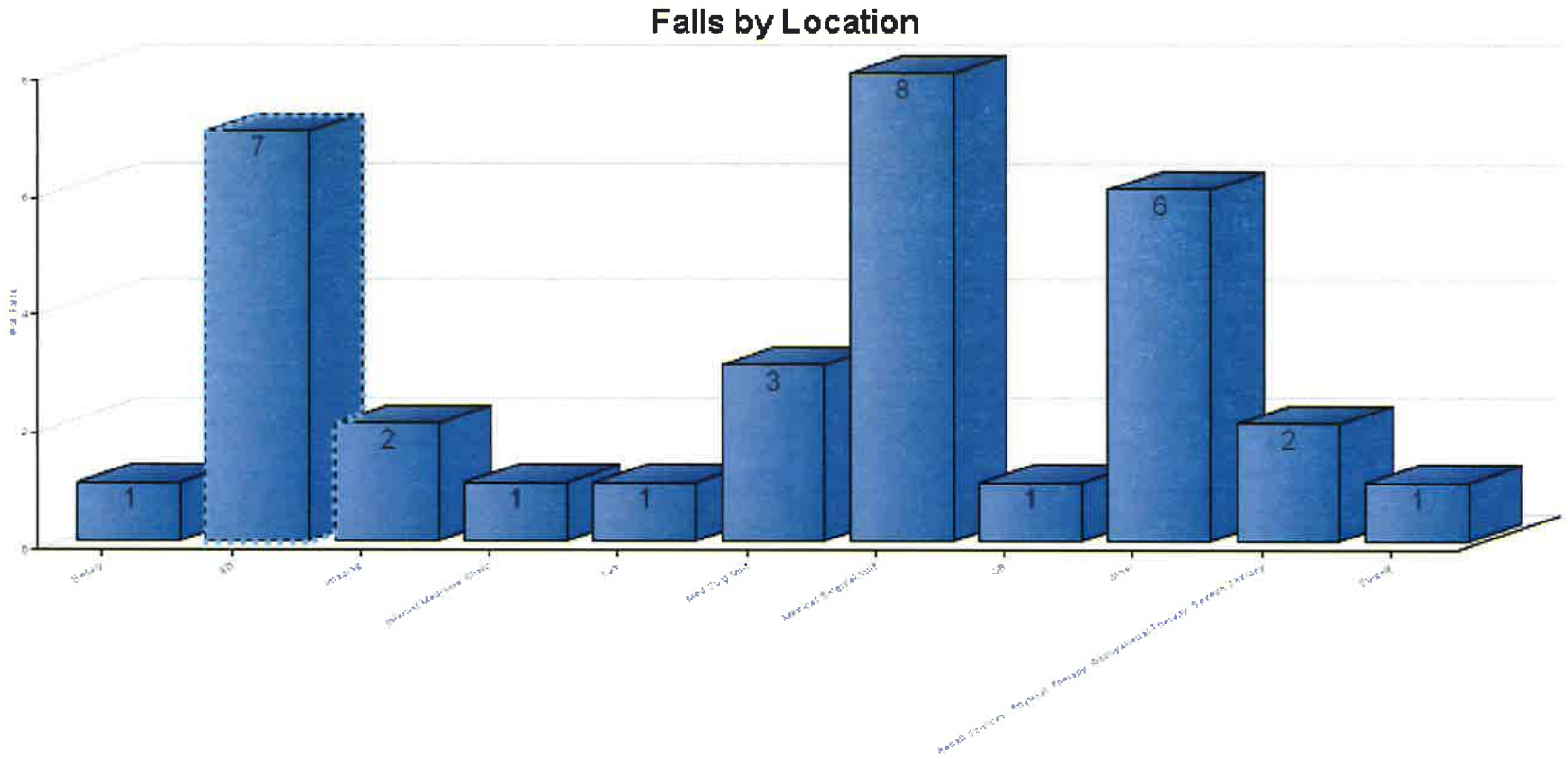




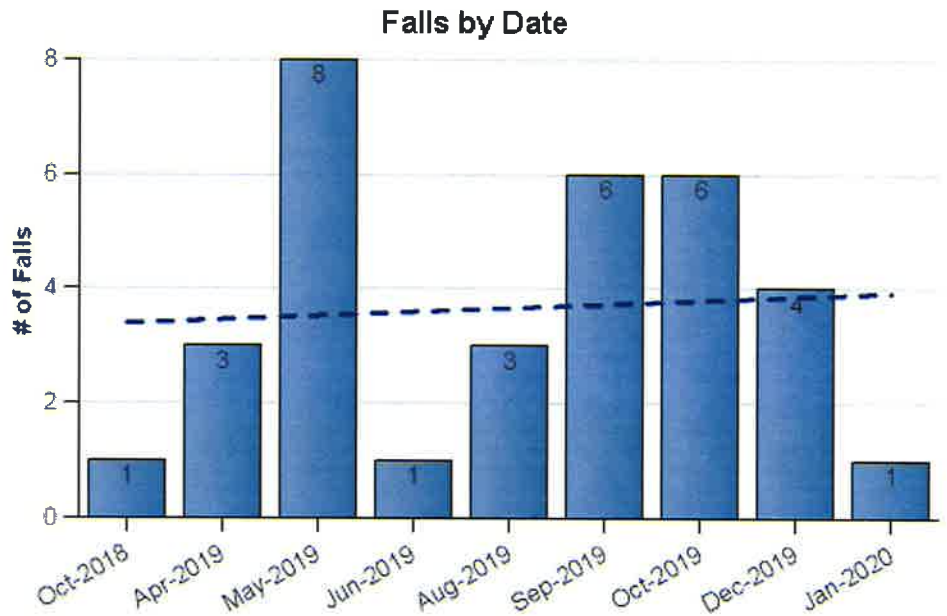
Unusual Occurrence Trends

# of Falls	Falls/Slips	Total
Dietary	1	1
ED	7	7
Imaging	2	2
Internal Medicine Clinic	1	1
Lab	1	1
Med Surg Unit	3	3
Medical Surgical Unit	8	8
OB	1	1
Other	6	6
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	2	2
Surgery	1	1
Total	33	33

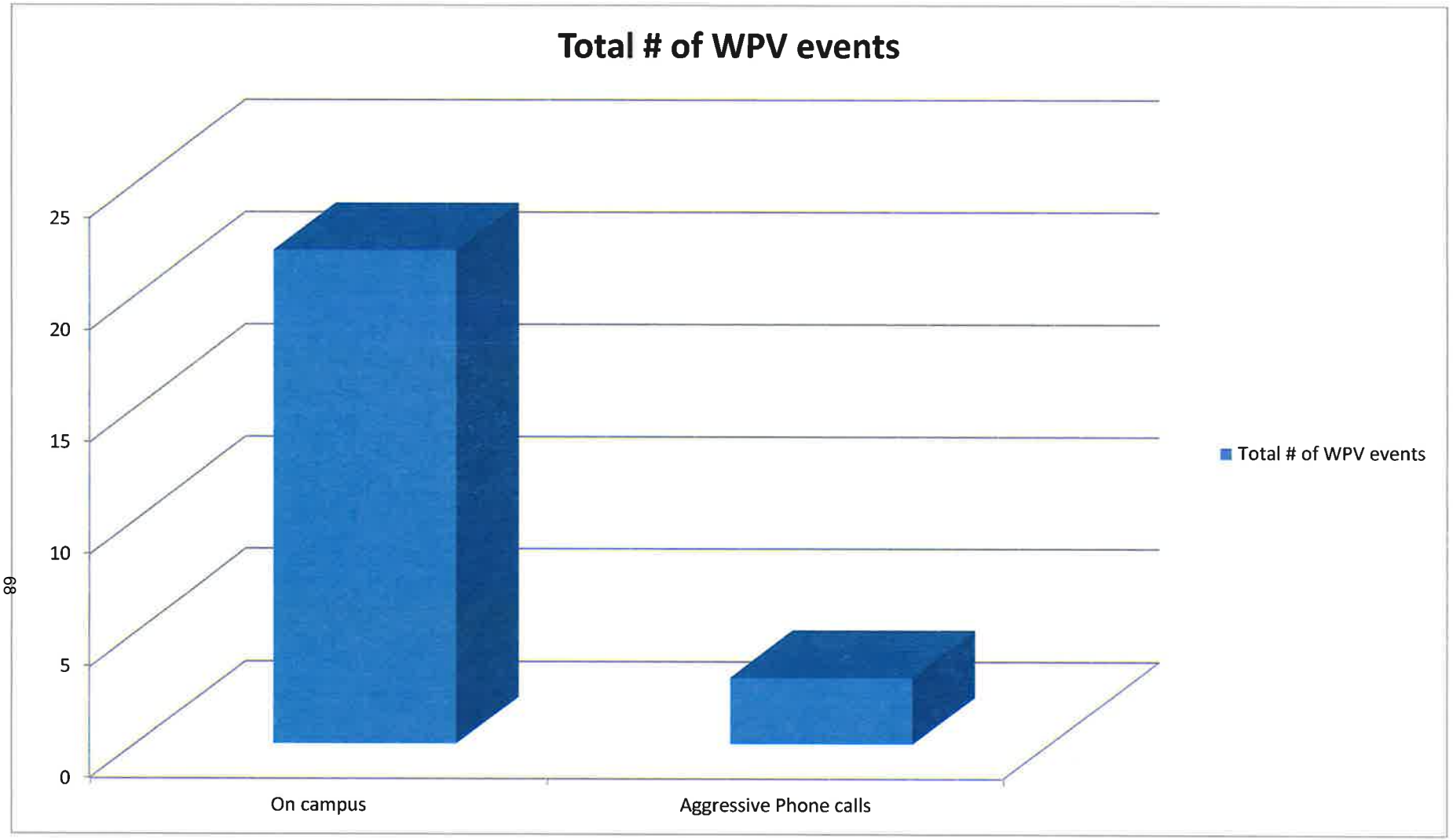
Unusual Occurrence Trends



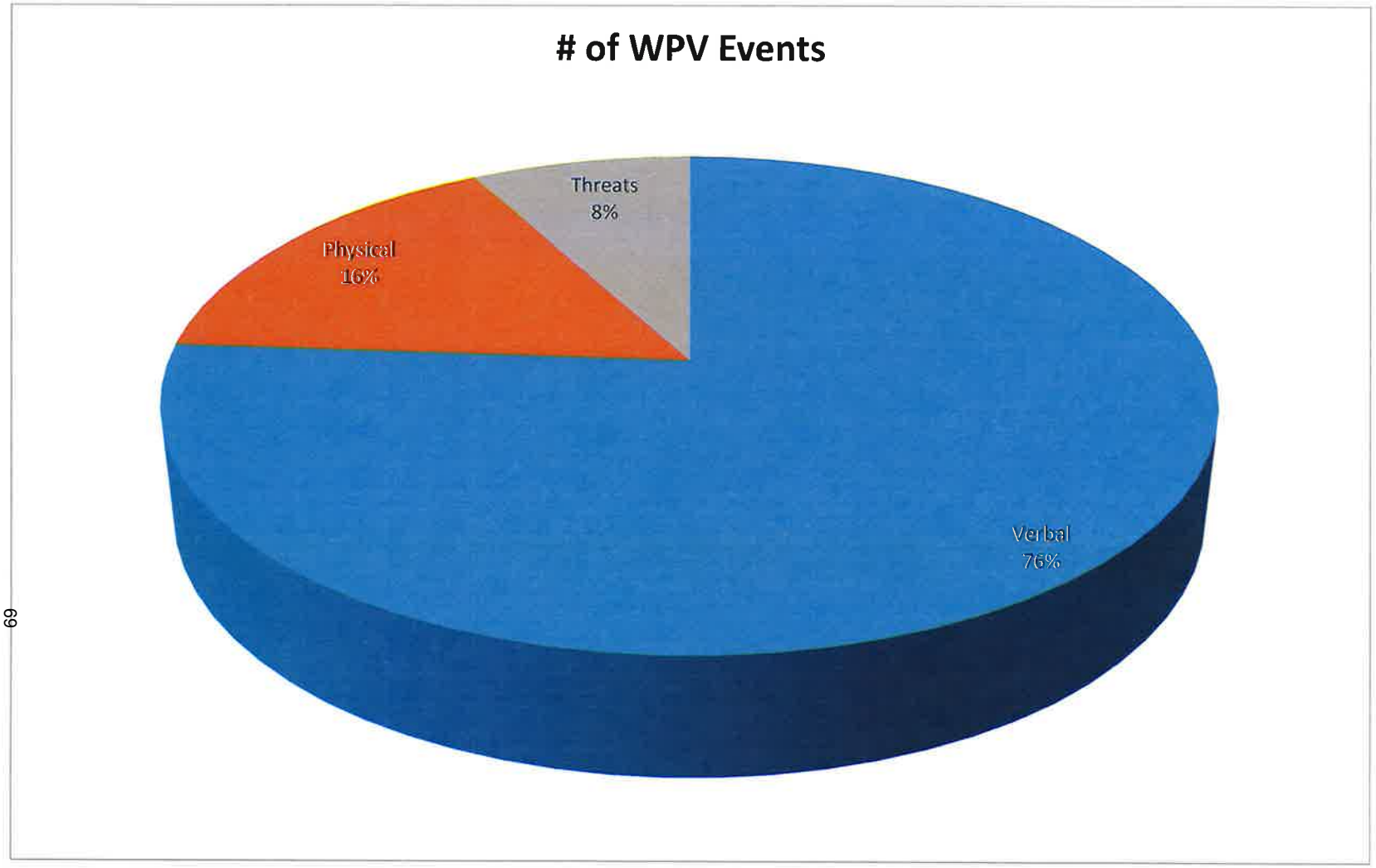
Unusual Occurrence Trends



# of Falls	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Ice/weather related	Other	Stretcher/Table	Total
Not Identified	3	3			2	1	3	1	**13**
Confused	1	1	1						**3**
Oriented	6	1	1	2			6	1	**17**
Total	**10**	**5**	**2**	**2**	**2**	**1**	**9**	**2**	**33**



Location type	Total # of WPV events
On campus	22
Aggressive Phone calls	3
	25



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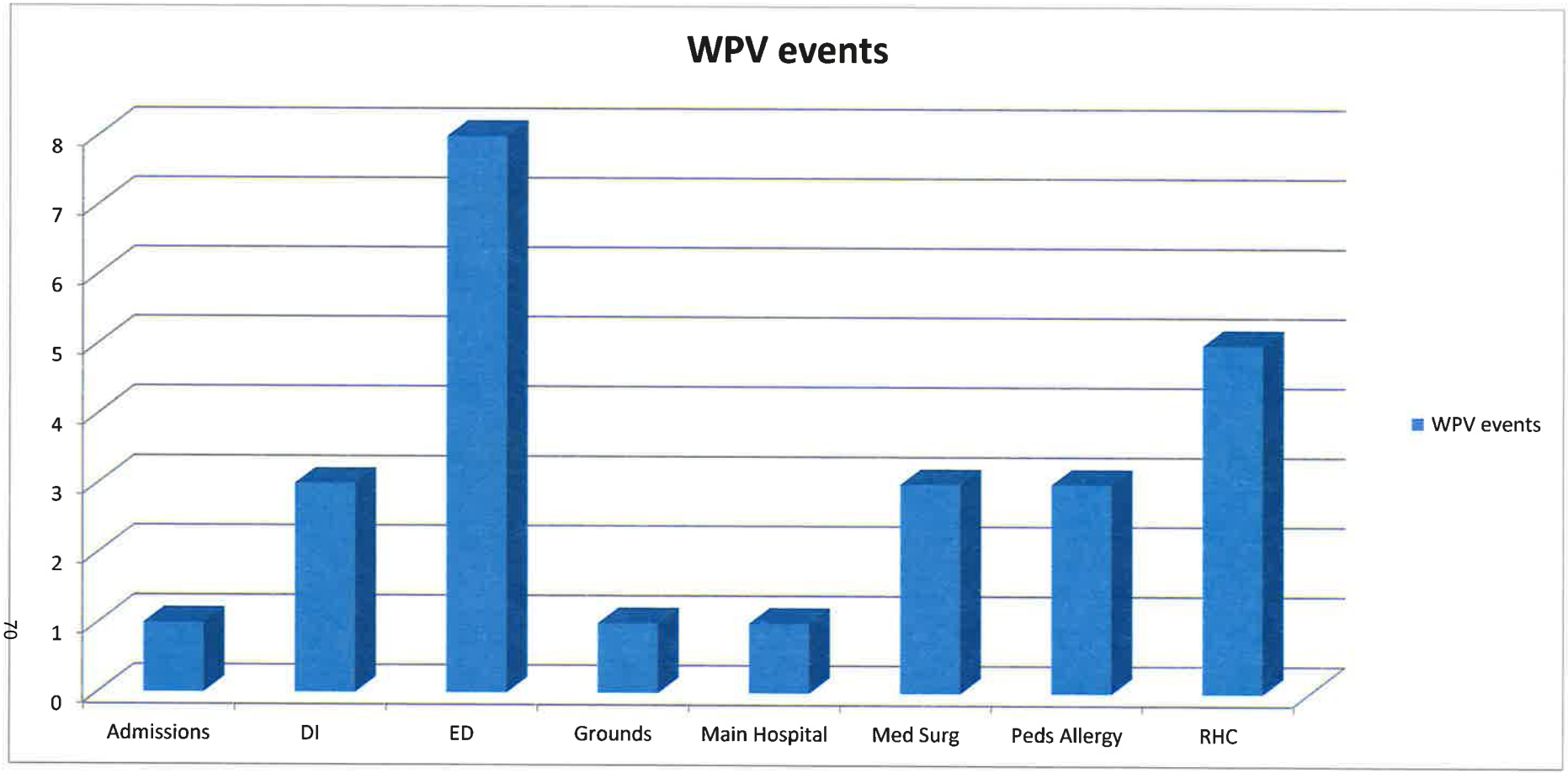
Type of Violence	# of WPV Events
Verbal	19
Physical	4
Threats	2



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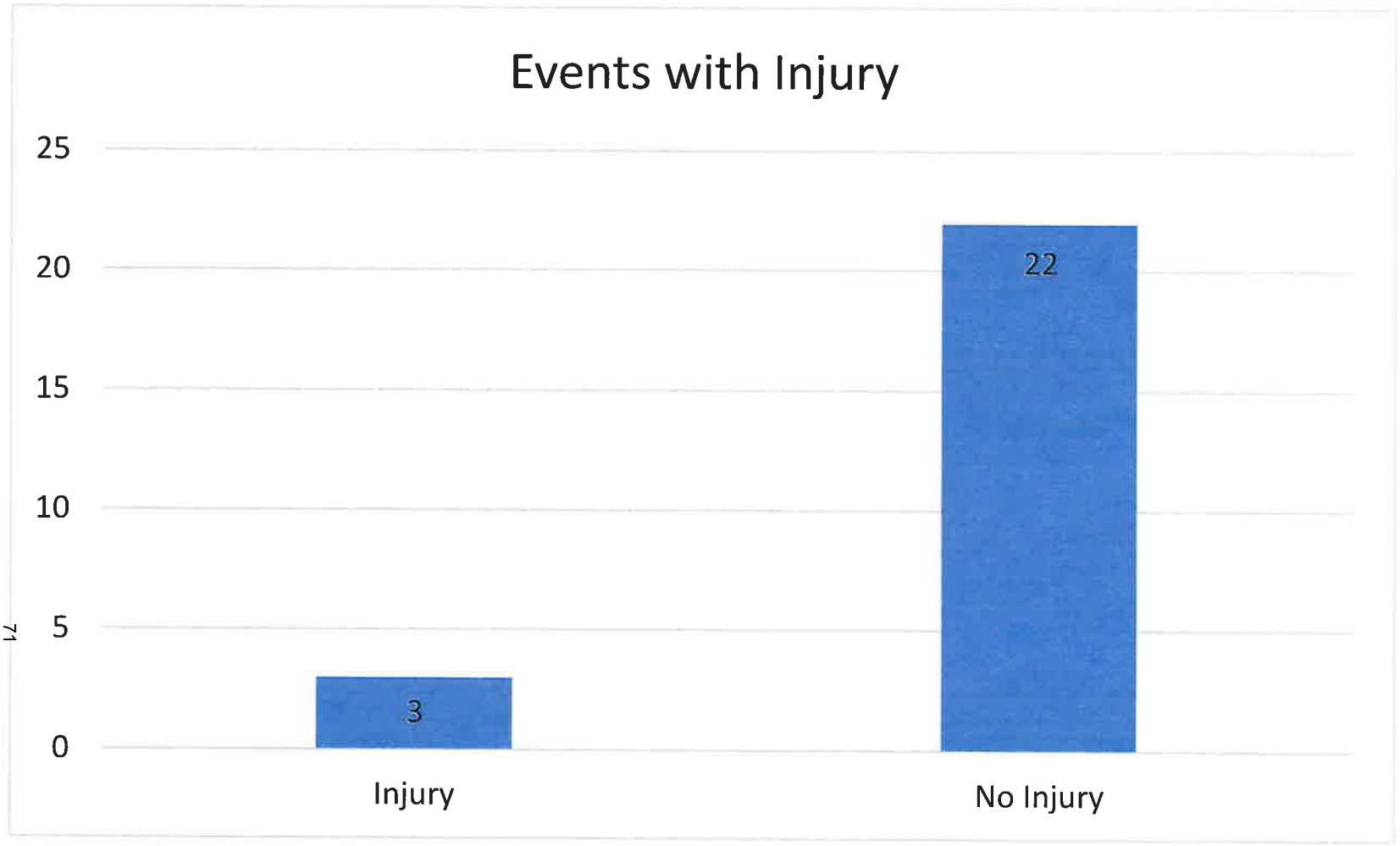
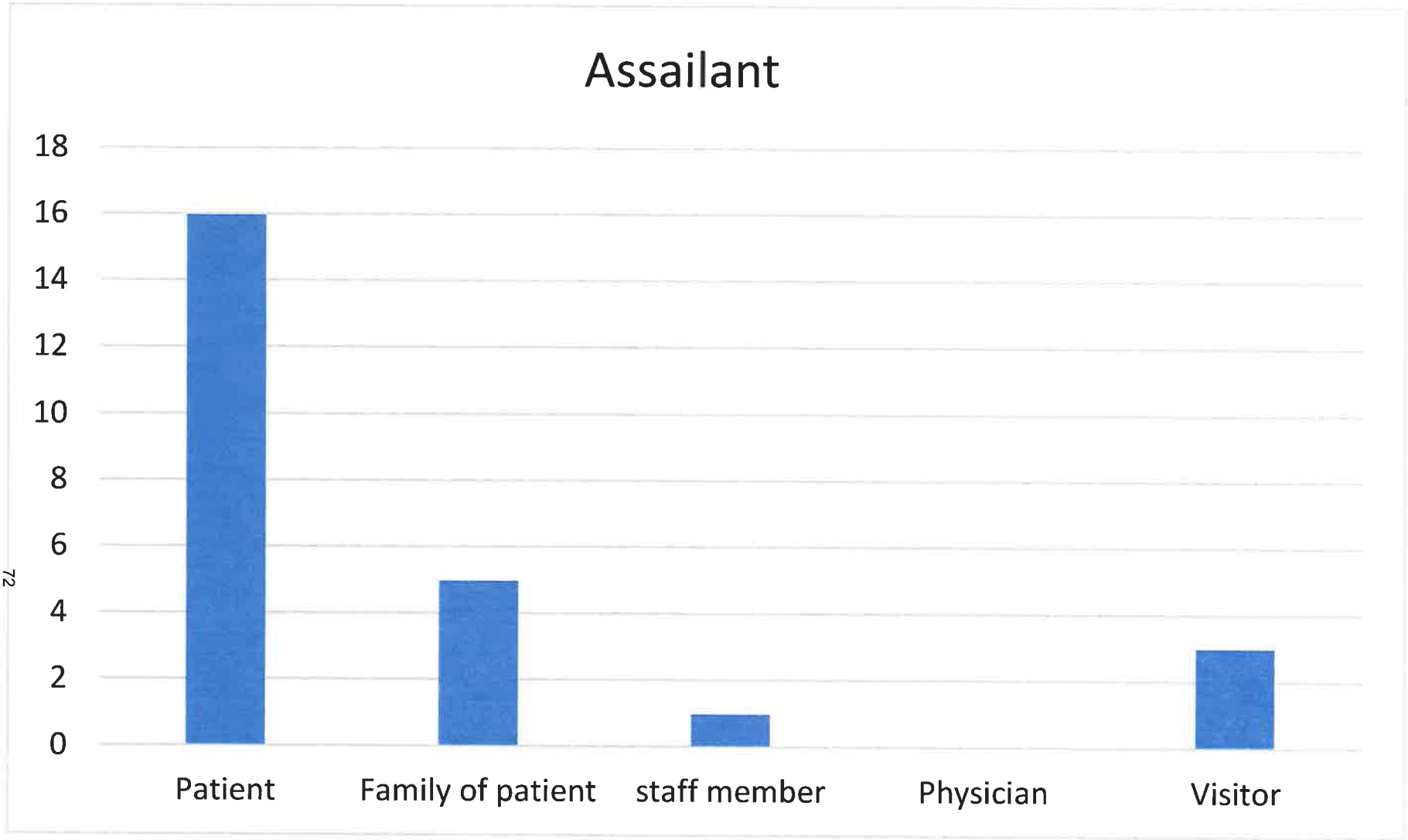
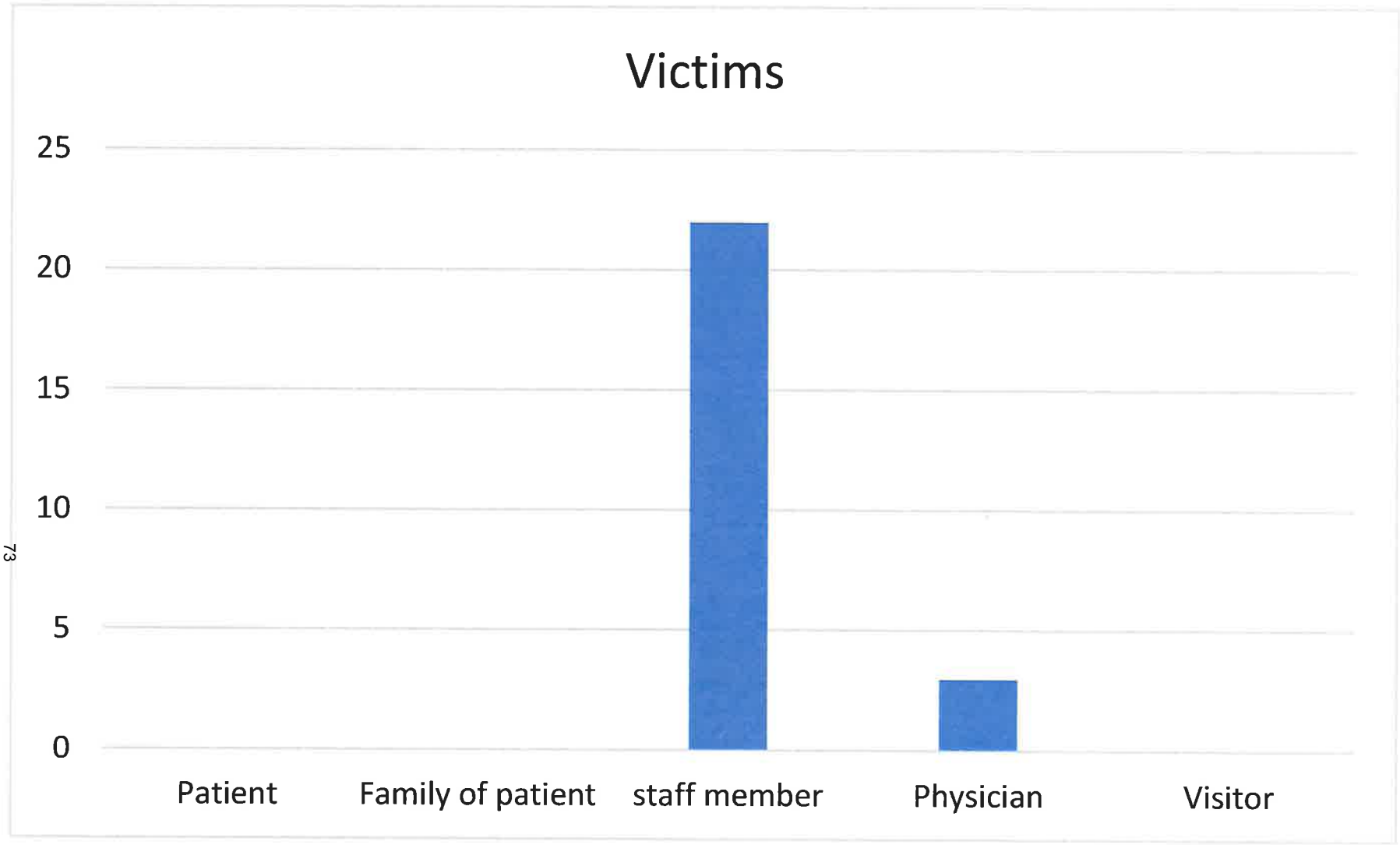
Location	WPV events
Admissions	1
DI	3
ED	8
Grounds	1
Main Hospital	1
Med Surg	3
Peds Allergy	3
RHC	5



Events w/Injury	Number
Injury	3
No Injury	22



Assailant	# events
Patient	16
Family of patient	5
staff member	1
Physician	
Visitor	3

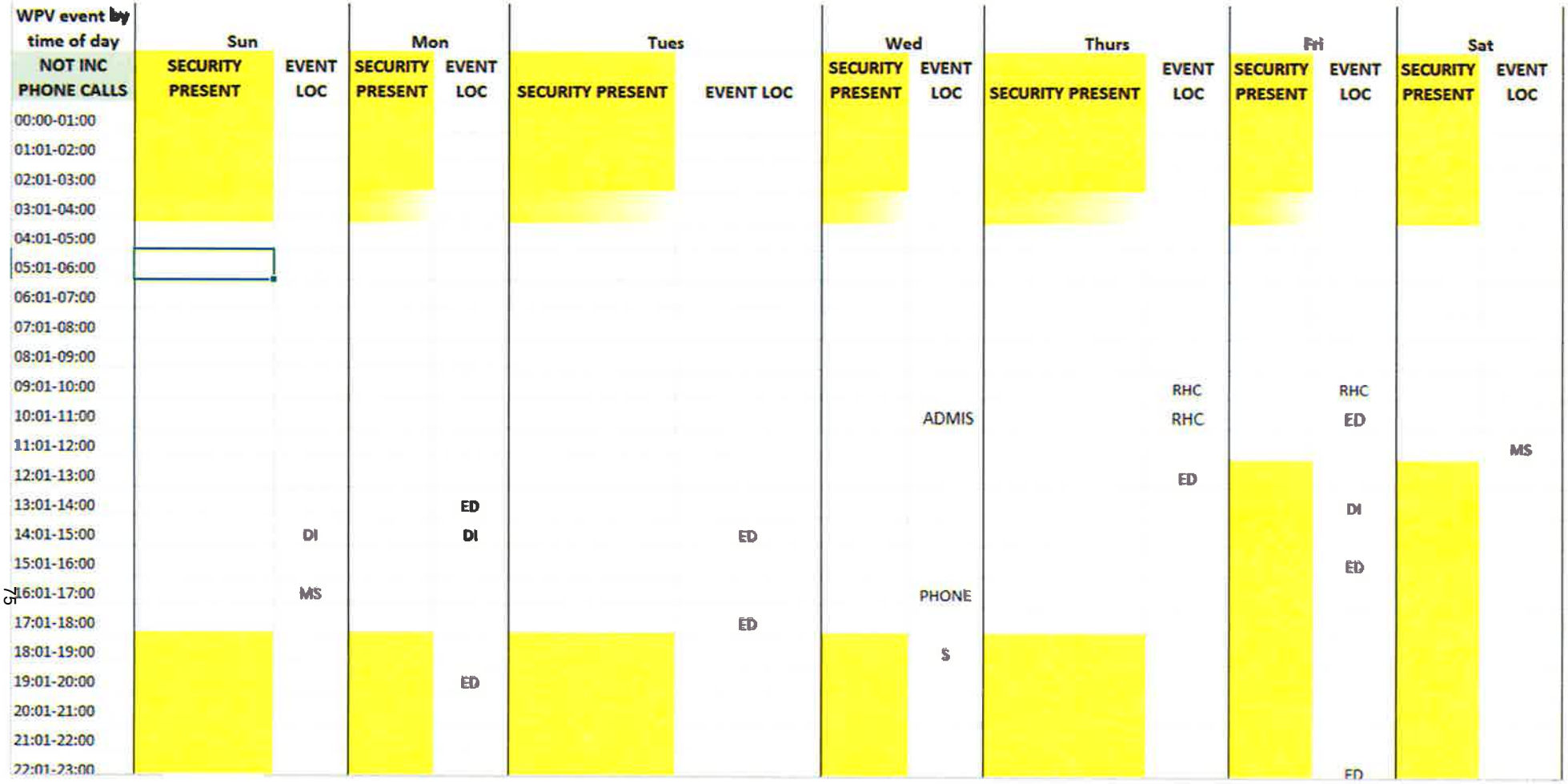


Victim	# events
Patient	
Family of patient	
staff member	22
Physician	3
Visitor	

Security present	Hours
Sunday	18:00-03:30
Monday	18:00-03:30
Tuesday	18:00-03:30
Wednesday	18:00-03:30
Thursday	18:00-03:30
Friday	12:00-0400
Saturday	12:00-0400

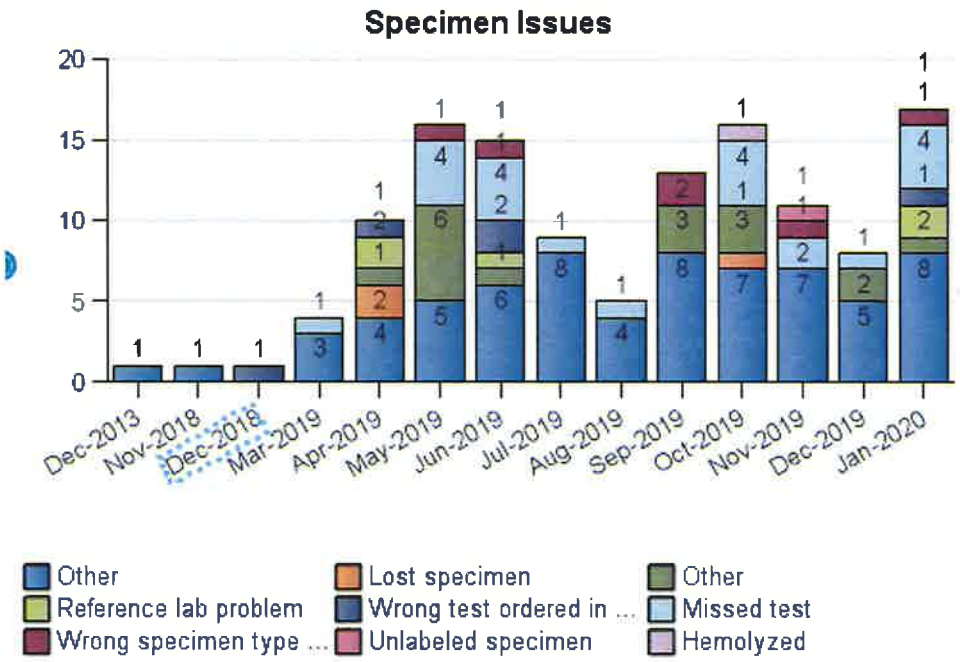
WPV events by Month	# of events
Apr-19	4
May-19	0
Jun-19	2
Jul-19	1
Aug-19	2
Sep-19	6
Oct-19	2
Nov-19	6
Dec-19	2
Jan-20	

Day of week	# events (not including phone calls)
Sunday	2
Monday	3
Tuesday	3
Wednesday	4
Thursday	3
Friday	5
Saturday	1

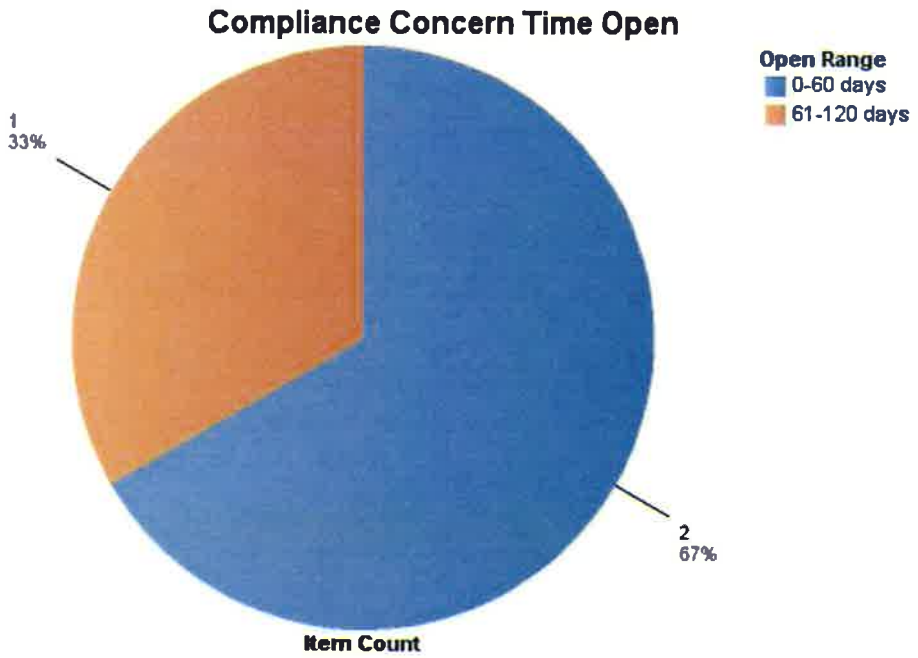


WPV event by time of day NOT INC PHONE CALLS	Sun SECURITY PRESENT	Sun EVENT LOC	Mon SECURITY PRESENT	Mon EVENT LOC	Tues SECURITY PRESENT	Tues EVENT LOC	Wed SECURITY PRESENT	Wed EVENT LOC	Thurs SECURITY PRESENT	Thurs EVENT LOC	Fri SECURITY PRESENT	Fri EVENT LOC	Sat SECURITY PRESENT	Sat EVENT LOC
00:00-01:00														
01:01-02:00														
02:01-03:00														
03:01-04:00														
04:01-05:00														
05:01-06:00														
06:01-07:00														
07:01-08:00														
08:01-09:00														
09:01-10:00										RHC		RHC		
10:01-11:00								ADMIS		RHC		ED		
11:01-12:00														MS
12:01-13:00										ED				
13:01-14:00				ED								DI		
14:01-15:00		DI		DI		ED								
15:01-16:00												ED		
16:01-17:00		MS						PHONE						
17:01-18:00						ED								
18:01-19:00								S						
19:01-20:00				ED										
20:01-21:00														
21:01-22:00														
22:01-23:00												ED		

Unusual Occurrence Trends



Unusual Occurrence Trends



Compliance Concern Id		2019				2020		Total
		Jul	Sep	Nov	Total	Jan	Total	
			1		1			1
	Total		1		1			1
Billing				1	1	1	1	2
	Total			1	1	1	1	2
Compliance			1		1			1
	Total		1		1			1
HIPAA Security		1			1			1
	Total	1			1			1
Total		1	2	1	4	1	1	5

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E239	1. Developed new policy "Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners"	One day per month, for three months, all scheduled infusion patients' ordering provider(s) will be verified to be on the list of providers with a "documented Referral Arrangement " by a designated workforce member.	1 day/mon X 3 months; when at 100% 1 day/quarter x 3 addl quarters.	7/18/2018	DON Perioperative services to have oversight of data and report to Compliance. Compliance to report to Board of Directors (BOD) no less than annually	Monthly x 3, Quarterly x 3	Additional training provided			100%	100%	100%			100%							100%	100%	100%	Complete
	2. NIHD enters into a documented Referral Arrangement for Non-Staff Ordering Practitioners.			9/1/2018																					Complete
	3. Provided education and training to Infusion nursing staff via in-person and email.			9/1/2018																					Complete
E 242	Draft policy "Pediatric and Newborn Consultation Requirements" and obtain approval at perinatal/pediatrics medical staff committee on 10/12/2018, full approval anticipated on 11/21/2018. Education has been provided to the Medical Staff via committee process (see attached minutes).	All pediatric admissions are retrospectively reviewed by the Chief of Pediatrics on a monthly basis.	Monthly	11/23/2019	Audit data will be collected and tracked by the Medical Staff Office Manager and presented to the Chief of Pediatrics for review and presentation to the Medical Executive Committee quarterly. Once reviewed by Medical Executive Committee, aggregate data will be presented to the Board of Directors, no less than annually.	Monthly x 2 6 month OPPE periods or one year								100%	100%	100%	100%						1	Monitoring is current
E 276	Provided education and training to workforce regarding "Code Amber," "Code Amber" practice drills conducted on day and night shift.	Code Amber knowledge question added to Environment of Care monthly audit. Monthly data will be collected for trending by department for additional targeted training. Data tracking will occur until no wrong answers for 3 consecutive months, or 12 months. If goal not met, review and update plan of correction.	Monthly	10/12/2019	EOC trending, Operations?	100% correct answers for 3 consecutive months or a total of 12 months (reassess if no 3 consec month period)							<100%	<100%			100	100	100					Completed
E280	All contract RNs will particpate in skills days specific to their routinely assigned unit(s) during orientation.	Nursing administration and education will monitor 100% of contract RN orientation documentation for completion of competency validation routine assigned units. If 100% compliant, monitor 50% of contract RN orientation documentation for completion of competency validation routine assigned units for the following 2 months. If at 100%, sustainability goal will have been met. If not, review and update plan of correction		10/1/2019	CNO will have oversight of competency validation process for contracted RNs. Data will be reported to Nurse	3 months	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	<100%	100%	100%	100%	100%					Completed
	All contract RNs competency binders will contain documentation of completion of competency validations and skills validations for any unit to which they may be routinely assigned. Per policy,																								
	Competency orientation plans and supporting documents for contract RNs are reviewed by nursing administration or designee prior to independent assignments.																								

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CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E239	1. Developed new policy "Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners"	One day per month, for three months, all scheduled infusion patients' ordering provider(s) will be verified to be on the list of providers with a "documented Referral Arrangement " by a designated workforce member.	1 day/mon X 3 months; when at 100% 1 day/quarter x 3 addl quarters.	7/18/2018	DON Perioperative services to have oversight of data and report to Compliance. Compliance to report to Board of Directors (BOD) no less than annually
	2. NIHD enters into a documented Referral Arrangement for Non-Staff Ordering Practitioners.			9/1/2018	
	3. Provided education and training to Infusion nursing staff via in-person and email.			9/1/2018	
E 242	Draft policy "Pediatric and Newborn Consultation Requirements" and obtain approval at perinatal/pediatrics medical staff committee on 10/12/2018, full approval anticipated on 11/21/2018. Education has been provided to the Medical Staff via committee process (see attached minutes).	All pediatric admissions are retrospectively reviewed by the Chief of Pediatrics on a monthly basis.	Monthly	11/23/2019	Audit data will be collected and tracked by the Medical Staff Office Manager and presented to the Chief of Pediatrics for review and presentation to the Medical Executive Committee quarterly. Once reviewed by Medical Executive Committee, aggregate data will be presented to the Board of Directors, no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 276	Provided education and training to workforce regarding "Code Amber." "Code Amber" practice drills conducted on day and night shift.	Code Amber knowledge question added to Environment of Care monthly audit. Monthly data will be collected for trending by department for additional targeted training. Data tracking will occur until no wrong answers for 3 consecutive months, or 12 months. If goal not met, review and update plan of correction.	Monthly	10/12/2019	EOC trending, Operations?
80 E280	All contract RNs will particpate in skills days specific to their routinely assigned unit(s) during orientation.	Nursing administration and education will monitor 100% of contract RN orientation documentation for completion of competency validation routine assigned units. If 100% compliant, monitor 50% of contract RN orientation documentation for completion of competency validation routine assigned units for the following 2 months. If at 100%, sustainability goal will have been met. If not, review and update plan of correction		10/1/2019	CNO will have oversight of competency validation process for contracted RNs. Data will be reported to Nurse
	All contract RNs competency binders will contain documentation of completion of competency validations and skills validations for any unit to which they may be routinely assigned. Per policy,				
	Competency orientation plans and supporting documents for contract RNs are reviewed by nursing administration or designee prior to independent assignments.				

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E 475	1b. Policy "Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)" completed.	1. Pharmacist-in-charge will monitor cleaning log once a month for 3 months and then once a quarter for 2 additional quarters for 100% complete ceiling cleaning. If goal not met, review and update plan of correction.			The Infection Preventionist has oversight responsibility. Data monitoring will be sent to the Infection Prevention Medical Staff Committee, quarterly, for review. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	once a month X 3 months, then once/quarter for 2 additional quarters for 100% completion					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	Completed
	Training completed for the pharmacy department on the updated draft policy while awaiting approval process. Just-in-time training will be completed by the Clinical Engineering and Compliance as needed.	2. Pharmacist-in-charge has oversight of this process. Compliance to review log reports for daily checks of temperature monitoring software, monthly for three months.			Aggregate data reported to the Pharmacy and Therapeutics Medical Staff Committee quarterly. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.	3 months			100%	100%	100%														Completed
E 479	1a. Posting of Signage: Sign posted in ED at past location of the Malignant Hyperthermia Cart directing staff to the new location in PACU. 1b. Email Notification of RN Staff: Current RN staff will be sent an email with reminder of current location of the Malignant Hyperthermia Cart location.	1. Added knowledge question to RN rounding form, Nursing Leadership is rounding regularly and asking a minimum of 5 RNs (17% of the workforce monthly) per week as to the location of the Malignant Hyperthermia Cart.	When 3 months of RN Rounding form documentation results in 100% knowledge of the location of the Malignant Hyperthermia Cart we will consider the knowledge of cart location to be known by the nursing team.		Data will be tracked and trended by the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	3 months					75%	73%	62.50%		100%		100%	100%	100%						Completed
E480	Immediately verified the medications belonging in the crash cart and added the list to the policy.	All policies are reviewed by appropriate committees, leadership, and Board of Directors no less than once every three years. This review will ensure sustainability of this change. No additional monitoring needed.	No additional monitoring	10/17/2018	No additional monitoring	None	complete																		Completed
E485	Staff were educated at Sept 2018 MS/ICU staff meeting. Staff were educated about use of appropriate sedation scales and titration orders.	100% of ICU patient charts will be audited for titratable sedative dosing per order, and the appropriate use of RASS sedation scales. This will be completed by the unit management and just in time training will be completed if a deficient practice is found.	3 months at 100% compliance is reached	10/15/2018	Audit data will be collected and tracked by the Nursing Administration Office and presented to the Chief Nursing Officer. Once reviewed aggregate data will be submitted to the Compliance department for presentation to the Board of Directors, no less than annually.	If goal not met in one year, review education and training, and update plan of correction.						100%	100%	100%									Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
82 E 475	1b. Policy "Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)" completed.	1. Pharmacist-in-charge will monitor cleaning log once a month for 3 months and then once a quarter for 2 additional quarters for 100% complete ceiling cleaning. If goal not met, review and update plan of correction.			The Infection Preventionist has oversight responsibility. Data monitoring will be sent to the Infection Prevention Medical Staff Committee, quarterly, for review. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.
	Training completed for the pharmacy department on the updated draft policy while awaiting approval process. Just-in-time training will be completed by the Clinical Engineering and Compliance as needed.	2. Pharmacist-in-charge has oversight of this process. Compliance to review log reports for daily checks of temperature monitoring software, monthly for three months.			Aggregate data reported to the Pharmacy and Therapeutics Medical Staff Committee quarterly. Aggregate data will be reported to the Board of Directors by the Compliance office no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 479 83	1a. Posting of Signage: Sign posted in ED at past location of the Malignant Hyperthermia Cart directing staff to the new location in PACU. 1b. Email Notification of RN Staff: Current RN staff will be sent an email with reminder of current location of the Malignant Hyperthermia Cart location.	1. Added knowledge question to RN rounding form, Nursing Leadership is rounding regularly and asking a minimum of 5 RNs (17% of the workforce monthly) per week as to the location of the Malignant Hyperthermia Cart.	When 3 months of RN Rounding form documentation results in 100% knowledge of the location of the Malignant Hyperthermia Cart we will consider the knowledge of cart location to be known by the nursing team.		Data will be tracked and trended by the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.
E480	Immediately verified the medications belonging in the crash cart and added the list to the policy.	All policies are reviewed by appropriate committees, leadership, and Board of Directors no less than once every three years. This review will ensure sustainability of this change. No additional monitoring needed.	No additional monitoring	10/17/2018	No additional monitoring

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

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84 **E485**	Staff were educated at Sept 2018 MS/ICU staff meeting. Staff were educated about use of appropriate sedation scales and titration orders.	100% of ICU patient charts will be audited for titratable sedative dosing per order, and the appropriate use of RASS sedation scales. This will be completed by the unit management and just in time training will be completed if a deficient practice is found.	3 months at 100% compliance is reached	10/15/2018	Audit data will be collected and tracked by the Nursing Administration Office and presented to the Chief Nursing Officer. Once reviewed aggregate data will be submitted to the Compliance department for presentation to the Board of Directors, no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 503	1. Clove oil was removed from the Dental Box in the ED. 2. Dental Box content list has been updated. 3. Emergency Medicine Providers' group determined clove oil will no longer be used in the facility dental box 4. Education provided to ED workforce.	Dental box located in the ED will be audited once per month until 3 consecutive months of no Clove Oil. Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil.	3 months at 100% compliance is reached	7/20/2018 10/11/2018 10/8/2018 9/25/2018	Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil. This data will be reported to the Compliance Dept. and the Board of Directors no less than annually.	Until 3 consecutive months of no Clove oil in the ED Dental box.		100%	100%	100%	100%													Completed
E 511	1. Pharmacist in charge has directed pharmacy staff to remove AddVantage system supplies from all facility Omnicells. Pharmacy will switch to Baxter MiniBag Plus system, which comes in single use per overwrap package. Pharmacy staff has been educated on this change via email.	No additional monitoring is required.	None	7/20/2018	Pharmacist-in-charge is responsible for oversight of this change.	None	complete																		Completed
	2. Medication storage will be in accordance with manufacturer's specifications based on the FDA approved information in the package insert.	No additional monitoring is required.	None	10/12/2018	Pharmacist-in-charge is responsible for oversight of this change.	None	complete																		Completed
85 E 1363	Spreadsheets for tracking all supplies in the crash cart had been developed by the Cardiopulmonary department. The spreadsheet was updated to include month/day/year. Additional training was provided to the Cardiopulmonary Department to review the expiry dates monthly and replace all supplies prior to expiration.	If during monthly checks, an expired supply is found, a Quality Review/Unusual Occurrence report will be completed by the staff member. Compliance will review and trend UOR/QRRs for outdated supplies in crash cart. Time: Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters. Success is less than or equal to 1 UOR during the monitoring period. THis data will be reported to the Resuscitation Medical Staff Committee quarterly and to the Board of Directors no less than annually.	monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	10/12/2018	Resuscitation Medical Staff Committee	Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters.			100.0%	100.0%	100.0%	100.0%	<100% 1 UOR	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Completed
E 2115	Staff identified by the CDPH inspectors, and all other NIHD workforce, were within the timeframe identified by the Inyo County Health Officer, however, NIHD did not notify CDPH of this letter until the inspection. Inspectors instructed CNO to include the letter from the Inyo County Health Officer with the response to the licensing inspection.	No additional monitoring is required.		7/20/2018	Chief Nurse	None	complete																		Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 503	1. Clove oil was removed from the Dental Box in the ED.	Dental box located in the ED will be audited once per month until 3 consecutive months of no Clove Oil. Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil.	3 months at 100% compliance is reached	7/20/2018	Monitoring by the nursing unit manager will be complete following 3 consecutive months of no clove oil. This data will be reported to the Compliance Dept. and the Board of Directors no less than annually.
	2. Dental Box content list has been updated.			10/11/2018	
	3. Emergency Medicine Providers' group determined clove oil will no longer be used in the facility dental box			10/8/2018	
	4. Education provided to ED workforce.			9/25/2018	
E 511	1. Pharmacist in charge has directed pharmacy staff to remove AddVantage system supplies from all facility Omnicells. Pharmacy will switch to Baxter MiniBag Plus system, which comes in single use per overwrap package. Pharmacy staff has been educated on this change via email.	No additional monitoring is required.	None	7/20/2018	Pharmacist-in-charge is responsible for oversight of this change.
	2. Medication storage will be in accordance with manufacturer's specifications based on the FDA approved information in the package insert.	No additional monitoring is required.	None	10/12/2018	Pharmacist-in-charge is responsible for oversight of this change.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 1363 87	Spreadsheets for tracking all supplies in the crash cart had been developed by the Cardiopulmonary department. The spreadsheet was updated to include month/day/year. Additional training was provided to the Cardiopulmonary Department to review the expiry dates monthly and replace all supplies prior to expiration.	If during monthly checks, an expired supply is found, a Quality Review/Unusual Occurrence report will be completed by the staff member. Compliance will review and trend UOR/QRRs for outdated supplies in crash cart. Time: Review and trend UOR/QRRs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters. Success is less than or equal to 1 UOR during the monitoring period. THis data will be reported to the Resuscitation Medical Staff Committee quarterly and to the Board of Directors no less than annually.	monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	10/12/2018	Resuscitation Medical Staff Committee
E 2115	Staff identified by the CDPH inspectors, and all other NIHD workforce, were within the timeframe identified by the Inyo County Health Officer, however, NIHD did not notify CDPH of this letter until the inspection. Inspectors instructed CNO to include the letter from the Inyo County Health Officer with the response to the licensing inspection.	No additional monitoring is required.		7/20/2018	Chief Nurse

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E 2150	1. Staff education that IV infusion tubing in the outpatient infusion department shall be discarded once disconnected from the patient.	1. PACU management will monitor daily for sterilely capped, patient labeled, re-used tubing in the infusion department for two months. If zero are found, no additional monitoring required.	Daily x 2 months	7/20/2018	This information will be reported to Nursing Executive Committe until two consecutive months of zero found goal is met. Compliance will report to the Board of Directors.	2 months with 100% compliance		100%	100%																Completed
	2. "Point of care -Accu-Chek Blood Glucose Testing" policy was reviewed and no changes regarding disinfection of the unit were required in the policy. Training and education have been provided to the NIHD staff who utilize the glucometer. Review of wet time procedures at department meetings and hospital orientation has occurred. Just-in time training is provided during rounding of unit managers and nursing leadership.	2. "Wet time" knowledge question added to Environment of Care monthly audits and Nursing Unit Rounding questions. Anyone getting the Wet-time answer wrong will receive "just-in-time" training. Monthly data will be collected for trending by department for additional targeted training.	When 3 months of RN Rounding form documentation results in 98% correct answers, we will consider the undestanding of "wet-times" to be known by the nursing team.	7/20/2018-ongoing	Data will be compiled and sent to the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually	Data tracking will occur until no wrong answers for 3 consecutive months. If goal not met, review and update plan of correction.				43.8%	85.7%	75.0%	92.30%		92.3%	70.0%	100.0%	100.0%	80.0%					Monitoring is current
	3. Paper towel and soap dispenser installed near sink in supply room in the Infusion department.			9/21/2018			complete																		Completed
	4. Additional dual tip protectors were ordered to ensure all sterilized hinged instruments are more clearly in an open position and cannot move to the locked position inadvertently after sterilization. Additional education and training to ensure all staff are knowledgeable that hinged instruments must be in an open position. All staff memebers in the Central Sterile Processing will participate in the auditing of sterilized instrument packets.	Audit processed peel packs weekly: 20 / week for September and October 2018 with 100% compliance.	If at 100% Compliance, no additional monitoring requirements.	10/15/2018	DON of perioperative services	No ongoing monitoring requirements.		100%	100%	100%	100%	100%			100%		100%								Completed
	5. Each area in the 3 ORs and Sterile Processing, Infusion, and PACU is assigned to a staff member who goes through and checks each item for dates. The person checking must initial the form once the check has been completed. Expired supplies will be removed. An unusual occurrence report will be completed for any expired supply found	Oversight of the Monthly outdate review is overseen by the DON of perioperative services.Compliance will trend UORs for outdated supplies.	Monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	8/1/2018	submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.	Review and trend UORs for outdates monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%	100%		Completed
	6. Signs were placed on patient allocated refrigeration units with "For Patient Use Only" signs. Provide in-service with nursing managers to audit patient refridgeration units.	6. Nursing Managers are monitoring patient designated refrigeration units once a week for three months, and then once per quarter for three quarters to ensure no non-patient food and beverage is stored in patient designated areas.	Once per week X 3 months, Once per quarter X 3 quarters	7/25/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	Once per week X 3 months, Once per quarter X 3 quarters			75%	100%	100%		100%			100%			100%			100%	100%	100%	Completed
	7. Discard all multiple use Hormel Thick and Easy Thickener throughout NIH campus. Purchase single serving packets of Hormel Thick and Easy Thickener Powder. Provided in-service on corrective action inventory procedures with dietary staff.	Monitor invoices and unit checks once a month for three months to ensure no multi use Hormel Thick and Easy thickener is on NIH campus to ensure compliance, last purchased date of multiple use Hormel Thick and Easy Thickener to not exceed 04/27/2018.	Monitor invoices once per month for three months, if no purchases, continue to monitor once per quarter for three quarters	7/20/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.	once per month x 3 months, once per quarter x 3 quarters				100%	100%	100%	100%			100%			100%			100%	100%	100%	Completed

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
89	1. Staff education that IV infusion tubing in the outpatient infusion department shall be discarded once disconnected from the patient.	1. PACU management will monitor daily for sterilely capped, patient labeled, re-used tubing in the infusion department for two months. If zero are found, no additional monitoring required.	Daily x 2 months	7/20/2018	This information will be reported to Nursing Executive Committe until two consecutive months of zero found goal is met. Compliance will report to the Board of Directors.
	2. "Point of care -Accu-Chek Blood Glucose Testing" policy was reviewed and no changes regarding disinfection of the unit were required in the policy. Training and education have been provided to the NIHD staff who utilize the glucometer. Review of wet time procedures at department meetings and hospital orientation has occurred. Just-in time training is provided during rounding of unit managers and nursing leadership.	2. "Wet time" knowledge question added to Environment of Care monthly audits and Nursing Unit Rounding questions. Anyone getting the Wet-time answer wrong will receive "just-in-time" training. Monthly data will be collected for trending by department for additional targeted training.	When 3 months of RN Rounding form documentation results in 98% correct answers, we will consider the undestanding of "wet-times" to be known by the nursing team.	7/20/2018-ongoing	Data will be compiled and sent to the Nursing Administrative Team. The aggregate data will be submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually
	3. Paper towel and soap dispenser installed near sink in supply room in the Infusion department.			9/21/2018	

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 2150 90	4. Additional dual tip protectors were ordered to ensure all sterilized hinged instruments are more clearly in an open position and cannot move to the locked position inadvertently after sterilization. Additional education and training to ensure all staff are knowledgeable that hinged instruments must be in an open position. All staff memebers in the Central Sterile Processing will participate in the auditing of sterilized instrument packets.	Audit processed peel packs weekly: 20 / week for September and October 2018 with 100% compliance.	If at 100% Compliance, no additional monitoring requirements.	10/15/2018	DON of perioperative services
	5. Each area in the 3 ORs and Sterile Processing, Infusion, and PACU is assigned to a staff member who goes through and checks each item for dates. The person checking must initial the form once the check has been completed. Expired supplies will be removed. An unusual occurrence report will be completed for any expired supply found	Oversight of the Monthly outdate review is overseen by the DON of perioperative services.Compliance will trend UORs for outdated supplies.	Monthly for 3 months, if no incidents of outdates, follow quarterly for 3 additional quarters	8/1/2018	submitted to the Nurse Executive Committee quarterly, with the Chief Nursing Officer having oversight responsibility. Chief Nurse will supply report to Compliance to be submitted to the Board of Directors no less than annually.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
91	6. Signs were placed on patient allocated refrigeration units with "For Patient Use Only" signs. Provide in-service with nursing managers to audit patient refridgeration units.	6. Nursing Managers are monitoring patient designated refrigeration units once a week for three months, and then once per quarter for three quarters to ensure no non-patient food and beverage is stored in patient designated areas.	Once per week X 3 months, Once per quarter X 3 quarters	7/25/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.
	7. Discard all multiple use Hormel Thick and Easy Thickener throughout NIH campus. Purchase single serving packets of Hormel Thick and Easy Thickener Powder. Provided in-service on corrective action inventory procedures with dietary staff.	Monitor invoices and unit checks once a month for three months to ensure no multi use Hormel Thick and Easy thickener is on NIH campus to ensure compliance, last purchased date of multiple use Hormel Thick and Easy Thickener to not exceed 04/27/2018.	Monitor invoices once per month for three months, if no purchases, continue to monitor once per quarter for three quarters	7/20/2018	This process is overseen by the Dietary Manager. Data is reported to the Compliance Officer quarterly. The Compliance Officer will report this information to the Board of Directors no less than annually.

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility	Time frame for monitoring	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	CY 18 Q3	CY 18 Q4	CY 19 Q1	CY 19 Q2	
E 2151	1. Created fit testing project team. 2.Team reviewed Aerosolized Transmissable Disease plan, which delineates job roles that require fit testing. 3. Developed tracking and reminder system for annual testing. 4. Developed process such that all new hires are tested before or within 3 weeks of hire.	A statistically significant sample of employees requiring fit-testing will have an audit of the fit test record to ensure compliance with the policy.	Auditing will occur monthly for 3 months or until 97% or greater compliance rate is achieved. Additional auditing will occur quarterly for 3 quarters with the sustainability goal of 97% or greater compliance rate is achieved.	11/1/2018	The Infection Preventionist is responsible for oversight. This data will be reported to the Infection Control Medical Staff Committee and Medical Executive Committee, quarterly. This data will be reported to the Board of Directors no less than annually.	I										88.0%		98.7%	98.0%	99.7%				99.7%	Completed
92 E 2354	1. Staff trained to look at the stickers and see if they are in compliance. **If out of date: Item to be pulled out of service**. Email to Engineering to request service. UOR completed. During transition year, staff will know that no piece of equipment is in date for greater than 1 year after inspection. 2. All equipment that can hold a PM sticker will be labeled with inspection date and expiration date to let clinical staff when a device is due for service. EOC rounds will ensure equipment is current for inspections as well as EOC reporting to the safety committee.	Unusual Occurrence Reports (UOR) will be utilized to document outdated PM Service tags, which indicate need for service, when found by the end user.	Quarterly review of the UORs will be expected to show 90% compliance of Non-High Risk Medical Equipment, and 100% complaince of High Risk Medical Equipment.	10/19/2018	Compliance Officer will provide oversight for this process. Compliance will report data to the Director of IT Services and the Board of Directors no less than annually.	After 3 concurrent Quarters of review at 90% and 100%, respectively, the audit will be complete															100% 100%	100% 100%	100% 100%	Completed

Results did not meet goals | Results met goals | Monitoring is ongoing and current.

CDPH 2018 Survey
Monitoring and Oversight of Corrective Action Plans

Tag	Corrective Action	Monitoring Plan	Frequency	Date Correction Completed	Oversight Responsibility
E 2151 93	1. Created fit testing project team. 2.Team reviewed Aerosolized Transmissable Disease plan, which delineates job roles that require fit testing. 3. Developed tracking and reminder system for annual testing. 4. Developed process such that all new hires are tested before or within 3 weeks of hire.	A statistically significant sample of employees requiring fit-testing will have an audit of the fit test record to ensure compliance with the policy.	Auditing will occur monthly for 3 months or until 97% or greater compliance rate is achieved. Additional auditing will occur quarterly for 3 quarters with the sustainability goal of 97% or greater compliance rate is achieved.	11/1/2018	The Infection Preventionist is responsible for oversight. This data will be reported to the Infection Control Medical Staff Committee and Medical Executive Committee, quarterly. This data will be reported to the Board of Directors no less than annually.
E 2354	1. Staff trained to look at the stickers and see if they are in compliance. **If out of date: Item to be pulled out of service**. Email to Engineering to request service. UOR completed. During transition year, staff will know that no piece of equipment is in date for greater than 1 year after inspection. 2. All equipment that can hold a PM sticker will be labeled with inspection date and expiration date to let clinical staff when a device is due for service. EOC rounds will ensure equipment is current for inspections as well as EOC reporting to the safety committee.	Unusual Occurrence Reports (UOR) will be utilized to document outdated PM Service tags, which indicate need for service, when found by the end user.	Quarterly review of the UORs will be expected to show 90% compliance of Non-High Risk Medical Equipment, and 100% complaince of High Risk Medical Equipment.	10/19/2018	Compliance Officer will provide oversight for this process. Compliance will report data to the Director of IT Services and the Board of Directors no less than annually.

NORTHERN INYO HOSPITAL MEDICAL STAFF
POLICY AND PROCEDURE

Title: Practitioner Re-entry Policy	
Scope: Medical Staff and Advanced Practice Providers	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

PURPOSE:
To enable a practitioner, under certain circumstances, to return to clinical practice after an extended period of clinical inactivity while ensuring the high standard of patient care expected at Northern Inyo Healthcare District (NIHD).

DEFINITIONS:
- **Full Re-entry:** Defined by the American Medical Association as "return to clinical practice for which one has been trained, certified or licensed after an extended period of clinical inactivity not resulting from discipline or impairment". For the purposes of this policy an extended period is further defined as greater than or equal to 2 years and no more than 5 years.
- **Partial Re-entry:** Process of resuming a portion of clinical practice for which an actively practicing clinical practitioner has been previously trained, certified or licensed but is not currently able to qualify for privileges due to inactivity in that area of practice.

POLICY FOR FULL RE-ENTRY:
1. To qualify for full re-entry, the applicant must meet the following requirements:
    a. Meet the definition of full re-entry above.
    b. Abide by state medical board re-entry rules or recommendations, if any.
    c. Abide by any re-entry policy of the relevant specialty board(s), if any.
    d. Abide by malpractice insurance policy for practitioner re-entry, if any.
    e. Have evidence of recent continuing medical education in accordance with current medical staff standards.
    f. Be board certified.
    g. Meet all other qualifications for credentialing as per the medical staff bylaws.
2. A potential applicant who has been out of clinical practice for more than 5 years will not qualify for re-entry but may apply for medical staff membership after completion of a full standardized re-entry program or an equivalent program adequate to prove current competency.
3. The full re-entry plan requirements are as follows:
    a. Re-entry plan may include a full standardized re-entry program, re-entry evaluation with a standardized re-entry program, specific skills proctoring at a teaching facility or other appropriate facility (e.g. robotic surgery, NICU for neonatal care, high volume of deliveries to resume obstetrical privileges, etc.) shadowing/proctoring within our organization, or an appropriate combination thereof at the discretion of the relevant department and/or credentialing committee.
    b. The re-entry plan will identify a mentor to oversee the re-entry process. The mentor must have sufficient time and experience and be a member of the medical staff in good standing.
    c. The re-entry plan will include a Focused Practice Performance Evaluation (FPPE) for documentation of the re-entry process completed by the identified mentor. The

FPPE plan will be individualized to each applicant, but will be no less than the minimum requirements for initial FPPE plans normally used by the department.

d. The re-entry plan will be agreed upon by the applicant, the relevant department(s) and the credentialing committee.
e. The length and scope of the re-entry plan will account for the type of practice/procedures privileges requested, previous level of training/experience, MOC status, and any relevant interim activities. The expected length and scope of the re-entry plan will be included in the initial plan but may be extended by the applicant or the department upon recommendation of the mentor if more time is deemed necessary to show competency.
f. Any practitioner who practices in a field in which the volume of patients at NIHD makes re-entry proctoring impractical to complete within a reasonable amount of time will be required to complete a full standardized re-entry program or an equivalent program at the discretion of the relevant department and/or credentialing committee.

POLICY FOR PARTIAL RE-ENTRY:

1. A practitioner who is currently in clinical practice but unable to prove current competency/recent experience for some portion of core privileges may be eligible for a partial re-entry plan.
2. The partial re-entry plan requirements are as follows:
    a. A partial re-entry plan may include specific skills proctoring at a teaching facility or other appropriate facility (e.g. robotic surgery, NICU for neonatal care, high volume of deliveries to resume OB privileges, etc.) shadowing/proctoring within our organization or an appropriate combination thereof at the discretion of the relevant department and/or credentialing committee.
    b. The partial re-entry plan will be agreed upon by the applicant, the relevant department(s) and the credentialing committee.
    c. The length and scope of the partial re-entry plan will account for the type of practice/procedures privileges requested, previous level of training/experience, MOC status, and any relevant interim activities.
    d. The partial re-entry plan will identify a mentor to oversee the re-entry process. The mentor must have sufficient time and experience and be a member of the medical staff in good standing.
    e. The partial re-entry plan will include a FPPE for documentation of the re-entry process completed by the identified mentor.
    f. Once the agreed upon partial reentry plan has been completed the practitioner may be released from FPPE for the appropriate additional clinical privileges.

Title: Practitioner Re-entry Policy	
Scope: Medical Staff and Advanced Practice Providers	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

PROCEDURE:

1. A practitioner who qualifies for full or partial re-entry as stated above may complete an application for medical staff or Advanced Practice Provider staff membership with the medical staff office as per the NIHD bylaws.
2. Once the application is otherwise complete, a re-entry plan will be required in lieu of current competencies/recent experience. An example re-entry plan is included in Attachment 1.
3. The re-entry plan must be agreed upon by the applicant, the relevant department(s) and the credentialing committee before the application process can proceed. NIHD medical staff will attempt to complete this process in a timely manner.
4. If a re-entry plan cannot be agreed upon, the application will be deemed incomplete and can be withdrawn without penalty.
5. The re-entering practitioner will be responsible for any cost incurred from the re-entry plan unless otherwise agreed upon by NIHD administration/ board at the recommendation of the department and or credentialing committee.
6. Once a re-entry plan is agreed upon the application process can proceed as per current bylaws.

REFERENCES:

1. American Medical Association. Resources for physicians returning to clinical practice. https://www.ama-assn.org/practice-management/career-development/resources-physicians-returning-clinical-practice
2. Community Memorial Health System. “Medical Staff Re-entry Plan.” Policy and procedure. Revised 10/4/2016.
3. National Association of Medical Staff Services. “Back in the Saddle Again: Credentialing Conundrums Surrounding the Reentry Physician.” Educational Conference and Exhibition. 9/20/2016.
4. State Medical Licensure Requirements and Statistics. “Physician Re-entry.” 2013.

Approval	**Date**
Credentials Committee	10/09/2019
Medical Staff	01/14/2020
Medical Executive Committee	02/04/2020
Board of Directors	
Last Board of Directors Review	

Developed: 10/2019 ch
Reviewed:
Revised:
Supersedes:
Index Listings:

Title: Practitioner Re-entry Policy	
Scope: Medical Staff and Advanced Practice Providers	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

ATTACHMENT 1
SAMPLE RE-ENTRY TO PRACTICE PLAN

Name: _____

Clinical Experience:

Specialty: _____

Time Spent in Clinical Practice: _____

Date and Location of Last Clinical Practice: _____

Reason for Leaving Clinical Practice: _____

Intended Clinical Practice:

Intended Practice Setting and Location: _____

Special Privileges requested: _____

Description of How I Maintained Competency After Leaving Clinical Practice

_____

_____

_____

_____

_____

_____

Maintenance of Certificate status: _____

Applicable Medical Board status including most recent test date: _____

Continuing Medical Education within last 2 years: _____

Plan for Obtaining Re-entry Education and Clinical Competency

Refresher Course(s)/ Mini-Residency Offered by a Medical School or Other Formal Program:

_____

Title: Practitioner Re-entry Policy	
Scope: Medical Staff and Advanced Practice Providers	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date:

Mentorship/Preceptorship:

Name/Medical Specialty of Mentor/Preceptor: _____

Number of Work Days/Hours per Week: _____

Total hours of patient care expected: _____

Total number of procedures expected (if applicable): _____

Method of Direct Supervision and Review of Clinical Care: (e.g. The mentor shall participate in the care of each patient to the degree necessary to be personally responsible for the care rendered, to be able to certify to the quality of such care, and to provide prompt meaningful feedback and guidance)_____

_____

_____

_____

_____

Frequency of Written Reports to Department/Credentialing committee: _____

Content of Written Reports to the Department/Credentialing committee: (e.g. Practice activities, hours, workload, functioning, knowledge, skills, general professionalism, any deficiencies, and overall ability to practice safely and competently. Minimum must be equivalent to department FPPE standard):

_____

_____

_____

_____

Signatures: _____ (applicant)

_____ (department chair(s))

_____ (credentials committee)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: MetaNeb	
Scope: Respiratory Therapist	Manual: Respiratory
Source: Director of Cardiopulmonary	Effective Date:

PURPOSE:
The MetaNeb system is indicated for mobilization of secretion, lung expansion therapy and the treatment and prevention of pulmonary atelectasis.

POLICY:
1. Patient Population:
    - Adult and children over the age of 2

2. Patients who may benefit from The MetaNeb System include those with one or more of the following disease states:
    - Bronchiolitis
    - Cystic Fibrosis
    - Asthma
    - Chronic Bronchitis
    - Bronchiectasis
    - Emphysema
    - Chronic Obstructive Pulmonary Disease
    - Neuromuscular Disorders
    - Patients who need Post-Operative Airway Management

Absolute Contraindications:
- Untreated tension pneumothorax
- Untrained or unskilled operator

Relative Contraindications:
The decision to use The MetaNeb System in the presence of the conditions listed below requires careful consideration and assessment of the individual patients' case.
- History of pneumothorax
- Pulmonary air leak
- Recent pneumonectomy
- Pulmonary hemorrhage
- Myocardial infarction
- Vomiting

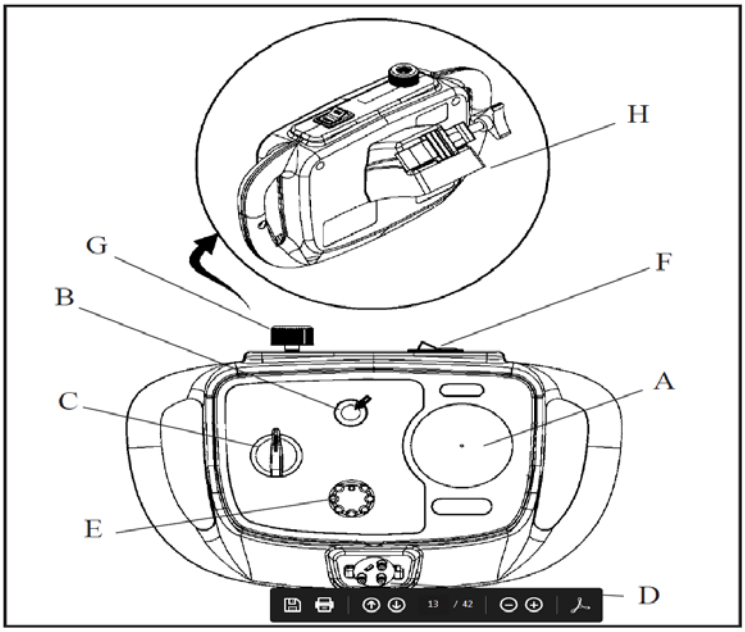
Possible Adverse Reactions:
Use of The MetaNeb System should be evaluated or modified if the following circumstances occur:
- Hyperventilation
- Gastric distension
- Decreased cardiac output
- Increased intracranial pressure

- Increased air trapping
- Hyperoxygenation
- Pneumothorax
- Pulmonary air leak
- Pulmonary hemorrhage

The MetaNeb System is a therapeutic device that uses a systematic approach to enhance normal mucus clearance and resolve or prevent patchy atelectasis.

The system has three modes:
• CHFO (Continuous High Frequency Oscillation)—a pneumatic form of chest physiotherapy that delivers medicated aerosol while oscillating the airways with continuous pulses of positive pressure.
• CPEP (Continuous Positive Expiratory Pressure)—supplies medicated aerosol combined with continuous positive pressure to help hold open and expand the airways.
• Aerosol—for the delivery of aerosol only. In this mode CHFO and CPEP are not available.

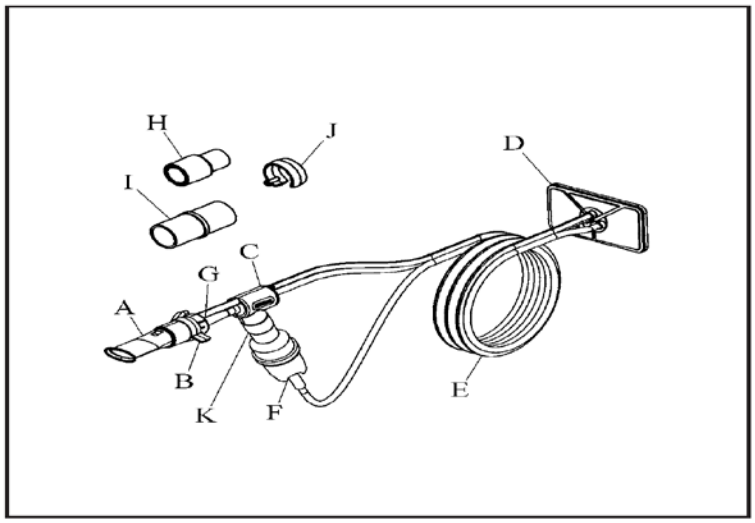
Controller



Item	Description	Item	Description
A	Pressure manometer	E	CPEP flow adjuster
B	Higher/lower switch	F	Master on/off switch
C	Mode selector	G	Oxygen gas connector
D	Circuit tri-connector port	H	Mount bracket

Title: MetaNeb	
Scope: Respiratory Therapist	Manual: Respiratory
Source: Director of Cardiopulmonary	Effective Date:

Circuit



Item	Description	Item	Description
A	Mouthpiece	G	Orifice indicators
B	Selector ring	H	Adapter, 22 mm x 15 mm
C	Handset	I	Adapter, 22 mm x 22 mm
D	Circuit tri-connector/ bio-filter	J	Occlusion ring
E	Tubing	K	Silicon adapter
F	Nebulizer	L	Nebulizer tubing

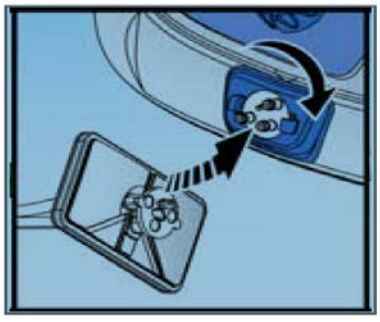
ASSEMBLE THE CIRCUIT

1. Put the circuit tri-connector/bio-filter into the tri-connector port on the control unit.
2. Turn the connector 45° counterclockwise to lock it into position.
3. Remove the mouthpiece from the package.
4. Attach the mouthpiece to the handset: insert the mouthpiece at a 45° angle and gently push it in and twist it to the correct orientation.

PRE-USE CHECK

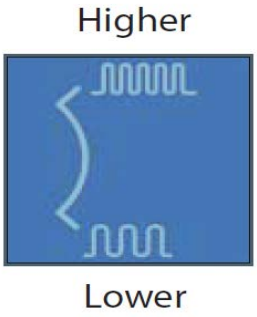
Do this prior to each use:

1. Connect the gas hose to a 50 psi oxygen source.
2. Connect the circuit to the controller.
3. Set the mode to **CHFO,** and select **Higher**.



Title: MetaNeb	
Scope: Respiratory Therapist	Manual: Respiratory
Source: Director of Cardiopulmonary	Effective Date:

4. Set the selector ring on the handset to the **three-dots** position.
5. Put the master switch in the **ON** position.
6. Occlude the patient opening of the handset.
7. Watch the pressure gauge. The average of pressure fluctuations should not be less than 15 and not more than 30 cm H2O.
8. Set the mode to **CPEP**.
9. Turn the CPEP flow dial counterclockwise to **full flow**.
10. With the selector ring on three dots, occlude the patient opening of the handset and monitor the manometer. Make sure there is a peak pressure occurrence of not less than 20 and not more than 30 cm H2O.
11. If the device is not within the parameters specified above, do not use the unit. Contact Hill-Rom Technical Support to examine and repair the unit.



METATHERAPY TREATMENT PROTOCOL

- Physician order is to be placed in Athena under custom respiratory as Metatherapy and with frequency.
- Respiratory Therapy will verify order from the physician for Metatherapy, frequency of treatments must be included in order

Frequency

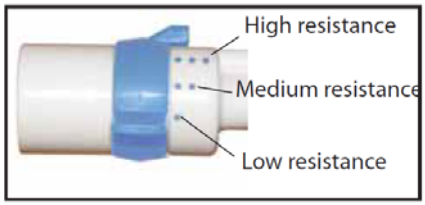
The common strategy for frequency of MetaTherapy Treatment, in the acute care setting, ranges from two (2) to four (4) times daily. The patient's response to the therapy should determine any frequency adjustments.

Procedure

1. Make sure the unit operates correctly. Do a "Pre-Use Check" prior to each use.
2. Follow your institutional guidelines for infection control.
3. Introduce yourself, and explain the procedure to the patient. Verify patient using two identifiers.
4. The patient should be in an upright and comfortable position, if possible.
5. Assess patient.
6. Fill the nebulizer with the prescribed medications, if applicable.
7. Set the mode to **CPEP**.
8. Turn the CPEP flow dial all the way clockwise to the **lowest** position.

9. Set the selector ring on the handset to the **one-dot** position.
10. Connect The MetaNeb System to an approved 50 psi oxygen source.
11. Put the master switch in the **ON** position.
12. Adjust the CPEP flow to observe the aerosol that comes from the patient end of the handset.

13. Attach the mouthpiece to the handset.



NOTE:
A cushion mask or tracheotomy tube may also be connected to the handset using the appropriate provided adapter.

14. Instruct the patient to inhale normally and exhale slowly (3-4 seconds) through the mouthpiece or facemask.
15. Adjust the selector ring up to the **two-dot** setting for higher resistance or **three-dot** setting for highest resistance as tolerated by the patient.
16. Encourage the patient to exhale slowly (3-4 seconds).
17. Continue CPEP mode approximately 2 ½ minutes, adjusting the flow to achieve a therapy that is comfortable yet challenging for the patient.
18. Instruct the patient that the mode will now change to CHFO. Proceed with changing the mode to **CHFO**.
19. Move the **Higher/Lower** switch to **Higher**
20. During the treatment, the selector ring may be adjusted and the **Higher/Lower** switch may be moved to **Lower**.

NOTE:
The Lower setting on the **Higher/Lower** switch reduces the percussion rate and the pressure, and may be used as an introductory mode. Subsequently, the switch may be returned to the Higher position for enhanced therapy.

21. Encourage the patient to inhale normally and exhale slowly (3-4 seconds) against pulsations, keeping his or her cheeks firm to avoid pressure loss.
22. Continue CHFO mode for approximately 2 ½ minutes.
23. Alternate between CPEP and CHFO for 10 minutes or depending on patient need.
24. When the treatment is complete, turn the unit off, disconnect the circuit, and store the unit for future use.

NOTE:

When you store the circuit, keep the tubing attached to the bottom of the nebulizer cup and disassemble the top of the nebulizer from the handset. Place in a patient set-up bag.

Assessment of Outcome
Therapy will be discontinued when one of these occur:
• Secretion clearance is < 5 cc per treatment for a 24 hr period.
• The post therapy chest exam shows an absence of retained secretions and atelectasis.
• Breath sounds have become clear or have improved.

Re-Evaluation
Patients should be evaluated every 24 hrs at a minimum or as clinical changes dictate by a Respiratory Therapist while on The MetaNeb System to make sure that an acute change has not occurred.

THE METANEB SYSTEM IN-LINE WITH VENTILATOR PROTOCOL
WARNING:

- Only persons trained to use the The MetaNeb System and ventilators should perform therapy on ventilated patients..
- Physician order is to be placed in Athena under custom respiratory as Metatherapy and with frequency.
- Respiratory Therapy will verify order from the physician for Metatherapy, frequency of treatments must be included in order.

Frequency
In-line use of The MetaNeb System with a ventilator ranges in frequency from four (4) to eight (8) times daily as determined by the patient's response to the therapy.
There is no need for CPEP, as this therapy can be accomplished with the ventilator.

Procedure
1. Make sure the unit operates correctly. Do a “Pre-Use Check” prior to each use
2. Follow your institutional guidelines for infection control.
3. Introduce yourself, and explain the procedure to the patient. Verify patient using two identifiers.
4. Make a note of the current ventilator alarm and mode settings.
5. The patient should be in a position to maintain the head of the bed angle at > 30 degrees if possible.
6. Assess patient.
7. Prepare the handset for in-line use as follows:
a. Remove the selector ring from the patient end of the handset.
b. Install the black occlusion ring to make sure the exhalation orifice is blocked.
c. Use the adapter (15 mm x 22 mm) to connect the handset to the spring-valve tee adapter.
8. Fill the nebulizer with the prescribed medications as applicable.
9. Connect The MetaNeb System to an approved 50 psi oxygen source.

10. Set the mode to **CHFO** and select **Higher**.
11. Put the master switch in the **ON** position.
12. Put a spring-valve "tee" adapter into the inspiratory limb of the ventilator circuit.
13. Monitor the patient response to the therapy, and continue the treatment for 10 minutes or depending on patient need.
14. Adjust the alarm parameters as necessary while The MetaNeb System supplies in-line therapy.

WARNING:
As secretions mobilize it is not uncommon for plugs to momentarily occlude the upper airways. Do Not Leave the patient during the therapy and be prepared to suction.

15. Suction secretions as necessary during treatment.
16. Remove the handset and adapter from the spring-valve tee and cap the spring-valve tee before you put the The MetaNeb System master switch in the **OFF** position.
17. Return the ventilator alarms and mode to their previous settings.
18. Monitor and document the patient's tolerance during and after the treatment (HR, SpO2, BP, Auscultation, and such).
19. Store The MetaNeb System circuit in a patient set-up bag.

Assessment of Outcome
Therapy will be discontinued when one of these occur:
• Secretion clearance is < 5 cc per treatment for a 24 hr period.
• The post therapy chest exam shows an absence of retained secretions and atelectasis.
• Breath sounds have become clear or have improved.

Re-Evaluation
Patients should be evaluated every 24 hrs at a minimum or as clinical changes dictate by a Respiratory Therapist while on The MetaNeb System to make sure that an acute change has not occurred.

CLEANING
WARNING:
Failure to follow these cleaning instructions could cause injury or equipment damage.
Failure to discard the SPU circuit in accordance with facility policy could cause the spread of infection.
Do not steam clean the controller, stand, or circuit. Injury or equipment damage could occur.
Do not expose the unit to excessive moisture. Injury or equipment damage could occur.
Do not use harsh cleansers, solvents, or detergents. Equipment damage could occur.
Failure to follow the cleaner manufacturer's instructions could cause equipment damage.

Cleaning
The MetaNeb System has been tested for compatibility with the following cleaning and disinfecting solutions:

- Caviwipes, wet time 2 minutes
- Bleach Germicidal wipes, wet time 3 minutes. Then wipe with a damp cloth

Cleaning the Controller and Stand

Clean the controller and stand between patients, when visibly soiled, or according to facility protocols. Do not spray the cleaner on to the controller. We recommend that you clean the controller and stand with a soft cotton cleaning pad that is moistened with the cleaner.
Do not use excessive liquid or harsh cleansers. Do **not** immerse the controller in water or let liquids enter the controller.

Clean the controller and stand as follows:

a. Make sure the air supply hose is connected to the controller.
b. Wipe down the controller or stand with the moistened cloth.
c. After you clean the controller or stand, make sure it is dry before you use it.

REFERENCES:

1. The MetaNeb System User Manual 174432 REV, (2016)
2. Egan's Fundamentals of Respiratory Care 10th Edition, (2013)

CROSS REFERENCE P&P:

1. Infectious/non-infectious waste disposal procedure
2. Patient Identification for clinical care and treatment/armband usage

Approval	**Date**
Clinical Consistency Oversight Committee	10/21/19
Cardiopulmonary Committee	10/14/19
Med Services/ICU	12/05/19
Emergency Services Committee	11/13/19
Perinatal/Pediatrics Committee	12/05/19
Medical Executive Committee	02/04/20
Board of Directors	
Board of Directors Last Review	

Developed: 10/19kc
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE

Title: Standards of Care in the Perioperative Unit	
Scope: Perioperative Unit	Manual: Surgery, PACU – Standards of Care (S of C)
Source: DON Perioperative Services	Effective Date: 3/31/18

POLICY STATEMENT:

1. The Perioperative Unit nursing is provided using an interdisciplinary team approach, based on a holistic assessment of patient needs, capabilities and limitations, nursing diagnosis, planning, interventions, and evaluation of patient response.
2. The patient age-specific population served is:
   - Pediatric: 2 years of age up to 13 years of age
   - Adult: 13 years of age to 65 years of age
   - Geriatric: > 65 years of age

PROCEDURE:

The Perioperative patient and/or family-caregiver can expect:

1. **THROUGHOUT THE STAY**
   a. To be treated in accordance with NIH's policy entitled "Patients' Rights"
   b. To be kept informed of and involved in the plan of care including medications, procedures, and discharge needs.
   c. To have care delivered based on standards of practice for the diagnosis identified.

2. **PRIOR TO ADMISSION**
   A. A preoperative interview initiated by a perioperative RN by phone at least one day prior to the scheduled surgery. If the patient chooses to come to the hospital the day prior to surgery – the interview may be conducted in person. The preoperative interview will include:
      a. Preoperative teaching, based on individualized needs
      b. Description of the pre-op preparation, the OR, and the PACU
      c. Review of past procedures and problems, allergies, implants, immunizations, family history, use of alcohol, tobacco, other drugs
      d. Review of current medications, medications to be taken prior to surgery
      e. Estimated times for surgery and discharge from the PACU (outpatient surgery) or transfer to inpatient unit
      f. The interview will be documented in the EHR (electronic health record).

3. **ON ADMISSION OR TRANSFER INTO THE PERIOPERATIVE DEPARTMENT:**
   A. Orientation to the surgical experience but not limited to:
      To be greeted immediately upon arrival to the unit including:
      a. Introduction of nursing and ancillary staff
         i. Explanation of what to expect within the next hour
         ii. Expected timing of the surgery
      b. A clean patient cubicle with appropriate supplies and equipment and orientation to:
         i. Call light use and TV controls
         ii. Bathroom location
         iii. Equipment in use including warming measures, athrombic pumps if ordered
   B. Assessment and preparation for surgery within 30 minutes of arrival by an RN

a. Assessment of level of assistance required to complete activities of daily living, including transferring, ambulation, self-care, and feeding; support provided to meet identified needs postoperatively
b. Personal belongings checked and placed in labeled belongings bag or given to designated responsible adult accompanying patient
c. Height, Weight and vital signs taken and recorded
d. Physical assessment (skin, lungs, heart, pulses, pupils, mobility)
e. Social and learning needs assessment (continued using information from the perioperative interview)
f. IV access obtained
g. Informed consent for surgery reviewed / signed per policy
h. Surgical site preparation performed if ordered / needed
i. Review of postoperative equipment (crutches, braces, shoes, briefs)
j. A Surgical Checklist will be completed on each preoperative patient prior to the patient going to the OR
k. To have a surgery RN review chart, explain surgery and answer questions before going into surgery. The Surgical Checklist will be reviewed by the Circulating RN prior to the patient being moved to the OR
l. The patient will participate in signing the surgical site per policy
m. To speak with the surgeon and have any questions answered prior to going to the OR
n. If anesthesia provider is assigned to the patient – the anesthesia provider will assess the patient, review the medical record, and explain anesthesia plan to patient prior to the patient entering the OR

C. To receive information about the patient/family's Speak Up Program, Patient Rights, Patient Safety, Patient Advocate, Advance Directives, Infection Control, and Rapid Response.
D. The nursing care of patients will be supervised by RNs adept in skills and knowledge of a surgery patient. The priority of data collection activities is driven by the patient's immediate condition and/or anticipated:
    a. Nursing plan of care individualized for patient. Information from the preoperative interview, medical record, preoperative checklist, and interviews done the day of surgery will be used to formulate an ongoing plan of care which will be documented in the EHR
    b. Review and initiation of preoperative orders by the RN
        i. To have an RN review and initiate physician admitting orders within 30 minutes of admission, including review of medical staff plan of care as written
    c. To have an RN initiate discharge planning at time of admission, to be readdressed throughout stay including:
        i. Patient goals for hospitalization
        ii. Referral to interdisciplinary team, including but not limited to: dietary, social services, physical therapy, speech therapy, and pharmacy.

d. The Perioperative RN's practice is guided by the ANA's Code for Nurses, AACN's Ethic of Care, and ethical principles, ASPAN Standards and Practice Recommendations as well as AORN Guidelines for Perioperative Practice.
e. The AHA ACLS protocol will be instituted when necessary for all PACU patients, older than 13 years of age, and the AHA PALS protocol instituted when necessary for all patients younger than 13 years of age.

E. During the Surgical procedure the patient will be accompanied by a surgical RN (the RN will accompany the patient to surgery, a Surgical RN will be with the patient through surgery and will accompany the patient out of surgery. The Surgical nurse will ensure safety for the patient addressing:
   a. Positioning – assessing and ensuring correct alignment and tissue integrity
   b. Site mark visible after draping
   c. Risk for fire in the OR
   d. Medication labeling on and off the sterile field
   e. Aseptic technique will be implemented and maintained throughout the surgical procedure
   f. Specimens properly labeled
   g. Universal Protocol will be followed. A time-Out is performed before an incision is made and before the incision is closed

F. The patient will be accompanied from surgery by an anesthesia provider, the RN that administered sedation, or surgeon

G. The patient will be monitored continuously throughout the operative procedure by an anesthesia provider or an RN.

H. All patients undergoing operative, manipulative, or diagnostic procedures under general or regional anesthesia shall stay in the PACU before being returned to the nursing unit except those patients who, in the judgement of the surgeon and anesthesia provider should be taken directly to an in-patient hospital room. The anesthesia provider, surgeon, or responsible physician shall ascertain the patient is in satisfactory condition before delegating the immediate care to the PACU RN.

I. A report is given to the Postoperative RN (PACU or other unit RN) by the Surgical RN and the anesthesia provider. Such discussion shall include pre-existing medical problems, anesthetic technique used, surgery or procedure performed, any untoward reactions or unusual incidents, special orders, needs or precautions.

4. **THROUGHOUT THE PACU STAY:**

A. To have an RN monitor and assess the patient from PACU admit to PACU discharge as the patient's condition warrants. Patients will receive nursing care based on an assessment of their needs.

B. All patients will have cardiac monitoring in the most appropriate leads. Monitor strips will be placed on the chart preoperatively and postoperatively. Changes in rate, rhythm, or morphology will be documented PRN.

C. Vital signs including Blood Pressure, Pulse, Respiratory rate and O2 saturation will be completed per policy. A temperature will be obtained on PACU admission and discharge or more often as the condition dictates.

D. All completed assessments (vital signs, level of consciousness, nerve and circulation checks, pain scales), intravenous fluids, medications, blood and blood product administration will be documented in the EHR in a timely manner.

E. All inpatients will be on intake and output monitoring. I&O's will be recorded every 2 hours.

F. All patients will have an IV or saline lock unless otherwise ordered by the physician.

G. All patients will have suctioning performed whenever indicated. This includes oral/naso pharyngeal and endotracheal suctioning.

H. In the event that a patient's status deteriorates, the PACU RN will immediately notify the anesthesia provider or the surgeon. The responsibility for the PACU patient is a joint one, shared by the surgeon and the anesthesia provider. Requests for assistance by the PACU personnel shall evoke immediate and appropriate response on the part of the anesthesia provider or surgeon. In the event that the patient's status deteriorates, the PACU RN will immediately notify the anesthesia provider or surgeon. If no anesthesia provider is involved in the care of the patient, the surgeon responsible.
   a. Abnormal or worsening ~~critical~~ vital signs specific to patient's baseline
   b. Abnormal or worsening lab values
   c. Significant change in Level of Consciousness (LOC)
   d. Significant or worsening change in physical assessment
   e. Significant change or imbalance in Input and Output (I&O)
   f. Any adverse drug and/or blood reactions, or untoward change as a response to treatment
   g. Inability to control pain or obtain pain relief
   h. Any untoward occurrence/event occurring in the hospital
   i. Significant change in cardiac rhythm

I. To receive prompt identification of and intervention for potential and actual complications/side effects, including Rapid Response Team initiation. All unusual incidents, untoward reactions, and notification of and response by the anesthesia provider and surgeon shall be noted in the PACU record.

J. Care of the PACU patient will be guided by the policies and procedures at Northern Inyo Hospital. The PACU is not to be used as a substitute for routine post-operative care and patients requiring prolonged observations should be admitted to a 23 hour "Observation Status".

K. ~~A FSBS may be performed by the RN i~~If the patient is demonstrating signs or symptoms suspicious for hypo/hyperglycemia, the provider will be informed~~. The physician will be informed of all abnormal results.~~.

L. In the event of medication incompatibility, a second IV at TKO rate or saline lock may be inserted.

M. Nursing staff will be responsible for knowledge of medication given and utilizing appropriate resources to gain that knowledge.

N. All sedation/analgesia will be given according to the Procedural Sedation guidelines.

O. The nurse may obtain a 12-lead EKG and will call the anesthesia provider or surgeon in the event of:

a. New onset of chest pain.
b. Significant changes in the cardiac rhythm.

P. To have pain assessed and managed in a systematic way to achieve optimal relief.
Q. Environment assessment, to include maintenance of clean, quiet, and therapeutic atmosphere. *Universal precautions will be followed*
R. To have safety measures identified specific to each patient including:
   a. Patient identification band in place; staff to use at least two patient identifiers for medications and procedures.
   b. 5 rights of medication administration practiced.
   c. Fall risk assessment completed at admission (pre-operatively) and discharge from hospital.
   d. Skin assessment at admission (pre-operatively) and discharge from hospital.
      i. Interventions in place specific to patient to prevent new breakdown (positioning in the OR), and to treat existing skin breakdown
   e. Restraints only used if less restrictive measures not successful and the patient is at risk for injury of self.
   f. Smoke-free environment
S. To have preventative measures followed to avoid patient infections, pneumonia, and blood clots.
T. To have visitors as patient condition warrants per PACU RN, anesthesia provider, and surgeon discretion.
U. To have continuity of care maintained between preoperative RN, Surgery RN, PACU RN, and inpatient unit RN through appropriate sharing of information (SBAR-QC [Situation-Background-Assessment-Recommendation-Questions-Concerns]).
V. To have confidentiality and privacy maintained in accordance with policy on Patient Rights, State Law, and Federal Law.
W. To have nutritional needs assessed, and nutrition provided that meets the patient's special diet, including cultural, religious, or ethnic preferences.
X. Patients have the right to refuse care, treatment and services in accordance with the law and regulation
Y. All admitted patients will be entered in the PACU logbook.

5. **ON TRANSFER WITHIN NIH:**
   A. To have discharge transfer assessment completed by transferring RN.
   B. To have patient assessment completed by receiving RN.
   C. The inpatient may be transferred from the PACU utilizing STTA (Surgery, Tissue, Transfusion, and Anesthesia) Committee approved PACU Discharge Criteria
   D. To have transferring RN provides report of patient condition (SBAR-QC) to receiving RN.
   E. To have patient/family updated on reason for transfer, location moved, and expected time of transfer.
   F. To be transferred with all belongings.

6. **ON DISCHARGE:**
   - A. To have discharge assessment completed by RN.
   - B. A physician will discharge the patient. STTA Committee approved PACU Discharge Criteria will be used to determine readiness for discharge.
   - C. To have written discharge instructions provided to patient/family member by RN, including clarification of:
     - a. Who to call for questions.
     - b. Nature of medical condition and what symptoms to report to MD.
     - c. Medications to take, list of medications already given that day, new prescriptions.
     - d. Follow-up appointment, including outpatient diagnostic test and lab work orders.
     - e. Medical equipment needed at home, including vendor to call for assistance.
     - f. Activity level and return to work.
     - g. A responsible adult should take the patient home – driving is not permitted for 24 hours following anesthesia / sedation
     - h. Dietary restrictions.
   - D. To be discharged with all belongings and medications.
   - E. To receive hospital follow-up call.

REFERENCE(S):

1. American Nurses Association. (2010). Nursing Scope and Standards of Practice. Silver Spring, MD: Nursesbooks.org
2. JCAHO (CAMH): UP.01.01.01, RI.01.03.01, PC.03.01.01, PC.03.01.03, PC.03.01.05, PC.03.01.07, PC.04.01.05, RC.01.03.01 Jan 2019
3. CA Code of Regulations Div. 5, Title 22: 70223, 70225, 70233 (2018)
4. CMS: 482.52 2009
5. ASPAN Perianesthesia Nursing Standards, Practice Recommendations, and Interpretive Statements (2012-2014)
6. AORN 2018 Edition Guidelines for Perioperative Practice

CROSS REFERENCE HOSPITAL P&P:

1. Preoperative Interview
2. Operative Consents
3. Hand Off; Standardized Nursing Communications Policy
4. Postoperative Teaching
5. Patients' Rights
6. Universal Protocol
7. Pain Management and Documentation
8. Obtaining Blood Bank Samples from Patients in Surgery

Approval	**Date**
Clinical Consistency Oversight Committee (CCOC)	11/18/19
STTA	1/22/20

NORTHERN INYO HEALTHCARE DISTRICT
STANDARD OF CARE

Title: Standards of Care in the Perioperative Unit	
Scope: Perioperative Unit	Manual: Surgery, PACU – Standards of Care (S of C)
Source: DON Perioperative Services	Effective Date: 3/31/18

Medical Executive Committee (MEC)	2/4/20
Board of Directors	
Last Board of Director review	

Developed: 3/96
Reviewed:
Revised: 02/01, 08/11 bs, 08/12bs, 01/19aw, 11/19 aw
Last Board of Director review: 1/16/19
Index Listings: Standards of Care, Perioperative

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Heparin Dosing Protocol (Adult)	
Scope: NIH	Manual: Pharmacy
Source: Pharmacy Director	Effective Date: 7/18/18

PURPOSE:
This policy and procedure is intended to provide an improved/alternate standardized process for the initiation, maintenance, and monitoring of intravenous unfractionated heparin in adults.

POLICY:

The rationale for updating the Heparin Nomogram is to keep up with current guidelines with dosing and aPTT reference ranges. This policy would apply to adult patients receiving intravenous unfractionated heparin infusions in the inpatient or emergency department setting.

DEFINITIONS:
1. IBW – Ideal Body Weight
2. ABW – Actual Body Weight
3. A~~dd~~jBW – Adjusted Body Weight
4. UFH – Unfractionated Heparin
~~4.~~5. aPPT – activated partial thromboplastin time

PLEASE NOTE:
1. Heparin infusion will not be interrupted unless discontinued by physician.
2. Do not use this protocol for stroke/TIA patients unless specifically requested by physician.
3. Avoid intramuscular injections
4. Heparin infusion order MUST be renewed every 5 days.

PROCEDURE:

1. Pharmacy~~Lab~~:
   After a provider orders "Heparin per Pharmacy Protocol" in the EHR, the pharmacist or pharmacist on call will complete the calculations for dosing weight, initial bolus, and initial infusion rate. The pharmacist will communicate these calculations to the Nurse initiating the therapy. If the diagnosis is not included or not clear, the pharmacist will contact the ordering provider.

~~1.~~2. Lab:
   a. Order baseline aPTT, PT/INR, and CBC **PRIOR** to initiation of heparin.
   b. Order an~~Sent~~ aPTT 6 hours after starting infusion or 6 hours after any dosage change. Nurses will place an order for the next aPTT in the EHR after resuming or adjusting the infusion.
   *(PHYSICIANS – DO NOT ORDER ADDITIONAL ROUTINE aPTT STUDIES)
   c. Obtain aPTTs Q6 hours and adjust infusion by the Heparin Sliding Scale until the aPTT is therapeutic
   d. Obtain aPTT q24 hours once two consecutive aPTTs are therapeutic (aPTT = 60 to 100 sec)
   e. Obtain CBC q3days

~~2. Occult blood test all stools while on Heparin and notify physician if occult blood present.~~

3. Notify Physician for any signs of bleeding.

~~4. Stat CBC without differential with signs and symptoms of significant bleeding and notify the physician.~~

~~5.~~4. Activate Rapid Response Team and implement RRT Protocols if condition warrants.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Heparin Dosing Protocol (Adult)	
Scope: NIH	Manual: Pharmacy
Source: Pharmacy Director	Effective Date: 7/18/18

~~6.~~5.DOSING WEIGHT: (all calculations performed by pharmacy and verified with nursing)

a. Patient Actual Body Weight (ABW) _____(kg)
b. Ideal Body Weight (IBW) _____(kg)
   Men Ideal Body Weight (IBW)~~IBW~~ = 50 kg + (2.3 kg x [For every inch~~es~~ over~~>~~ 5 feet tall])
   Women Ideal Body Weight~~IBW~~ (IBW= 45 kg + (2.3 kg x [For every inch~~es~~ over~~>~~ 5 feet tall])
c. Dosing Weight _____(kg)
   Use Actual Body Weight (ABW) ~~ABW~~, unless obese (>20% Ideal Body Weight~~IBW~~)
   If obese, use Adjusted Body Weight = Ideal Body Weight~~IBW~~ + 0.4(Actual Body Weight ~~ABW – IB~~Ideal Body Weight~~W~~)

Deep Vein Thrombosis/Pulmonary Embolism Treatment Protocol:	**Acute Coronary Syndrome dosing protocol:**
Initial Bolus = 80 units/kg (**Dosing Weight**) max = 10,000 units (Round to nearest 1,000 units)	**Initial Bolus** = 60 units/kg (**Dosing Weight)** max = 4,000 units (Round to nearest 1,000 units)
Start Infusion at 18 units/kg/hr max = 2000 units/hr (Round to closest 5~~4~~0 units/hr)	**Start infusion** at 12 units/kg/hr max = 1000 units/hr *(may be exceeded in morbidly obese patients) (Round to nearest 5~~4~~0 units/hr)
Infusion titration instructions:	**Infusion titration instructions:**
aPTT < 35 sec: 50 units/kg RE-BOLUS (max = 8,000 units), then increase infusion rate by 4 units/kg/hr (maximum change = 400 units/hr) aPTT = 35 to 59: 25 units/kg bolus, INCREASE infusion by 2 units/kg/hr (max change = 200 units/hr) aPTT = 60 to 100: NO CHANGE aPTT = 101 to 120 sec: DECREASE infusion by 2 units/kg/hr, (max change = 200 units/hr) aPTT > 120 sec: Hold heparin for 1 hour, then DECREASE infusion by 3 units/kg/hr (max change = 300 units/hr)	aPTT < 25 sec: 60 units/kg bolus (max 4,000 units), then INCREASE infusion by 3 units/kg/hr (max change = 300 units/hr) aPTT = 25 to 49 sec: INCREASE infusion by 2 units/kg/hr (max change = 200 units/hr) aPTT = 50 to 70 sec: NO CHANGE aPTT = 71 to 90 sec: DECREASE infusion by 2 units/kg/hr (max change = 200 units/hr) aPTT > 90 sec: Hold heparin for 1 hour, then decrease infusion by 3 units/kg/hr (max change = 300 units/hr)

REFERENCES:

Title: Heparin Dosing Protocol (Adult)	
Scope: NIH	Manual: Pharmacy
Source: Pharmacy Director	Effective Date: 7/18/18

1. Vandiver J. Vondracek T. Antifactor Xa levels vs activated partial thromboplastin time for monitoring unfractionated heparin. Pharmacotherapy: Official Journal of the American College of Clinical Pharmacy. 32(6);546-58
2. Erstad B. (Editor) Laboratory Testing with Anticoagulation. Critical Care Pharmacotherapy, American College of Clinical Pharmacy (2016);499-507
3. Heparin Dosing protocol from Highland Hospital in Oakland, CA. Accessed 6/8/18.

CROSS REFERENCE P&P:

1. NPSG 03.05.01

Approval	**Date**
Pharmacy & Therapeutics Committee	10/17/19
MEC	11/5/19
Board of Directors	
Last Board of Directors Review	7/18/18

Developed by: N. Vu 6/29/18
Reviewed:
Revised:
Supersedes:
Index Listings:

Emergency Room Service Critical Indicators

~~2019~~2020

1. Physician and Staff Concerns
2. All non-5150 Transfers
3. ~~Formal Patient Complaints~~
4. ~~.~~3. Unscheduled Return within 72 Hours with admission, transfer, or death.
4. All ED physician attended codes ~~and~~
5. All ED deaths
6. Suicide or Attempted Suicide in the ED

Approvals:

Emergency Room Service Committee: ~~07/10/2019~~01/08/2020
Medical Executive Committee: ~~07/15/2019~~02/04/2020
Board of Directors: 08/21/2019

Anesthesia Critical Indicators

2020

Adopted from 'MACRA Ready' Adverse Events Reporting Form

Cardiovascular

1. Dysrythmia requiring intervention
2. Cardiac arrest (unplanned)
3. Unexpected death
4. Stroke, CVA, or coma
5. Myocardial ischemia
6. Myocardial infarction
7. Vascular access injury (arterial/pneumothorax)
8. Uncontrolled HTN

Respiratory

9. Aspiration
10. Pneumothorax (related to anesthesia)

Regional

11. Failed Regional Anesthetic
12. Systemic local anesthetic toxicity
13. Post-dural puncture headache
14. Epidural hematoma after spinal/epidural
15. Epidural abscess after spinal/epidural
16. Peripheral nerve injury following regional
17. Infection following peripheral nerve block

PACU

18. Temperature <95.9° F or <35.5° C
19. Inadequate Reversal
20. Reintubation (planned trial extubation documented)
21. Reintubation (no planned trial extubation)

Medication

22. Medication administration error
23. Adverse transfusion reaction
24. Anaphylaxis

Process

25. Wrong site surgery
26. Wrong patient
27. Difficult airway
28. Unplanned hospital admission
29. Unplanned ICU admission
30. Wrong surgical procedure

Miscellaneous

31. Dental trauma
32. Visual loss
33. Malignant Hypothermia
34. Awareness under GA
35. Equipment malfunction
36. Fire in OR
37. Airway fire in OR
38. Corneal abrasion
39. Fall in OR
40. Other

Approvals:

Surgery/Tissue/Transfusion/Anesthesia: 01/22/20
Medical Executive Committee: 02/04/20
Board of Directors:

Surgical Critical Indicators

2020

1. Death within 30 days of a surgical or anesthetic procedure.
2. Unanticipated admission to the Intensive Care Unit from a lower level of care.
3. Unanticipated return to the Operating Room.
4. Unanticipated readmission to the hospital within 30 days following a surgical procedure.
5. Unanticipated return to the hospital following surgery.
6. Unanticipated removal or repair of tissue not considered to be a common outcome of the procedure.
7. Unanticipated patient retention of foreign material.
8. Complication consequent to implantation of prosthetic devices or their malfunction or failure.
9. Documented significant postoperative complication within 30 days. These will include ventilator failure, myocardial infarction, stroke, renal failure, pulmonary embolus or deep vein thromboembolic disease, sepsis, or impairment of body function to a level less than that present prior to a surgical or anesthetic procedure, and less than commonly expected as a result of the operative procedure.
10. Airway management for moderate sedation (oral airway or bagging patient).
11. Wrong-site surgery.

Approvals:

Surgery/Tissue/Transfusion/Anesthesia: 01/22/2020
Medical Executive Committee: 02/04/2020
Board of Directors:

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: William Timbers, MD, Chief of Medical Staff
DATE: February 4, 2020
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action items*)
    1. *Practitioner Re-Entry Policy*
    2. *MetaNeb Policy*
    3. *Standards of Care in the Perioperative Unit*
    4. *Heparin Dosing Protocol*

B. Medical Staff Appointments (*action items*)
    1. Joe Miller, MD (*urology*) – provisional consulting staff
    2. Louis Rivera, MD (*surgical oncology*) – provisional consulting staff
    3. Andrew Tang, MD (*internal medicine/hospitalist*) – locums/temporary staff

C. Telemedicine Staff Appointments – credentialing by proxy (*action items*)
    1. Muhammad Alim, MD (*pulmonology, Adventist Health Bakersfield*) – telemedicine staff.

D. Temporary Privileges for 120 days (*action item*)
    1. Ruhong Ma, DO (*internal medicine/hospitalist*) – locum tenens/temporary staff

E. Additional Privileges in Surgery (*action items*)
    1. Jon Bowersox, MD (*general surgery*) – addition of privileges in EGD and colonoscopy
    2. Jeannie Pflum, DO (*obstetrics and gynecology*) – addition of outpatient core privileges in obstetrics and gynecology

F. Additional Privileges in Mammography (*action items*)
    1. Farres Ahmed, MD (*radiology*)
    2. John Erogul, MD (*radiology*)
    3. Carly Harvey, MD (*radiology*)
    4. Jared Kasper, MD (*radiology*)
    5. Stephen Loos, MD (*radiology*)
    6. Edmund Pillsbury, MD (*radiology*)
    7. Kinsey Pillsbury, MD (*radiology*)

G. Advancement (*action item*)
    1. Samantha Jeppsen, MD (*emergency medicine*) – recommendation for advancement from Provisional Active staff to Active Staff.

H. Annual Reviews (*action items*)
    1. Critical Indicators
        i. Emergency Medicine
        ii. Anesthesia
        iii. Surgery

I. Chief Medical Officer job description (*action item*)

J. Physician recruitment update (*information item*)

Northern Inyo Healthcare District
Job Description
Human Resources Department

Position Title: Chief Medical Officer

Job Summary:	The Chief Medical Officer (CMO) is a key member of the executive team and an active member of the Medical Staff whose primary role is to engage, align and act as a liaison between the medical staff and administration at the Northern Inyo Healthcare District (District). The CMO provides medical oversight, expertise and leadership to assist the Medical Staff and District Administration. The CMO has responsibilities to patients for the provision of quality care, and has responsibility for resource utilization across all departments and service line development. As a member of District leadership the CMO provides clinical expertise and leadership in the design and implementation of new clinical projects and innovations within the District. The CMO works closely with the Chief of Staff and other physician leaders, including Department Medical Directors, Medical Staff Committee Chairs, and Administrative Directors to create and fulfill operational goals and objectives. The CMO must be responsive to the concerns and needs of Medical Staff practitioners and is expected to foster and contribute to a close and mutually beneficial relationship between the Medical Staff and District leadership. The CMO maintains the highest degree of confidentiality in all areas involving patients and their related District business. Conducts District business in an ethical and lawful manner, and is willing to report any knowledge of real or potential fraud or abuse according to the NIHD Compliance Code of Conduct and abides by the NIHD Personnel and Payroll Policies and Procedures as well as Medical Staff By-laws. Additionally, CMO will attend Medical Executive Committee meetings, District Board meetings including Strategic planning sessions, provide medical perspective to strategic and operational planning and goal setting and in partnership with the Medical Staff Chief of Staff will ensure continuity of information flow between Medical Staff and District leadership.
Job Relationships:	Directly responsible to the Chief Executive Officer. Provides supervision and leadership to District departments as assigned. Works closely with District & Medical Staff leadership and is available to all employees and Medical Staff members.
Job Responsibilities:	• Serves as a member of the District Executive Team (C-Suite) • Leads and manages Department heads assigned to report to the CMO. • Liaison between Medical Staff and District including communication of District issues, new items of business and strategic direction/progress to the Medical Staff • Liaison with Chief of Staff when CEO is not available to meet with the Chief of Staff • Keep abreast of emerging models in health care delivery; identify and define new and innovative strategies to achieve business goals and objectives. • Identify opportunities to collaborate and develop clinical integration opportunities to achieve affordable outcomes (ie Accountable care Organizations, Value-Based Purchasing). • Promote collaboration between District and other community providers • Sets operational and financial goals/objectives in collaboration with the Department heads assigned to report to the CMO. • Performs leadership and management duties, specific projects and studies as assigned by the CEO in addition to regular duties. • Investigates assigned irregularities and identified District policy violations, when necessary takes corrective action. • Serves as District leadership representative at Medical Staff meetings • Develops and interprets District policies, objectives and operational procedures • Support assigned Directors/Managers and service areas to allow them to succeed • Routinely reviews and proposes changes/improvements to existing District policies and procedures • Serves as chairperson of various District committees as assigned by the CEO • Attends and participates in District Board meetings. • Participates in evaluating, selecting and integrating health care technology and information management systems that support patient care needs and efficient utilization of hospital resources. • Interfaces with regulatory bodies when necessary (such as TJC, CDPH, OSHPD…). • Acts as interim Director/Manager of any Department assigned to the CMO in the absence of the Department's regular Director/Manager or while a management vacancy exists. • Champion for Electronic Health Record and related initiatives • Works with Medical Directors in developing performance standards and monitoring process improvements • Participates with District Board in development of strategic plan • Works with Executive Team for implementation of strategic plan in alignment with District Mission, Vision & Values • Partner with Chief of Staff in recruitment and retention of practitioners • Develop and enforce contractual relationships with District practitioners

Position Title: Chief Medical Officer

	• Meet and work with Medical Directors in a regular and structured manner • Participate in assigned District and Medical Staff committees
Qualifications:	**Required** • A current unrestricted license to practice medicine in the State of California. • Currently an active member of the District Medical Staff or become an active member of the District Medical Staff within six months of hire. • A Bachelor's degree from an accredited college/university. • MBA, MHA or MPH or attain such degree within 24 months of hire or five to seven years of progressively more administrative experience in a healthcare environment, including experience in a compliance program. • Minimum seven years of clinical experience at a Critical Access Hospital or similar healthcare system **Expectations of employee** • Adheres to District Policy and Procedures • Acts as a role model within and outside the District • Performs duties as workload necessitates • Maintains a positive and respectful attitude • Communicates regularly with CEO about District issues related to areas of responsibility • Demonstrates flexible and efficient time management and ability to prioritize workload • Consistently reports to work on time prepared to perform duties of position • Works as a practicing clinician within the District **Competencies – Skills, Knowledge, Attributes** • Active Listening - Ability to actively attend to, convey, and understand the comments and questions of others. • Adaptability - Ability to adapt to change in the workplace. • Business Acumen - Ability to grasp and understand business concepts and issues. • Change Management - Ability to encourage others to seek opportunities for different and innovative approaches to addressing problems and opportunities. • Coaching and Development - Ability to provide guidance and feedback to help others strengthen specific knowledge/skill areas. • Communication, Oral and Written - Ability to communicate effectively with others using the spoken word and to communicate in writing clearly and concisely. • Conflict Resolution - Ability to deal with others in an antagonistic situation. • Decision Making - Ability to make critical decisions while following company procedures. • Delegating Responsibility - Ability to allocate authority and/or task responsibility to appropriate people. • Honesty / Integrity - Ability to be truthful and be seen as credible in the workplace. • Interpersonal - Ability to get along well with a variety of personalities and individuals. • Leadership - Ability to influence others to perform their jobs effectively and to be responsible for making decisions. • Negotiation Skills - Ability to reach outcomes that gain the support and acceptance of all parties. • Resource Management (People & Equipment) - Ability to obtain and appropriate the proper usage of equipment, facilities, materials, as well as personnel. • Working Under Pressure - Ability to complete assigned tasks under stressful situations.
Physical and Environmental Requirements:	To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Reasonable accommodations may be made to enable qualified individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is occasionally required to stand; walk; sit; use hands to finger, handle, or feel objects, tools or controls; reach with hands and arms; climb stairs; balance; stoop, kneel, crouch or crawl; talk or hear; taste or smell. The employee must occasionally lift and/or move up to 25 pounds. Specific vision abilities required by the job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus. Ability to wear Personal Protective Equipment (PPE) - as required in case of disaster. Typically in office environment in a controlled atmosphere building. See attached.

Position Title: Chief Medical Officer

Signatures

District management has reviewed this job description to ensure that essential functions and basic duties have been included. It is intended to provide guidelines for job expectations and the employee's ability to perform the position described. It is not intended to be construed as an exhaustive list of all functions, responsibilities, skills and abilities. Additional functions and requirements may be assigned by management as deemed appropriate.

This document does not represent a contract of employment, and hospital management reserves the right to change this job description and/or assign tasks for the employee to perform, as may be deemed appropriate. This job description has been approved by all levels of management:

Chief Executive Officer – print name/signature_____Date:_____

Employee signature below constitutes employee's understanding of the requirements, essential functions and duties of the position.

By signature I acknowledge that: 1) I have read this job description and I accept the responsibilities and authorities of this position; 2) I realize that there will be some meetings and in-services which I may be required to attend; 3) I understand how I will be compensated and that the position that I have accepted is Salaried/Exempt position; 4) I understand that my evaluation will be based on this job description; 5) this job description may be revised with my knowledge, as necessary, and I will receive any revised copies; 6) I have received a copy of this job description.

Employee – print name/signature_____Date:_____

Approved by CEO _____ Date: _____

Position Title: Chief Medical Officer

Please check one box below in Section I and Section II that apply to this job description. Comments can be made in Section III.

Physical Requirements								
C = Constant (76-100%) F = Frequent (51-75%) O = Occasional (26-50%) S = Seldom (1-25%) N = Never (0%),						E = Essential – Regardless of frequency, this activity is indispensable. M = Marginal – This activity is useful and helpful but not absolutely essential.		
	Section I					**Section II**		**Section III**
	C	**F**	**O**	**S**	**N**	E	**M**	**Comments:**
Basic Skills:								
Reading			✓			✓		
Writing			✓			✓		
Math			✓			✓		
Talking			✓			✓		
Hearing			✓			✓		
Physical Demands:								
Sitting			✓			✓		
Standing			✓			✓		
Walking			✓			✓		
Stooping			✓			✓		
Crawling				✓			✓	
Climbing			✓				✓	
Reaching Overhead			✓				✓	
Crouching			✓				✓	
Kneeling			✓				✓	
Balancing				✓			✓	
Pushing or pulling			✓			✓		
Lifting or carrying			✓			✓		
Lifting or carrying (up to 10 lbs.)			✓			✓		
Lifting or carrying (up to 25 lbs.)			✓			✓		
Lifting or carrying (up to 50 lbs.)					✓		✓	
Lifting or carrying (up to 75 lbs.)					✓		✓	
Lifting or carrying (up to 100 lbs.)					✓		✓	
Lifting or carrying (over 100 lbs.)					✓		✓	
Moving patients				✓		✓		
Repetitive motions			✓			✓		
Environmental Requirements:								
Exposure to periods of stress			✓			✓		
Exposure to static electricity and electric amperes capable of doing bodily harm				✓			✓	
Exposure to blood, blood products, tissues, bodily fluids and excretions, as well as patients in infectious states				✓			✓	
Other:								

CALL TO ORDER	The meeting was called to order at 5:30 pm by Jean Turner, Chair.
PRESENT	Jean Turner, Chair Robert Sharp, Vice Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Davis, MBA, Chief Operating Officer John Tremble, Chief Financial Officer
ABSENT	Tracy Aspel RN, BSN, Chief Nursing Officer Will Timbers, MD, Chief of Staff
PUBLIC COMMENT	Ms. Turner announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. No comments were heard.
PIONEER MEDICAL ASSOCIATES (PMA) PARTNERSHIP PURCHASE AND RENT NEGOTIATION	Northern Inyo Healthcare District (NIHD) Chief Executive Officer Kevin S. Flanigan, MD, MBA opened discussion on the District's possible purchase of the Pioneer Medical Associates (PMA) partnership interest owned by Asao Kamei MD and Nickoline Hathaway MD, and the subject of the terms of NIHD's office space lease with the partnership. Discussion on these topics included the following: - Doctor Flanigan provided an overview of the progression and timeline regarding the District's potential purchase of the Hathaway and Kamei partnership interest. - Doctor Flanigan stated that the District's position is that NIHD must pay fair market value if it is to purchase the partnership interest, in order to comply with federal Stark Laws. - Statement of the District's position that office space rent payments in the PMA building must also be within fair market value in order to be in compliance with Stark Laws (the District has withheld 3 months of rent payments pending the resolution of this issue). During discussion it was noted that commercial rental rates in Bishop have decreased as a result of current market conditions. - Dr. Kamei provided an overview of the history of the PMA Partnership and building, as well as a review of how negotiations got to where they are today. He additionally stated that he and Doctor Hathaway are still interested in selling their partnership interest if an agreement can be reached with the District. At the conclusion of discussion Ms. Turner noted that it appears the two sides have a difference of legal opinion which needs to be addressed. She mentioned that if necessary, arbitration might be considered in order to

resolve those issues. Both sides are interested in engaging in a process that is fair to both sides and complies with Federal regulations.

It was determined that the District will script an email on its legal position and forward it to Doctor Hathaway, who will consult with her attorney further on both topics. Doctor Hathaway will inform the District when she and Doctor Kamei are prepared to discuss both matters further.

The consensus of the District Board was that the District should pay the PMA partnership the back rent which has been withheld for the last three months. It was moved by Mary Mae Kilpatrick, seconded by Jody Veenker, and unanimously passed to approve the District bringing its PMA rent payments up-to-date. Additionally, Doctor Flanigan will work on updating the existing office lease agreement between NIHD and the PMA Partnership to meet the desired specifications of both sides.

Public comment on the agenda item was also heard from Ms. Leslie Manzonie.

_____
Jean Turner, President

Attest: _____
Jody Veenker, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 pm by Jean Turner, Chair.
PRESENT	Jean Turner, Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Will Timbers MD, Chief of Staff Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Davis, MBA, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, BSN, Chief Nursing Officer
ABSENT	Robert Sharp, Vice Chair
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner 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. The Board is prohibited from generally discussing or taking action on items not included on the agenda. Comments were heard from: - Dorothy and Lloyd Wilson - Robin Cassidy, Northern Inyo Healthcare District (NIHD) Information Technology Director - Stacey Brown, MD - Sam Walker
STRATEGIC PLAN UPDATE, PATIENT EXPERIENCE COMMITTEE	The NIHD Patient Experience Committee provided an update on the patient experience-related goals of the District's Strategic Plan. The Committee's report included the following: - Review of projects underway relating to customer service and access to patient care - Information on AIDET customer service training for NIHD staff, and follow-up assessment of the effectiveness of that training - Review of results of a recent NIHD patient satisfaction survey - Action plans for additional patient experience improvements going forward - Plans for implementing noise-reduction improvements throughout the hospital environment
NIHD AUXILIARY REPORT	NIHD Auxiliary President Judy Fratella and Treasurer Sharon Moore provided an update on activities of the NIHD Auxiliary. This year's holiday fundraising boutique raised $34,987 for the purchase of equipment for Northern Inyo Hospital. The grand total of Auxiliary fundraising donations made to date now totals $641,824.

WIPFLI AUDIT REPORT FYE JUNE 30 2019

Jeff Johnson with Wipfli LLP presented NIHD's annual audit report for the fiscal year ending June 30 2019. Mr. Johnson's report included the following:

- Financial statement review and analysis
- Accounting standards updates
- Review of material weaknesses identified, including acknowledgement of difficulties with District information systems
- Notation that the Balance Sheet shows an increase in cash and cash equivalents, and an increase in capital assets
- Notation that Accounts Payable and salaries expense increased significantly during the last fiscal year
- Report that the District realized an overall net profit of approximately $494,000 for the 2018/2019 fiscal year

It was moved by Jody Veenker, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the NIHD annual audit report for the 2018/2019 fiscal year as presented by Wipfli LLP.

NORTHERN INYO ASSOCIATES CONVERSION TO A PROVIDER-BASED ENTITY

Mr. Johnson additionally provided information on the advantages of converting the Northern Inyo Associates (NIA) physician clinics to a provider-based model, in order to realize an increase in government reimbursements. The NIA clinics are currently treated like freestanding clinics, however if they are integrated into the NIHD Rural Health Clinic (RHC) the District will realize an approximate 15% increase in Medicare and MediCal reimbursements.

AD HOC COMMITTEE REPORT AND APPOINTMENT OF NEW BOARD MEMBER FOR DISTRICT ZONE 5

Director Veenker reported the Ad Hoc Committee established for the purpose of selecting a new Board representative for District Zone 5 interviewed multiple strong candidates. Following careful consideration the Committee recommends appointing Mr. Topah Spoonhunter to fill the Zone 5 Board vacancy for the remainder of the term ending in November 2022. It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and unanimously passed to appoint Mr. Topah Spoonhunter to fill the District Zone 5 Board vacancy. Mr. Spoonhunter was then sworn into office, and respectfully requested abstention from voting on action items listed on the agenda for this meeting.

CARE GRANT AWARD, POPULATION HEALTH, AND BEHAVIORAL HEALTH UPDATE

NIHD Rural Health Clinic Care Coordination Manager Dan David provided an update on services provided by Care Grant funding received for the provision of Medication Assisted Treatment (MAT) of substance abuse disorders. Mr. David's report included an overview of current programs and services available at the NIHD Rural Health Clinic, stating that the program began in February of 2019 with 2 healthcare providers, and it has now grown to 14 practitioners. NIHD’s MAT program includes the following:

- Recovery support groups for males and females
- A syringe services program
- Community outreach and education on substance abuse disorders
- Transportation support and support for families

- Low barrier access to services
- A Narcan distribution program (6 successful deployments to date)
- Wrap-around case management services
- Hepatitis C treatment services
- Youth education and prevention outreach
- Expansion of services including psychotherapy and Cognitive Behavioral Therapy
- Harm reduction interventions

LAIF ACCOUNT UPDATES

Chief Financial Officer John Tremble called attention to District Board Resolution 20-01 authorizing investment of monies into the District's Local Agency Investment Fund (LAIF) money market account. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and passed to approve District Board Resolution 20-01 as presented, with Director Spoonhunter abstaining from the vote.

REVISED WORKPLACE VIOLENCE PREVENTION PLAN

Chief Operating Officer Kelli Davis called attention to a revised *Workplace Violence Prevention Policy* for Northern Inyo Healthcare District. The policy provides guidelines for facilitating NIHD's commitment to providing a safe and healthful environment, and calls for zero tolerance for any act of violence or any threat of violence occurring on District property. Following review of the updated policy it was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and passed to approve the revised *Workplace Violence Prevention Policy* as presented, with Director Spoonhunter abstaining from the vote.

POLICY AND PROCEDURE: OBTAINING BLOOD BANK SAMPLES FROM PATIENTS IN SURGERY

Chief Nursing Officer Tracy Aspel, RN called attention to a proposed Policy and Procedure titled *Obtaining Blood Bank Samples from Patients in Surgery*, which explains how specimens for blood bank work are collected from patients already in surgery. It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and passed to approve the Policy and Procedure titled *Obtaining Blood Bank Samples from Patients in Surgery* as presented, with Director Spoonhunter abstaining from the vote.

PHYSICIAN HOLIDAY EVENT AND PLANNING FOR THE FUTURE

Director Turner stated in order to ensure the continuation of event planning for District Board and Medical Staff gatherings, Directors Kilpatrick and Veenker will work together to come up with ideas for future events similar to a recently held holiday gathering.

AD HOC COMMITTEE TO REVIEW LEGAL SERVICES RFP RESPONSES

Ms. Turner also stated that she and Director Robert Sharp will serve as Ad Hoc Committee members to review submissions received in response to a recently published Legal Services Request for Proposal (RFP) for NIHD.

GOVERNANCE CONSULTANT UPDATE

Chief Executive Officer Kevin S. Flanigan, MD, MBA reported that Jim Rice with Gallagher Consulting will survey the Board of Directors to determine a foundation for where to begin regarding governance education for the District Board. Mr. Rice will seek input from all Board

REPORTS

members then determine the direction for future training on the topic of Board governance.

EASTERN SIERRA EMERGENCY PHYSICIANS REPORT

Sierra Bourne, MD provided an Eastern Sierra Emergency Physicians (ESEP) quarterly report which included the following:

- The ESEP group continues to have successes in the area of physician recruitment, and two new ED practitioners will come on board in the next six months
- The group structure of ESEP is that of a fully democratic physician group. The group plans on continued expansion, and Adam Hawkins, DO will soon come on board as a new ESEP Assistant Director
- NIHD Emergency Department physicians and hospitalist physicians are working together to develop a more sustainable and collaborative relationship between the two groups

MEDICAL STAFF SERVICES QUARTERLY REPORT

Medical Staff Support Manager Dianne Picken provided a Medical Staff Services Quarterly Pillars of Excellence report. The report revealed that the department did not meet its application processing goals for the 2nd quarter of the year, due in part to a high volume of work being processed during the quarter.

CHIEF OF STAFF REPORT

POLICY AND PROCEDURE APPROVALS

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

1. *Emergency Medication and Code Blue Crash Cart Policy*
2. *Fiberoptic Endoscopic Evaluation of Swallowing Policy*
3. *Steris Gravity - Prevacuum Sterilizer Surgery (Autoclave)*

It was moved by Ms. Veenker, seconded by Ms. Kilpatrick and passed to approve Policies and Procedures 1 through 3 as presented, with Mr. Spoonhunter abstaining from the vote.

MODIFICATION TO PROVIDER APPLICATION PACKETS

Doctor Timbers also reported the Medical Executive Committee recommends modification to Medical Staff and Advanced Practice Provider application packets, to include addition of criminal background checks. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and passed to approve modification to the Medical Staff and Advanced Practice Provider application packets to include the addition of criminal background checks, with Director Spoonhunter abstaining from the vote.

ADVANCED PRACTRICE PROVIDER APPOINTMENT

Doctor Timbers also stated the Medical Executive Committee requests approval of the Advanced Practice Provider appointment of Sarah Malloy, FNP (family practice). It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and passed to approve the appointment of Sarah Malloy, FNP as requested, with Mr. Spoonhunter abstaining from the vote.

MEDICAL STAFF REAPPOINTMENTS FOR 2020 AND 2021

Doctor Timbers additionally reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff reappointments for calendar years 2020 and 2021:

1. Daniel K. Davis, MD (*orthopedic surgery*) - Provisional Consulting Staff
2. Kevin Deitel, MD (*orthopedic surgery*) - Provisional Consulting Staff
3. Elizabeth Maslow, MD (*infectious disease*) - Telemedicine Staff

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and passed to approve all three Medical Staff reappointments as requested, with Director Spoonhunter abstaining from the vote.

EXTENSION OF TEMPORARY PRIVILEGES

Doctor Timbers also reported the Medical Executive Committee recommends extension of temporary privileges for 120 days for Shiva Shabnam, MD (internal medicine) - temporary/locum tenens privileges. It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and passed to approve the extension of temporary privileges for Shiva Shabnam MD as requested, with Mr. Spoonhunter abstaining from the vote.

ADDITIONAL PRIVILEGES

Doctor Timbers additionally requested the granting of additional privileges for Tammy O'Neill, PA-C (physician assistant) - addition of OR physician assistant protocol. It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and passed to approve the granting of additional privileges for Tammy O'Neill, PA-C as requested, with Director Spoonhunter abstaining from the vote.

MEDICAL STAFF ADVANCEMENT

Doctor Timbers also reported the Medical Executive Committee requests approval of the Medical Staff advancement of Monika Mehrens, DO (family medicine/hospitalist) - recommendation for advancement from Provisional Active Staff to Active Staff. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and passed to approve the Medical Staff advancement of Monika Mehrens, DO as requested, with Mr. Spoonhunter abstaining from the vote.

PEDIATRIC CORE PRIVILEGE FORM UPDATE

Doctor Timbers also requested approval of a *Pediatrics Core Privilege Form* update. It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and passed to approve the *Pediatrics Core Privilege Form* update as requested, with Mr. Spoonhunter abstaining from the vote.

MEDICAL STAFF ANNUAL REVIEWS

Doctor Timbers additionally requested approval of the following Medical Staff annual reviews:

1. Critical Indicators:
    - *i. Neonatal*
    - *ii. Perinatal*
    - *iii. Pediatrics*
    - *iv. ICU*
    - *v. RHC*

vi. Medical Services

It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and passed to approve all six Critical Indicators annual reviews as requested, with Director Spoonhunter abstaining from the vote.

PHYSICIAN RECRUITMENT UDPATE

Doctor Timbers also reported that two new Emergency Department physicians will come on board in the next several months, and that the District is currently in discussion with two potential hospitalist candidates.

CONSENT AGENDA

Ms. Turner called attention to approval of the Consent Agenda for this meeting, which contained the following items:

- *Approval of minutes of the December 18 2019 regular meeting*
- *Financial and statistical reports as of November 2019*
- *Chief Executive Officer Report*
- *Chief Operating Officer Report*
- *Chief Financial Officer Report*
- *Chief Nursing Officer Report*
- *Policy and Procedure annual approvals*

It was moved by Ms. Veenker, seconded by Ms. Kilpatrick, and passed to approve all seven Consent Agenda items as presented, with Mr. Spoonhunter abstaining from the vote.

BOARD MEMBER REPORTS

Ms. Turner asked if any members of the District Board of Directors wished to report on any items of interest. Director Veenker stated her intention to continue to attend NIHD All Clinics meetings, and Ms. Kilpatrick stated that she recently attended the District Quality Council meeting. Ms. Turner reported that Stacey Brown MD will provide a Healthy Lifestyles talk on Thursday February 23, and that NIHD Dietician Lindsey Hughes will provide a Healthy Lifestyles talk on the subject of Diabetes tomorrow night, January 16 2020.

ADJOURNMENT TO CLOSED SESSION

At 8:09 pm Ms. Turner reported the meeting would adjourn to Closed Session to allow the Board of Directors to:

A. Discuss a real estate negotiation regarding price, 152 Pioneer Lane, Bishop, California; Agency negotiators Kevin S. Flanigan MD, MBA, and Pioneer Medical Associates partners (*pursuant to Government Code Section 54956.8*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:42 pm the meeting returned to Open Session. Ms. Turner reported that the Board took no reportable action

ADJOURNMENT

The meeting was adjourned at 8:43 pm.

_____
Jean Turner, President

Attest: _____
Jody Veenker, Secretary

CALL TO ORDER	The meeting was called to order at 5:33 pm by Jean Turner, Chair.
PRESENT	Jean Turner, Chair Robert Sharp, Vice Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Topah Spoonhunter, Member At Large Kevin S. Flanigan, MD, MBA, Chief Executive Officer Kelli Davis, MBA, Chief Operating Officer Tracy Aspel, RN, BSN, Chief Nursing Officer
ABSENT	Will Timbers, MD, Chief of Staff John Tremble, Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner announced at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. Comments were heard from Stacey Brown MD, Northern Inyo Healthcare District (NIHD) Rural Health Clinic Medical Director.
REAL ESTATE PURCHASE AND LEASE BACK, 153 PIONEER LANE, BISHOP	Chief Executive Officer Kevin S. Flanigan, MD, MBA introduced Mr. Sam Walker to declare his vision for the upcoming Opportunity Zone investment that will allow the NIHD Rural Health Clinic (RHC) to be rebuilt, allowing for expansion and consolidation of patient services. Doctor Flanigan stated that for the project to be effective and within the IRS code, Mr. Walker will need to purchase the land the RHC is located on, develop it, and maintain ownership for 10 years, thereby allowing him to avoid capital gains taxes and at the same time provide members of this community with a new Rural Health Clinic facility. He stated that following Mr. Walker's purchase of the land, the District will lease back the property at an appropriate market rate, for the duration of Mr. Walker's ownership. Mr. Walker introduced himself and provided a brief history of his business experience and involvement in local communities. He explained that he intends for this project to be a collaborative effort between himself and the District, and that he will not oversee the building project itself, which will be managed by the District. He expressed his opinion that the design for the new facility will be very important, and that NIHD physicians should have significant input on that design. Mr. Walker's goals are safety, tax savings, and if possible, he would support a sustainable build that utilizes local businesses whenever feasible. Mr. Walker entertained questions from the Board, District leadership, and members of the public. He stated his intent for the project to be a

transparent collaboration with no hidden agendas. The following points were also made during discussion of this agenda item:

- The Opportunity Zone project will have a 31-month timeline from initial investment to completion. It will be extremely important that it moves forward in a timely manner.
- The possible re-location of Pioneer Lane in order to improve traffic flow in the area is part of the rebuild discussion. However, it is likely that the street relocation will happen after completion of the building project.
- It is expected that the District will contract with a design-build company for the project, and it was noted that it will be important to work with an experienced builder.
- Mr. Walker stated his desire not to be the center of personal publicity as a result of this project, indicating that he does not need his name in the headlines or on a building in recognition of his involvement.
- Developing a project budget and establishing a clear picture of the cost involved is one of the next priorities.
- Doctor Flanigan will complete drafting an agreement for the project and leaseback by the end of this month, and monthly building updates will be provided at future meetings of the NIHD Board of Directors.
- It is hoped that the NIHD workforce and the community at large will embrace the rebuild project and all it will do to enhance the provision of healthcare services for members of this community.

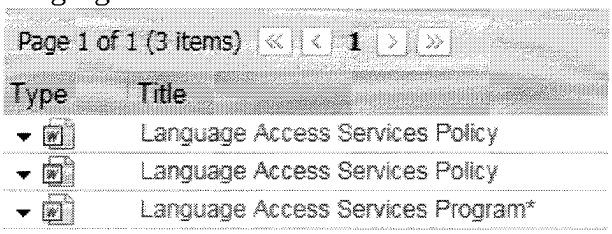
At the conclusion of discussion it was moved by Mary Mae Kilpatrick, seconded by Jody Veenker, and unanimously passed to direct District Administration and staff to complete the drafting of the purchase and sale agreement and leaseback agreement for this project by the end of the month.

ADJOURNMENT The meeting was adjourned at 6:43 pm.

_____
Jean Turner, President

Attest: _____
Jody Veenker, Secretary

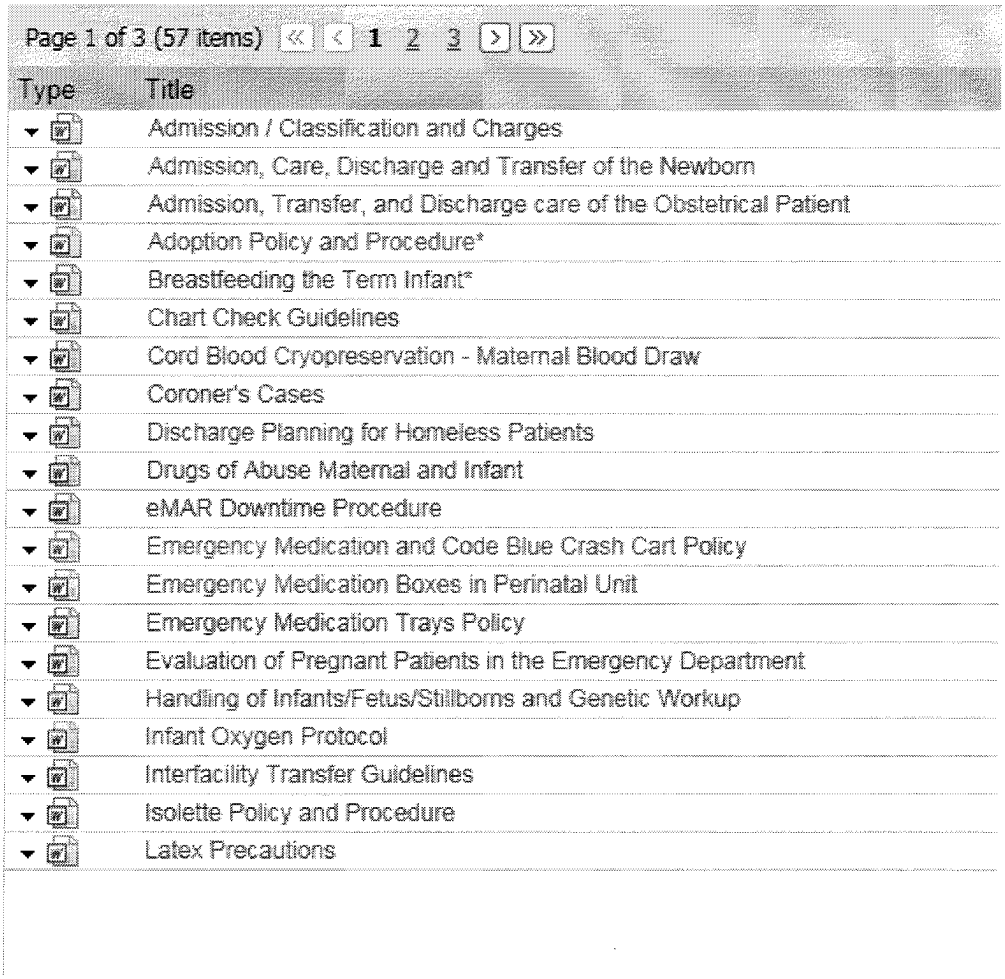
Language Services:



Page 1 of 1 (3 items) « ‹ 1 › »

Type	Title
	Language Access Services Policy
	Language Access Services Policy
	Language Access Services Program*

Perinatal:



Page 1 of 3 (57 items) « ‹ 1 2 3 › »

Type	Title
	Admission / Classification and Charges
	Admission, Care, Discharge and Transfer of the Newborn
	Admission, Transfer, and Discharge care of the Obstetrical Patient
	Adoption Policy and Procedure*
	Breastfeeding the Term Infant*
	Chart Check Guidelines
	Cord Blood Cryopreservation - Maternal Blood Draw
	Coroner's Cases
	Discharge Planning for Homeless Patients
	Drugs of Abuse Maternal and Infant
	eMAR Downtime Procedure
	Emergency Medication and Code Blue Crash Cart Policy
	Emergency Medication Boxes in Perinatal Unit
	Emergency Medication Trays Policy
	Evaluation of Pregnant Patients in the Emergency Department
	Handling of Infants/Fetus/Stillborns and Genetic Workup
	Infant Oxygen Protocol
	Interfacility Transfer Guidelines
	Isolette Policy and Procedure
	Latex Precautions

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Type	Title
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
	Medication Reconciliation
	Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure
	Newborn Blood Glucose Monitoring*
	Newborn Hearing Screening Program
	Newborn Pulse Oximetry Screen
	Newborn Screening Test
	Nursing Care of Outpatient Interventional Radiology Patient
	Nursing Management of Preeclampsia
	Observation in the Operating Room
	OmniCell Automated Dispensing Unit (ADU)
	Ordering Dietary Supplements
	Patient Nutritional Care
	Placenta Disposal
	Poison and Drug Overdose Information
	Postpartum Patient Care in the PACU
	Potassium Intravenous Administration
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Removal of Placenta from Hospital per Patient's Request

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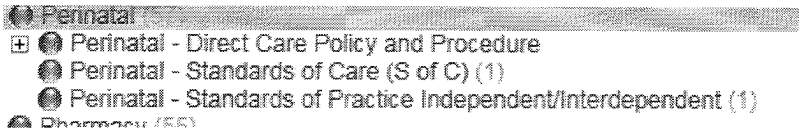
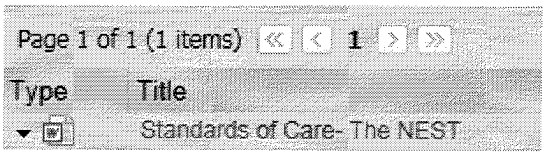
Type	Title
	Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
	Resuscitation Quality Improvement (RQI)
	Safely Surrendered Baby Policy and Procedure
	Saline Lock For Blood Draw
	Scope of Service Perinatal
	Staffing Guidelines Perinatal Unit Including High Risk
	Standardized Procedure - Medical Screening Exam for the Obstetrical Patient
	Standardized Procedure for Admission of the Well Newborn
	Standards of Care- The NEST
	Standards of Patient Care in the Perinatal Unit
	SUBMISSION OF BIOPSY (TISSUE) SPECIMENS (NOT FLUID)
	Telephone Triage*
	Temperature Monitoring of Storage Devices and Units
	Transcutaneous Bilirubin Testing (Bili Scan)
	Tuberculosis Exposure Control Plan
	Vaginal Delivery in the OR
	Warfarin Monitoring Protocol


Perinatal
Perinatal - Direct Care Policy and Procedure
Perinatal - Standards of Care (S of C) (1)
Perinatal - Standards of Practice Independent/Interdependent (1)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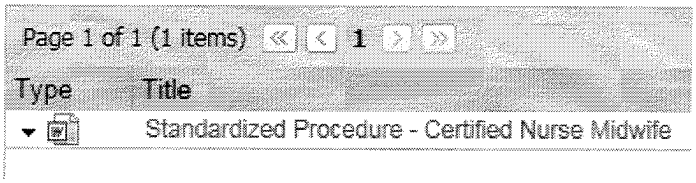
Type
Title
Standards of Care- The NEST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Type
Title
Standardized Procedure - Certified Nurse Midwife

DI policies for DOB review

ALARA Program
DI – Reportable / Recordable events in CT/ Fluoroscopy and nuclear medicine
Di- CT dose documentation
Di CT Radiation Safety Policy
Di lead Apron / Protective equipment policy
DI standards of Care
DI timeliness for critical results
Diagnostic imaging – C-Arm (fluoroscope) radiation safety
Diagnostic imaging – Guidelines for use of radiology equipment in other areas
Diagnostic imaging – imaging equipment quality control
Diagnostic imaging – Patient Priority
Diagnostic imaging chaperone policy
Diagnostic Imaging- Method of Practice
Diagnostic Imaging- ordering privileges and procedure
Diagnostic imaging repeat rate and analysis
Di-pregnant patients for Radiological procedures
Dosimetry Program-Occupational Radiation Exposure monitoring program
Monitoring of patients in rooms with no call lights
Radiation Safety Committee
Radiology services pregnant personnel
Responsibilities and duties of radiation safety committee
Diagnostic imaging – Mammography compliance requirements
Diagnostic imaging – imaging xray protocols procedure
Diagnostic imaging Department orientation and competency
Diagnostic imaging- Scope of services
Diagnostic imaging – lead interpreting mammographer responsibilities
Diagnostic Mammography – 3D
Diagnostic Imaging – Radiologist Peer Review Program
Diagnostic Imaging – self referral for breast screening exams
Diagnostic Imaging Department Orientation and Competency
Diagnostic Imaging – Monitoring and Documentation of Fluoroscopic Quality Control
Diagnostic Imaging – Premedication for radiographic contrast sensitivity
DI Venipuncture by Radiologic Technologists
Diagnostic Imaging - Ultrasound, Intimate Exams
Screening mammography -3D
DI - Communication of Mammography results to the patient
DI Mammography infection control policy
Contrast use with patients on metformin
Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel

Diagnostic Imaging - Teleradiology Services*
Radiology Critical Indicators for Chart Review
Diagnostic Imaging - Handling of Radioactive Packages, Non-nuclear medicine personnel

Overview: Organizational billed charges were poor in November and December with continued slowness in outpatient, OR cases and diagnostics. January saw a jump in OR cases and Infusion.

	Charges	Budget
October, 2018	12,311,788	12,324,875
November, 2018	12,965,830	13,205,209
December, 2018	11,320,722	13,205,209
January, 2019	13,649,585	13,645,381
February, 2019	11,808,879	12,324,875
March, 2019	12,927,842	13,645,381
April, 2019	14,479,237	13,205,209
May, 2019	13,190,872	13,645,381
June, 2019	12,985,554	13,205,327
July, 2019	14,142,468	13,645,381
August, 2019	14,486,110	14,095,678
September, 2019	12,636,290	13,640,980
October, 2019	14,348,923	14,095,678
November, 2019	12,900,439	13,640,980
December, 2019	13,526,106	14,095,678
January, 2020	15,821,794	14,095,678

Gross Accounts Receivables in Athena continue to be high at $50,609,241; 114.2; Gross Days in AR. Remaining Gross Accounts Receivable in Paragon is $2,286,982 and Centricity is $311,624.

Salaries and Wages for Hospital operations were lower even after Holiday pay; although temporary labor expenses were higher by $106,000 in the month of December due to open positions.

	Salaries & Wages	Cost Per Day
January, 2019	2,550,818	82,284
February, 2019	2,457,730	87,776
March, 2019	2,674,515	86,275
April, 2019	2,555,902	85,199
May, 2019	2,616,111	84,391
June, 2019	2,509,763	83,659
July, 2019	2,585,146	83,392
August, 2019	2,638,465	85,112
September, 2019	2,530,883	84,363
October, 2019	2,536,968	81,838
November, 2019	2,496,760	83,224
December, 2019	2,468,754	79,638
January, 2020	2,406,843	77,640

December Financial Results: December's services provided being ($569,570) below budget combined with continued high purchased services and contract labor resulted in a net loss.

Preliminary January 2020 Financial Results: A tremendous increase in the utilization of high cost drugs, surgical implants and reasonable other outpatient volumes appears to have started out 2020 nearly 16% ahead of 2019 in total charges.

Submitted by John Tremble

Northern Inyo Healthcare District - Summary of Key Ratios & Debt Covenants

Unit of Measure	12/31/2019	11/30/2019	10/31/2019	9/30/2019	8/31/2019	7/31/2019	6/30/2019
Cash, CDs & LAIF Investments:	$ 18,844,109	$ 19,088,332	$ 21,751,578	$ 24,551,976	$ 24,237,671	$ 26,353,608	$ 27,264,480
Days Cash on Hand	80.59	81.63	93.02	105.00	103.65	112.70	116.60
Athena Gross Accounts Receivable	$ 50,609,241	$ 51,533,089	$ 50,776,886	$ 48,766,032	$ 48,766,032	$ 44,505,205	$ 42,891,066
Average Daily Revenue	$ 443,212	$ 437,962	$ 444,616	$ 430,894	$ 440,084	$ 432,425	$ 420,533
Gross Days in AR	114.19	117.67	114.20	113.17	110.81	102.92	101.99
Key Statistics							
Acute Census Days	247	203	203	211	191	240	2,803
Swing Bed Census Days	16	14	14	23	15	7	454
Observation Days	27	32	44	36	38	39	485
Total Inpatient Utilization	290	249	261	270	244	286	3,742
Average Daily Inpatient Census	9.35	8.02	8.43	8.71	7.87	9.23	10.25
Average Acute Daily Charge	$ 12,959.53	$ 14,251.94	$ 13,682.15	$ 10,846.13	$ 10,281.36	$ 11,472.19	$ 10,982.78
Adjusted Daily Census (with OP)	38.53	36.75	40.88	35.91	41.27	41.54	38.29
Emergency Room Visits	703	726	767	641	868	889	9,153
Emergency Room Visits Per Day	23.4	24.2	24.7	21.4	28.0	28.7	25.1
Operating Room Inpatients	21	16	23	20	19	23	230
Operating Room Outpatient Cases	82	92	118	104	90	93	1,240
RHC Clinic Visits	2,546	2,423	2,377	2,439	2,377	2,675	29,446
NIA Clinic Visits	1,829	1,951	2,030	1,864	2,027	1,924	
Outpatient Hospital Visits	4,157	4,127					
Hospital Operations							**Fiscal 2019**
Inpatient Revenue	$ 3,408,357	$ 3,092,670	$ 2,969,027	$ 2,537,994	$ 2,117,960	$ 2,833,630	$ 35,770,899
Outpatient Revenue	9,581,304	9,301,405	10,838,533	9,608,636	11,774,827	10,843,405	110,939,678
Clinic (RHC) Revenue	536,445	506,364	541,363	458,568	593,322	465,433	6,784,060
Total Revenue	$ 13,526,106	$ 12,900,439	$ 14,348,923	$ 12,605,198	$ 14,486,109	$ 14,142,468	$ 153,494,636
Revenue Per Day	$ 436,326	$ 430,015	$ 462,868	$ 420,173	$ 467,294	$ 456,209	$ 420,533
% Change (Month over Month)	1.5%	-7.1%	10.2%	-10.1%	2.4%	1.8%	
Salaries	$ 2,469,711	$ 2,496,760	$ 2,536,958	$ 2,422,139	$ 2,528,362	$ 2,476,554	$ 25,697,886
PTO Expenses	190,609	294,562	266,736	254,834	254,720	269,335	3,255,428
Total Salaries Expense	$ 2,660,320	$ 2,791,322	$ 2,803,694	$ 2,676,974	$ 2,783,082	$ 2,745,889	$ 28,953,314
Expense Per Day	$ 85,817	$ 93,044	$ 90,442	$ 89,232	$ 89,777	$ 88,577	$ 79,324
% Change	-7.8%	2.9%	1.4%	-0.6%	1.4%	2.8%	
Operating Expenses	$ 4,014,639	$ 4,198,689	$ 4,370,650	$ 4,330,335	$ 3,930,250	$ 4,051,730	$ 49,294,043
Operating Expenses Per Day	$ 129,504	$ 139,956	$ 140,989	$ 144,344	$ 126,782	$ 130,701	$ 135,052
Capital Expenses	$ 630,855	$ 604,834	$ 589,185	$ 590,014	$ 589,257	$ 560,212	$ 7,103,119
Capital Expenses Per Day	$ 20,350	$ 20,161	$ 19,006	$ 19,667	$ 19,008	$ 18,071	$ 19,461
Total Expenses	$ 7,305,814	$ 7,594,845	$ 7,763,529	$ 7,597,323	$ 7,302,590	$ 7,357,830	$ 85,350,476
Total Expenses Per Day	$ 235,671	$ 253,162	$ 250,436	$ 253,244	$ 235,567	$ 237,349	$ 233,837
Gross Margin	$ 358,996	$ 53,621	$ 724,122	$ (522,456)	$ 435,083	$ 522,819	$ 1,772,471
Gross Margin Per Adjusted Day	$ 300.53	$ 48.63	$ 571.43	$ (484.97)	$ 340.09	$ 406.01	$ 126.82
Debt Compliance							
Current Ratio (ca/cl) > 1.50	2.19	2.29	2.21	2.20	2.26	2.19	2.12
Quick Ratio (Cash & Net AR/cl) >1.33	1.77	1.78	1.76	1.87	1.96	1.93	1.87
Days Cash on Hand > 75	80.59	81.63	93.02	105.00	103.65	112.70	116.60
Debt Service Coverage > 1.5	1.34	1.37	1.54	1.38	2.18	2.19	1.54
Debt Service Coverage > 1.25 > 75 cash	1.34	1.37	1.54	1.38	2.18	2.19	1.54

Northern Inyo Healthcare District
Income Statement
As of December 31, 2019

	Month To Date 12/31/2019	Month To Date 11/30/2019	Year To Date 12/31/2019	Year To Date 12/31/2018
Patient Services Revenue				
Inpatient Revenue	3,408,357	3,092,670	16,959,639	17,600,912
Outpatient Revenue	9,581,304	9,301,405	61,948,111	54,218,328
Clinic Revenue	536,445	506,364	3,101,494	3,169,540
Total Gross Patient Service Revenue	13,526,106	12,900,439	82,009,244	74,988,780
Deductions from Revenue	(6,606,120)	(6,002,790)	(40,189,012)	(38,051,346)
Other Patient Revenue	383	24,481	65,861	0
Total Net Patient Revenue	6,920,369	6,922,130	41,886,093	36,937,434
Income/Expense from Cost Reporting	(1)	23,576	47,131	3,129,782
Other Operating Revenue	744,442	702,760	4,618,688	4,871,717
Gross Operating Profit	7,664,810	7,648,466	46,551,912	44,938,933
Operating Expenses				
Repairs and Maintenance	12,468	54,740	114,547	298,339
Leases and Rental Expenses	50,901	35,296	154,194	417,212
Salary & Wages	2,469,711	2,496,760	14,930,484	14,585,645
Benefits	1,504,288	1,735,509	9,771,111	9,492,325
Non-Benefit Expenses	24,068	23,703	93,569	86,364
Professional Fees	918,617	920,625	5,114,450	6,166,669
Supplies	775,256	776,097	4,889,439	5,297,398
Contract Services	317,220	838,576	3,747,174	2,458,627
Other Department Expenses	180,293	115,586	702,510	493,334
Hospital Insurance Expenses	37,488	36,593	188,463	272,654
Utilities	120,727	109,534	788,868	787,020
Depreciation and Amortization	374,459	373,787	2,147,570	2,052,387
Other Fees	287,208	(148,797)	731,912	742,409
Interest Expense - Operating	233,110	231,047	1,393,539	1,409,897
Total Operating Expenses	7,305,814	7,599,056	44,767,830	44,560,280
Total Net Operating Profit (Loss)	358,996	49,410	1,784,082	378,653
Non-Operating Revenue				
Tax Payer General Support	48,743	48,743	292,459	292,458
Bond/ Tax Payer Bond Support	137,596	137,595	825,574	716,647
Fin Chgs-Pt Ar - Int Incm-Payors	2	918	2,900	9,108
Interest Income	34,560	36,638	284,784	302,976
Interest on Patient Account	1,367	493	8,356	26
Total Other Income	222,268	224,387	1,414,073	1,321,215
Grant Revenue	25,000	0	61,468	2,035,716
Other Non-Operating Income	1,596	1,596	7,980	19,628
Net Medical Office Activity	(689,191)	(582,868)	(3,278,711)	(3,256,579)
340b Net Activity	26,783	55,535	281,367	116,344
Donations	0	19,713	63,774	3,300
Rental Income	5,460	4,881	29,867	15,995
Gain/Loss on Sale of Assets	0	(31,762)	(31,763)	0
Gain - Investments - Other Income	(1,697)	4,524	17,214	5,080
Net Non-Operating Revenue	(409,781)	(303,994)	(1,434,731)	260,699
Non-Operating Expenses	45,000	50,000	225,000	0
Total Net Non-Operating Profit	(454,781)	(353,994)	(1,659,731)	260,699
Total Net Income	(95,785)	(304,584)	124,351	639,352

Northern Inyo Healthcare District
Balance Sheet
As of December 31, 2019

Assets	
Current Assets	
Cash and Liquid Capital	$ 3,544,476
Short Term Investments	13,606,064
PMA Partnership	801,030
Accounts Receivable	54,296,842
Allowances against Receivables	(32,281,394)
Total NIA Accrued Allowances	811,384
Total Accounts Receivable, Net of Allowance	21,204,064
Other Receivables	7,400,210
Inventory	2,071,838
Prepaid Expenses	1,373,576
Total Current Assets	50,001,258
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,193,799
Short Term - Restricted	150,577
LAIF - DC Pension Board Restricted	746,697
DB Pension	13,632,410
PEPRA	5,338
Total Limited Use Assets	14,384,445
Revenue Bonds Held by a Trustee	2,416,664
Total Assets Limited as to Use	18,145,484
Long Term Assets	
Long Term Investment	1,753,478
Fixed Assets, Net of Depreciation	
Fixed Assets	126,787,656
Accumulated Depreciation	51,728,072
Construction in Progress	1,839,000
Total Fixed Assets, Net of Depreciation	76,898,584
Total Long Term Assets	78,652,062
Total Assets	**$ 146,798,804**
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	$ 293,000
Accounts Payable	5,548,604
Accrued Payroll and Related	7,238,485
Accrued Interest and Sales Tax	122,728
Due to 3rd Party Payors	2,316,776
Other Deferred Credits - Pension	3,481,540
Total Current Liabilities	19,001,133
Long Term Liabilities	
Long Term Debt	39,253,947
Bond Premium	452,938
Accreted Interest	14,183,557
Other Non-Current Liability - Pension	32,705,323
Total Long Term Liabilities	86,595,764
Suspense Liabilities	22,871
Total Liabilities	**$ 105,619,768**
Fund Balance	
Fund Balance	39,449,164
Temporarily Restricted	1,605,520
Net Income	124,351
Total Fund Balance	**$ 41,179,035**
Liabilities + Fund Balance	**$ 146,798,804**